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Exploring the Experiences of Compassion in Men Living with Infertility

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requirements for the degree of
Doctor of Clinical Psychology
in the University of Hull

by
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Overview

This thesis portfolio comprises three parts: a systematic literature review, an empirical paper, and appendices.

Part One: The systematic literature review explores perceptions of masculinity in the context of infertility for men. A systematic search of relevant databases found eleven qualitative papers which met the inclusion criteria for this review. The National Institute for Health and Care Excellence quality appraisal checklist (NICE, 2012) was used to evaluate the methodological quality of the papers before a meta-narrative approach was used to synthesise the papers. Four overarching narratives were identified and summarised: multiple perspectives of masculinity; infertility's impact on self-perception of male identity; masculinity as an influence on coping with infertility; and "It's not ok for men to share": isolation and barriers to accessing support. Implications and suggestions for future research are discussed.

Part Two: The empirical paper explores experiential understanding of compassion in men living with infertility using Interpretative Phenomenological Analysis (IPA; Smith, 2009). Six men participated in semi-structured interviews. Three themes emerged which are described under the broad headings: self-perception; relationships; and 'it's opening that Pandora's Box again', with 6-subthemes developed from the data. Interpretation of the results is embedded in relevant literature of compassion and the clinical implications are discussed.

Part Three: The appendices compile resources from the systematic literature review and empirical paper, including author guidelines for the respective journals, a reflective statement and epistemological statement to inform the context of this portfolio thesis.

Total word count (excluding appendices): 19299

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Part One: Systematic Literature Review

Part One: Systematic Literature Review

This paper is written in the format ready for submission to the *Journal of Psychology of Men and Masculinities.*

Please see Appendix C. for the submission guidelines.

What can be Learned from Understanding Perceptions of Masculinity in the Context of Male Infertility? A Systematic Review of the Literature.

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Abstract

Background: Sociocultural contexts play key roles in shaping perceptions of masculinity. Previous reviews highlight the importance of viewing perceptions of masculinity through the lens of male infertility.

Aim: To contribute to an understanding of perceptions of masculinity in the context of male infertility and the resulting implications for men**.**

Methods: Key search terms were identified using an iterative approach ensuring the search was broad and inclusive. The quality of papers was assessed and the implications for the current review discussed. Meta-narrative synthesis was used to synthesise the literature.

Results: Four over-arching narratives were identified: (1) multiple perspectives of masculinity; (2) infertility’s impact on self-perception of male identity; (3) masculinity as an influence on coping with infertility; and (4)“It’s not ok for men to share”: isolation and barriers to accessing support**.**

Conclusions: The implications and suggestions for future research are discussed.

Introduction

Male infertility impacts 1 in 10 men in the UK (Joja et al., 2015; Datta et al., 2016) and globally 8–12% of couples experience challenges with fertility (Esteves et al., 2011). Of all infertility cases, approximately 40–50% are due to ‘male factor' infertility (Esteves et al., 2011; Kumar & Singh, 2015). Despite this, the understanding of the male experience of infertility is largely extrapolated from the literature about women’s experiences (Culley et al., 2013; Fisher & Hammarberg, 2012; Fisher et al., 2017).

In the UK and cross culturally, male-factor infertility is entwined with cultural fears and stigma. In many cultures, male infertility is a stigmatised topic (Greil, 1997): fatherhood represents adulthood, sexual adequacy, and normalcy (Hart, 2002), so when this is not possible men report experiencing shame (Greil, 1997). Informed by this, research has begun to explore the holistic impact of infertility for men and establish an understanding of the male experience of infertility independent of that of women. However, the connection between our understanding, the synthesis of this research, and application in real-life contexts is still lacking.

Two reviews (Fisher & Hammerberg, 2012; Hanna & Gough, 2015) drew together knowledge about factors compounding the male experience of infertility from the previous two decades. Both offered alternative perspectives towards understanding the experience of infertility for men that deviates from a focus on women. They generated discussion around themes specifically linked to the male experience of infertility, such as: ‘support seeking for infertility’ and the ‘emotional impact of fertility difficulties’, whilst simultaneously challenging perceptions of ‘traditional’ masculinity and acknowledging the contexts in which men living with fertility challenges exist.

However, the review by Hanna and Gough (2015) highlighted omissions in understanding the experience of infertility for men. One such omission was the link to masculinity. This led the authors to ask: “To what extent is masculinity and infertility connected with men’s experiences of infertility” and “Do men feel stigmatized by infertility diagnoses, and how does such stigma affect the lived experiences of men as they navigate infertility?” (Hanna & Gough., 2015, p. 11).

This raises pertinent questions relating to the notion of masculinity, and the ways in which it is defined and conceptualised. While ‘traditional’ masculinity is generally understood with respect to status, gender roles and expectations (Connell & Messerschmidt, 2005), it is also necessary to explore masculinity within a shifting social context in which modern redefinitions evolve to encompass the heterogeneity of male experiences (Hanna & Gough, 2018).

Acknowledging this, this review aims to focus on perceptions of masculinity across relevant literature about male experiences of infertility. The emphasis of the review is on contributing to discussions about understanding perceptions and attitudes towards male infertility and the resulting implications for men. It seeks to add an understanding about how perceptions of masculinity in the context of infertility impact accessibility of support for men living with fertility challenges, by asking: ‘What can be learned from understanding perceptions of masculinity in the context of male infertility?’

In doing so it tries to preserve the nuance of different perspectives of masculinity through a constructivist lens and not to represent a singular view of masculinity in the context of infertility.

Method

Approach to Analysis

The systematic review was conducted using a meta-narrative synthesis (Greenhalgh et al., 2005; Wong et al., 2013). Meta-narrative synthesis has emerged through the modernisation of methods used in health settings to synthesise evidence across multiple disciplines and fields. It aims to disentangle overarching narratives from a complex, varied body of literature while developing new insight.

The method is suited to exploring tension across literature, as well as variety in research approaches, perspectives, and assumptions (Wong et al., 2013). This makes it suitable for this review which seeks to synthesise sources that vary across contexts presenting the potential for discrepancy in the definition and construction of ‘masculinity’ and ‘infertility’.

The methodology is also particularly relevant to shaping a diverse understanding of a topic, rather than identifying consensus of a single story or a common set of experiences (Greenhalgh et al, 2005) and is compatible with the first author’s epistemological position (see Appendix B).

Information Sources

An electronic search was carried out across several databases: Medline, Academic Search Premier, CINAHL Complete, APA PsycArticles, and APA PsycInfo. These databases were chosen to include both psychological and broader health literature.

Search Strategy

The search strategy followed an iterative process exploring the search terms that yielded the most relevant literature. The search terms were discussed with the second and third author, and additional synonyms were considered. Following an initial scoping search, the following search terms were used:

(Experience* or perception* or attitude* or view* or feeling* or qualitative).

AND

(Men or man or “men’s” or “man’s” or male* or masculin* or manhood) AND (Infertil* or infertile* or procreati*) (in Title).

Selection Strategy

Screening of papers was carried out in three stages. Duplicate papers were removed during the initial screening. The remaining papers were then excluded at each stage if they did not meet the inclusion and exclusion criteria.

The first author was the primary reviewer carrying out the search and deciding the eligibility of studies to be included in the review, though the inclusion and exclusion criteria were influenced and agreed by the second and third authors.

Table 1.

Paper Inclusion and Exclusion Criteria and Rationale

Inclusion Criteria	Rationale
Available in English	To be read and understood by the researcher
Qualitative Design	The review is interested in experiences and perceptions of masculinity, therefore qualitative data is most suitable to answer the question
Peer Reviewed	To ensure papers of sound quality
Participant group men (or mixed participant group with sufficient focus on men)	The review is interested in the experiences of men in the context of infertility research
Exclusion Criteria	**Rationale**
Review Paper	The review aims to review and synthesise original research
Quantitative (or mixed methods where quality and/or quantity of the qualitative results was not sufficient)	Not suitable for answering the research question or providing necessary insight to lived experience
Mixed gender participant group (where insufficient reference to men's experiences)	The review is primarily interested in men's experiences
No reference to the theme of masculinity	The review is interested in perceptions of masculinity in the context of male infertility

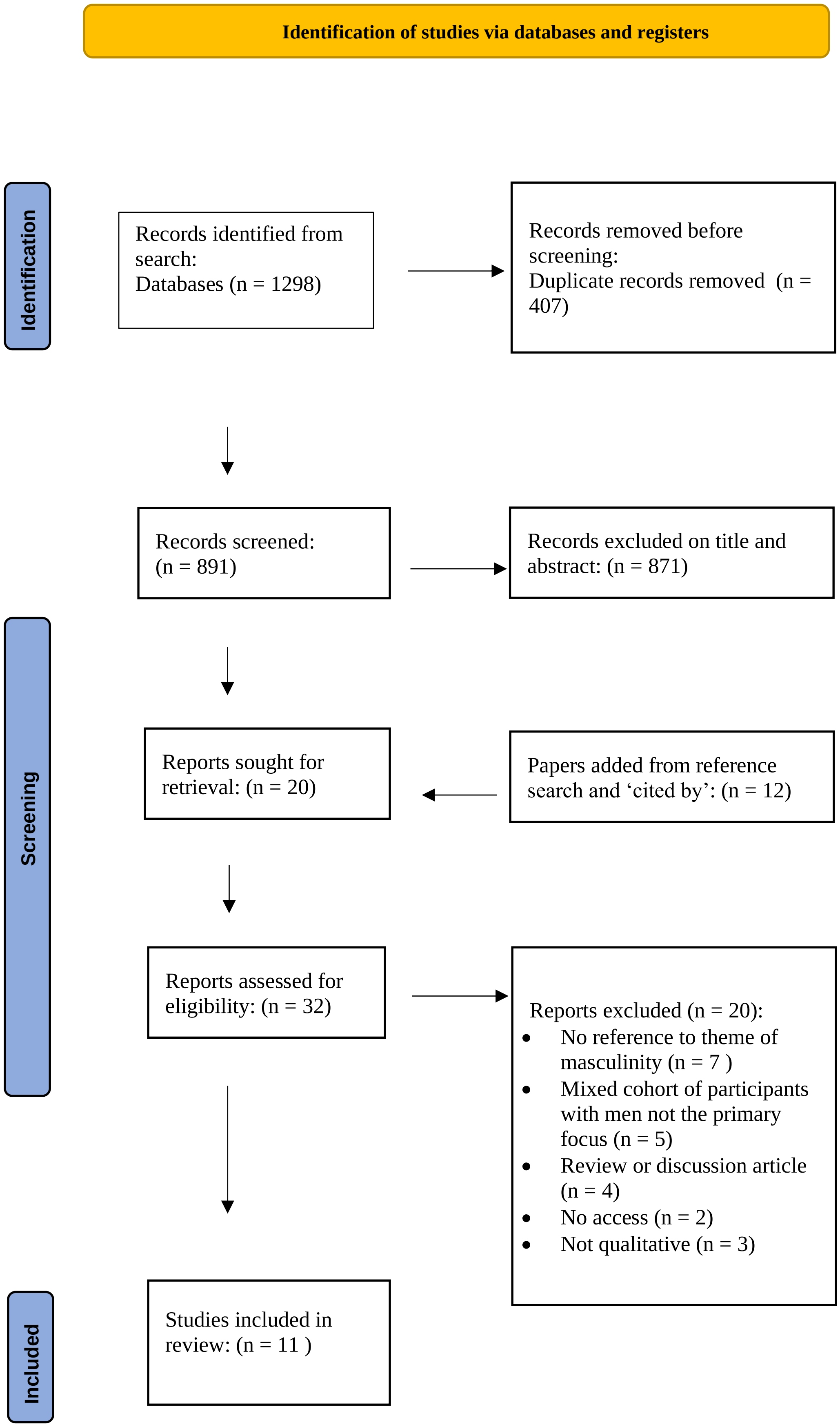
Following the initial search, papers were reviewed by title to select only relevant studies that explored experiences of infertility. Secondly, abstracts were screened to ensure that the papers selected included participants that were majority men and/or there was substantial reference to men's experiences. Finally, full text papers were screened. A detailed review of the methodology and results sections was conducted to look for emergent evidence of the theme of masculinity (primarily reported by participants or provided in quotations and judged to be describing perceptions of masculinity).

To ensure a complete search of the literature, articles that cited these papers were also reviewed, as well as references. Twelve additional articles were identified as relevant to the review, and these were screened, resulting in two additional papers being included in the review.

In total, 11 papers were included. See Figure 1 for a diagrammatic view of this process.

Figure 1

The Paper Identification and Selection Process Following the PRISMA Guidelines (PRISMA; Page et al., 2021)



Quality Review Tool

The National Institute for Health and Care Excellence (NICE, 2012) quality appraisal checklist (Appendix G) was used to assess the quality of the papers selected for inclusion in this review. The checklist assesses 14 aspects of qualitative research, rating each aspect on a three-point scale. The ratings are summarised by one of three overall ratings: '++' (all or most of the checklist criteria have been fulfilled, and where they have not been, the conclusions are very unlikely to alter); '+' (some of the checklist criteria have been fulfilled, but where they have not been, the conclusions are unlikely to alter); and '-' (few or no checklist criteria have been fulfilled and the conclusions are likely to alter). See Appendix H for ratings of included papers.

This tool was selected as it offered a framework to assess relevant characteristics of qualitative research, and factors which may affect the trustworthiness of the included papers. It is focussed on characteristics of qualitative research rather than characteristics of specific research traditions and is particularly designed to allow the simultaneous assessment of different qualitative approaches including: data from interviews, qualitative questionnaires and data collected from online forums.

Twenty five percent of the studies, selected randomly, were checked for inter-rater reliability by the researcher and a peer. Any disagreements, for example a disagreement about the importance of explicit reference to the researcher's position in the research, were discussed. This was resolved to conclude the importance for this to be clear due to the papers being qualitative, and the relevance of being a female researcher in the context of understanding men's experiences. Following resolution of this disagreement all studies were agreed as shown in Appendix H. No papers were excluded based on the quality assessment, nevertheless the scores provided an opportunity to evaluate the range in quality of methods of the selected papers.

Researcher Position

The first author is a white-British female, employed as a trainee clinical psychologist in the NHS. Their professional identity shapes their interest in completing this review and motivation to promote access to care and explore barriers for different groups of people. The researcher participated in regular research supervision throughout the process to reflect on their lens and perspective, and the implications of this for the transparency of the review.

Process of Analysis and Synthesis

Data were initially extracted from the abstracts, specifically drawing focus to research that looked at men's experiences of infertility. Secondly, papers that specifically either explicitly or implied – highlighted themes related to the construct 'masculinity' were identified. From those identified papers, the reviewer extracted information about the participant group, researcher's position, the methodology, the geographical location, field or discipline, and the aims of the research in order to capture the similarities and differences of the selected papers.

Below is a summary of the steps undertaken in the synthesis, following methods set out by Greenhalgh (2005):

1. *Planning phase*: devising the review question, and initial scope of sources for the availability of relevant research, and literature.
2. *Search and mapping phase*: narrowing the focus of the review to key concepts, ideas, demographics, and methodology.
3. *Appraisal phase*: complete quality assessment of selected papers, and critical appraisal of relevance to review question. Extract key results from selected papers.
4. *Synthesis phase*: identify key themes and derive a narrative account of the contribution of these themes towards the research question; as well as identifying any conflicting narratives within and between papers.

5. *Recommendation's phase*: summarise the overall narrative from the literature, embedded within other relevant theories and evidence. Use the generated narrative to distil and discuss recommendations for practice.

Results

Characteristics of Included Studies

In total, 11 papers meeting the inclusion criteria were included. Table 2 summarises the characteristics of the included studies.

Six studies used UK based samples, though participants within these represent multiple ethnicities. Geographically, the remaining five studies represent populations from South Africa, Australia, Western Africa, and Canada. All studies include men with experiences of infertility; while some looked at male and female experiences of infertility, it was stipulated that exploration of male experiences needed to be sufficiently proportionate to female experiences for inclusion in the review.

All data across the papers were qualitative, though the format and methodology varied: five completed interviews; one collected data from a focus group; four used data from online forums; and one gathered data from a qualitative questionnaire. Data were analysed by either thematic analysis (Malik & Coulson, 2008; Hanna & Gough, 2016; 2018; 2020; Patel et al., 2019; Dierickx et al., 2021; Pearson et al., 2021), grounded theory (Dyer et al., 2004; Blell, 2018), thematic review (Dolan et al., 2017) or phenomenological analysis (Webb & Daniluk, 1999).

The selected studies represent a range of fields of interest and disciplines, however, the overarching research question and results presented were relevant to the question of the current review, exploring the intersection of infertility and masculinity.

Table 2

Characteristics of Included Studies in the Review

Author(s), year and geographical location	Academic discipline	Aims of the study (as stated in the paper)	Methods	Participants and identifiable demographic information	Analysis of qualitative data	Key findings (themes relevant to thematic synthesis underlined)	Quality assessment score (NICE checklist; max score = 28)
Blell (2018), UK, British Pakistani communities	Health and wellbeing	To explore the relationship between gender and engagement with infertility treatment, focusing on British Pakistani men facing disrupted fertility.	A mixed-methods, multi-site ethnographic approach, completed across 2 phases: (1) A life-history interview (with women and men or differed ages and reproductive status) N = 86 (2) Semi-structured interviews with individuals and couples undertaking fertility treatment.	(1) N = 86 men and women from North- East England (age and reproductive status not stated); (2) N=15 British Pakistani men and women with infertility who had either undergone, or were undergoing fertility treatment (6 couples, 3 individual women).	Thematic analysis using grounded theory (Strauss and Corbin, 1998)	Themes: 1 Pakistani couples communication, and encounters with professionals 2 Masculinity and anger 3 Conjugality, blame, and disengagement	12 (-)
Dierickx et al (2021), The Gambia	Interdisciplinary (Sociology; reproductive health)	The study aims to contribute an understanding of male infertility in The Gambia, to a larger anthropological and health systems	A qualitative study using semi-structured interviews (interviews completed in English or local language with	N= 13 (age 21-50) (Marital status:11 = monogamous; 1 = 2 wives; 1 = 4 wives) (Children: 8 = childless; 5 = at least 1 child but difficulties with	Thematic analysis (Braun and Clarke, 2006).	Themes: 1 Aetiology knowledge of infertility. 2 Gendered interpretations and experiences of infertility.	27 (++)

		research programme designed to understand the lived experiences and access to appropriate care among people with infertility in Senegal (Casamance) and The Gambia (West Coast region)	translator).	subsequent conception)		3 Coping strategies	
Dolan et al (2017), UK	Sociology	To overall focus on exploring men’s experiences of infertility as a means of distinguishing the impact of the condition from the impact of its treatment.	A qualitative study using semi-structured interviews.	N= 22 men experiencing male factor infertility (self-identification)	Thematic review (Russell et al., 2009)	Themes: 1 Conceptualising men’s desires for children and help-seeking behaviour. 2 Men, masculinity, and diagnosis of infertility 3 Men, masculinity and living with infertility.	27 (++)
Dyer et al (2004), South Africa	Clinical science and medicine	To evaluate men's reproductive health knowledge with regard to fertility and infertility, to review health-seeking behaviour and to gain insight into their experiences of 'involuntary childlessness'.	A qualitative study with a grounded theory approach utilising semi-structured interviews in native language, transcribed into English.	N = 27 (Ethnicity: 9 black-skinned men (Xhosa-speaking); 6 brown-skinned men (Muslim community); 12 white-skinned men) (Marital status: 24 married; 3 unmarried) (Children: 14 have no living child at point of interview;	Grounded theory (Bryman and Burgess, 1996; Creswell, 1998)	Themes: 1 Knowledge of human fertility 2 Knowledge of causes of infertility 3 Expectations and concepts of modern infertility management 4 Treatment-seeking behaviour 5 Experiences of infertility 6 Effects on marital	18 (+)

				13 with a child).		relationships 7 Experiences in the family setting 8 Experiences in the community.	
Hanna & Gough (2016), UK-based forum	Interdisciplinary (Psychology; social psychology)	To further develop an understanding of how men experience infertility, and the emotional impact of infertility for men; and to more broadly develop insight into men's emotional experiences in relation to their reproductive journeys to contribute knowledge about the contemporary experience of men as fathers, and the emotional investment men may place in becoming fathers	A qualitative study using a netnography approach, and inductive thematic analysis - central question is 'how do men emote infertility online? '	UK (Online forum) 13 threads chosen for analysis: 415 posts; 20 different posters	Inductive thematic analysis (Braun and Clarke, 2006)	Themes: 1 The emotional rollercoaster 2 The tyranny of infertility 3 Infertility paranoia	23 (++)
Hanna & Gough (2018), UK-based forum	Interdisciplinary (Psychology; social psychology)	To explore men's help seeking behaviour online and the value and role of online forums for furthering our understanding of how men can best be supported as part of their fertility	A qualitative approach using thematic analysis to analyse online forum posts.	UK (Online men-only forum) 415 posts involving 20 unique contributors.	Thematic analysis (Braun and Clarke, 2006).	Themes: 1 The value of insider male-only support 2 It's ok to share, isn't it? 3 Getting things off your chest: Men's help seeking language. 4 The shadow of	22 (++)

		experience.				hegemonic masculinity	
Hanna & Gough (2020), UK	Interdisciplinary (Psychology; social psychology)	To explore the experience of men with a diagnosis of male-factor infertility.	A qualitative approach using thematic analysis to analyse qualitative responses to questionnaire.	N = 41	Thematic analysis (Braun and Clark, 2006).	Themes: 1 Failing at masculinity. 2 Invisibility 3 The trauma of infertility.	23 (++)
Malik & Coulson (2008), UK-based forum	Psychology	To seek to explore the psychological adjustment of couples to infertility through understanding the processes by which both men and women cope with infertility, with a particular exploration of the under-researched male perspective and male-experience of infertility	A qualitative approach using thematic analysis to analyse online forum posts.	UK (online forum) 53 threads; 728 messages (166 unique posters).	Thematic analysis (Braun and Clark, 2006).	Themes: 1 ‘Supporting partner dearest partner is our key role’. 2 ‘Is this a good or bad pain’ 3 ‘Us blokes are mere spectators in most people’s eyes’ 4 ‘Sometimes a male perspective' is needed’ 5 ‘I don’t want to get my hopes up, but I can’t help it.’	21 (+)
Patel et al (2019), International online form	Interdisciplinary (Reproductive health; social psychology)	To engage with online digital resources to explore men’s experiences of sharing experiences with other men and to explore how men use online forums when experiencing fertility difficulties.	A qualitative approach using thematic analysis to analyse online forum posts	603 online posts	Thematic analysis (Braun and Clark, 2006).	Themes: 1 Seeking and Providing Advice in Online Communities 2 Negative Emotions of Internalising Stigma 3 A Safe Space Online for Men to Share Anonymously	20 (+)

Pearson et al., (2021), Australia	Sexual and reproductive health	To explore reproductive-aged men's fertility-related information-seeking attitudes and behaviours	A qualitative approach using focus groups of men experiencing infertility.	N-39 (Focus groups: (a) aged 18-30, (b) aged 31-45). 3 focus groups per age group.	Thematic analysis of focus groups (Braun and Clarke, 2006)	Themes: 1. No need for fertility-related information 2. Knowledge and awareness of fertility 3. Fertility is women's business 4.Fertitity and manhood	24 (++)
Webb & Daniluk (1999), Western Canada	Masculinity studies	To explore the experience of men diagnosed with male-factor infertility.	A qualitative study with a qualitative phenomenological approach via interviews. Q: What is the experience and meaning of infertility as lived by infertile men?	N = 6 (age 28 – 39). Diagnosed male-factor infertility. (Children: none with children).	Phenomenological analysis (Colaizzi, 1978)	Themes: 1 Sense of profound grief and loss 2 Sense of powerlessness and loss of control 3 Sense of personal inadequacy 4 Sense of betrayal and isolation 5 Sense of threat and foreboding 6 Desire to overcome and survive 7 Need to positively construct their experience.	23 (++)

Quality Assessment

While the general quality of papers is good there are some exceptions. The paper by Blell, (2018) scored low relative to the other papers in this review. The authors reflect on the cultural context and underpinning values and assumptions that create the foundation for the research and subsequent research questions, however the participant group being represented was niche, with participants primarily recruited from IVF clinics in an isolated geographical region. Therefore, there may be lack of transferability of the outcomes of this research due to the narrowness of the sample. Similar quality issues were identified in the research by Webb and Daniluk (1999).

Issues of misinterpretation and trustworthiness of the analysis was considered in papers by Blell (2018), Dyer et al. (2004) and Dierickx et al. (2021) due to translation. The studies by Hanna and Gough (2016; 2018), Malik and Coulson (2008) and Patel et al. (2019) all retrieved data from online forums. Each had a lack of transparency of the position of the researcher and subsequent impact on the robustness of results with insufficient reflexivity about possible researcher bias. Similar evaluations were made about the use of focus groups by Pearson et al. (2021), and subsequently this paper scored low in quality and transparency of methodology and representation of the target population.

Finally, while papers by Hanna and Gough (2016; 2018; 2020) scored highly across most aspects of quality assessment, specifically their rationale for using a qualitative approach, richness of data and ethical considerations, there are inherent implications of the inclusion of several papers by the same authors. Issues of transparency and the influence of researcher bias in their contribution to the overall discourse surrounding men’s experience of infertility was considered.

Data Synthesis

Four overarching themes were identified within the literature which can be interrogated to establish a more comprehensive and encompassing understanding of the intersection between infertility and masculinity. Themes have been summarised into four overarching narratives: (1)

multiple perspectives of masculinity, (2) infertility’s impact on self-perception of male identity, (3) masculinity as an influence on coping with infertility, and (4) “It’s not ok for men to share”: isolation and barriers to accessing support.

These themes each inform the other and it is not clear that there is a rigid delineation between them. However broad thematic categories can be drawn, while acknowledging that the boundaries between them are permeable and fluid.

Multiple perspectives of masculinity

A key narrative that is woven through the literature establishes the theme ‘multiple perspectives of masculinity’ as central to understanding men’s experiences of infertility. This theme is represented by participants, authors, and wider socio-cultural perspectives and the synthesis seeks to grapple with the inconsistencies – related to cultural and social context and the positioning of the research in time - in how perceptions of masculinity are represented.

Pearson at al. (2021) embeds the discussion of masculinity within the context of gendered instinct for parenthood. This idea is also discussed by Dolan et al. (2017) who found that men reflect that they “don’t have the same drive” (Dolan et al, 2017, p. 882) as women to have a child or a family. Both papers represent a modern Western perspective though this is not the only viewpoint.

Interviews with men from the Pakistani community in North East England (Blell, 2018) tell a different story which represents cultural and religious perspectives on fatherhood: the role of fatherhood is seen as equal to motherhood and the role of a man in the community is to father and to pass down to the next generation (Chorley, 2005, as cited in Blell, 2018).

A further example where the importance of culture in shaping perceptions of masculinity was shared through research by Dierickx et al. (2021) which represents another perspective through their research with men in The Gambia. Here, infertility symbolises “black magic” or “God’s will” (Dierickx et al., 2021, p. 5), emphasising the significance of cultural diversity in understanding infertility and what it represents. In these contexts, infertility threatens both relational and intergenerational markers of masculinity.

Blell (2018) discussed the complexity of the intersectionality of gender, culture and infertility, as a framework for understanding experiences of accessing health services through an individual's journey with infertility. Where some men talked explicitly about the experience of infertility being an "attack on maleness" (Webb & Daniluk, 1999, p. 10), others reflected on the challenges with more nuance. For example, men discuss the accessibility of health services and fertility clinics in the context of cultural diversity, language barriers and socio-economic status. Pakistani men living in North East England reflected that "[they] have no money, [and they] have no skills," and on the implications of this in positioning them as powerless in UK health systems (Blell, 2018, p. 123). The author suggests that the impact of this lack of "skill" and "power" (p. 123) contradicts embedded notions of masculinity, and that this contradiction leads to a further sense of emasculation.

Within the research some men describe an incongruence between their lived experience of infertility, motivations for seeking support, and the pressures of social perspectives of being a 'man' (Dolan et al, 2017). Some reflected on the feeling of isolation that manifests from hiding the pain they experience through their challenges with infertility. This was referenced explicitly in the context of the desire for parenthood – "On the surface it's a bit different but deep down it's the same" (Dolan et al., 2017, p. 882). Across several papers, men suggest that disclosure and seeking help are blocked by fears of pity or ridicule and that this is a barrier to accessing support. Men discuss the need to meet traditional expectations of 'being a man' in their social and cultural context and to represent strength and stoicism for themselves, as well as being a pillar of strength for their partners (Malik & Coulson, 2008; Hanna & Gough, 2020).

Yet some of the research offers alternative perspectives that challenge gendered stereotypes and perceptions that men are insular and private, while women are open and emotional (Hanna & Gough, 2018). They reflect greater nuance and illustrate exceptions to the rigidity of perceptions towards masculinity. For example, men discussed their worry and isolation in their experiences of infertility. Many suggested that this motivated them to seek connection, form relationships and access networks of support with other men with similar experiences, though they still found it difficult to articulate their feelings and their experiences (Hanna & Gough, 2018; 2020). They expressed wanting support through the challenges of their experience and were seeking a feeling of togetherness and community (Hanna & Gough, 2018). Online spaces and forums were reported as being beneficial in enabling this support and in providing a space for unfiltered help-seeking, normalisation and validation from likeminded people. Others directly countered gendered stereotypes with their desire to parent, discussing their grief and distress surrounding infertility and subsequent autobiographical shift (Hanna & Gough, 2020).

Infertility's impact on self-perception of male identity

The impact of infertility on men's self-perception and construction of their identity is evident. The influence of broader social narratives appear to lead to the adoption of a unique and complex narrative of the self as a man in the context of infertility.

Men likened their experience of infertility to being "trapped", acknowledging the comprehensive and far-reaching impact that infertility has in relation to the self, relationships, future plans and finances (Hanna & Gough, 2016, p. 15). These authors discussed how men closely identify with infertility as an identity; the desire for parenthood and the aspiration to become a father is pertinent. This feeds into to a self-image of powerlessness and vulnerability in the instances where fertility challenges are faced.

This narrative was also identified in the research by Webb and Daniluk (1999) with men in Canada and suggests that introspection in the context of infertility is ingrained and cross-cultural. Men in this research discussed the implications of infertility on their position as a man, both in their relationships and in society, which reflected feeling "inadequate" (p. 15) in their roles. This represents an incompatibility with their self-perception through a masculine lens and is viewed by some as an attack on their “maleness” (p. 10). However, this does emerge as a stark contradiction with other research which positions parenthood in men as a lesser or secondary aspiration (Dolan et al., 2017).

The narratives of men are reflected within the community, yet there is diversity in their individual lived experience. Dyer et al. (2004) found that men in South Africa talked about the criticism they faced in their community and the implications of infertility as a threat to their masculinity. Reference to criticism and slurs such as “incabi” (p. 964) (meaning castrated cow) illustrate the impact of this. Men reflect on the cultural expectations of having children and the implications of not being able meaning that “you are not considered an adult, and not treated as a man” (p. 964).

The impact of infertility on male identity extends to perceptions of the self in the role of a partner or husband. Men discuss their experience of distress as two-fold: the experience of pain for themselves and the vicarious pain of watching their partner in their distress (Dolan et al., 2017). The accounts shared by men are saturated with narratives about expectations of responsibility and success in their ability to conceive. This can then create feelings of blame when not possible or straightforward.

A different perspective is explored by Webb and Daniluk (1999) which offers an alternative to the narrative of self-blame, through externalising causes of infertility and creating distance between narratives of infertility and perceptions of the self. Men instead talked about viewing infertility as a betrayal of God: “we were both angry at God”. Here, infertility is the impact of a greater power (Webb & Daniluk, 1999, p.16), though this was not a consensus between participants. There is a clear distinction between this attitude (which situates infertility within a person’s broader position within the world, especially within a religious context) and a more individualistic, self-blaming attitudes expressed by modern British men as seen in Dolan et al., (2017).

A contradictory perspective offered by other men suggested that their experience of infertility was ladened with less of a sense of shame, guilt and responsibility, framing infertility as something that “you can’t really control”. Instead, there was acknowledgement of the disappointment felt rather than the guilt, or interference with self-perception or identity (Pearson, 2021, p. 4). There was also an identification of resources that supported these men in building strength and confidence in their self-perception as a man. Patel (2019) discussed how men access support from other men which allows them to feel equipped with knowledge and experience empowering them in their role as a man and as a partner.

Masculinity as an influence on coping with infertility

This theme illustrates the way in which men’s internalisation of masculinity influences the way that they seek to cope with and navigate their journey with infertility, in the context of wider narratives around gendered help-seeking behaviour.

Dolan et al., (2017) describes how some men are motivated to conceal their emotions surrounding infertility from those around them. Men in this research spoke of their desire to be strong for their female partner and so concealing their own distress was the priority. This reflects the juxtaposition of a stoic exterior, alongside the “sledgehammer blow” (p. 884) being battled internally. Men articulated that they did not know how to share their emotional experiences in their close relationships and signalled a preference for health care professionals to communicate this with their partner on their behalf. This represents an underlying nuance to the ways in which men expressed their emotions to their partner, whereby men do want their partners to understand their experiences but seek detachment from being the one to start the conversation or introduce the idea.

However, other men explained that they would rather talk to friends and family about their experience than a stranger or professional (Pearson et al., 2021). Somewhere in the middle, men described using online forums for support, providing space to confront and grapple with difficult emotions, whilst maintaining anonymity (Hanna & Gough, 2016). This experience was not found to be universal though. While some used disguise to shield their emotions from those around them, others were able to openly confront emotions such as grief, sadness, anger and frustration (Webb & Daniluk, 1999; Dyer et al., 2004).

While aiming to protect themselves from negative emotions linked with infertility, men describe that refusing to confront their feelings can paradoxically lead to further detachment and isolation from others including their partners, ultimately contributing to worse emotional states (Webb & Daniluk, 1999).

When these emotions and broader feelings of emasculation stemming from infertility are unresolved, research suggests that this can contribute to instances of domestic abuse in relationships. In their research with men in South Africa, it was found that some men were "[taking] out [their] frustration" on their partner (Dyer et al., 2004, p. 964). This highlights that the need for men to be able to confront their emotions and avoid overwhelming sensations of frustration and anger has broader benefits outside of men's own perception of their masculinity.

What has been shown to be useful for some men is encountering others with similar experiences. In certain instances, this transformed their ability to cope and navigate their own journey (Webb & Daniluk, 1999). Where this was reported, men reflected that seeing their experience from the perspective of others and giving space to process their emotional suffering allowed for reflection about personal growth in their capacity for compassion, empathy and sensitivity. Others also reflected that the interview context gave them the opportunity to talk about their emotional response to infertility and the enmeshment with their identity as a man. Men spoke of their reluctance to disclose to their partner or family out of fear for repercussions for their relationships, reflecting to the researcher that "this is the first time I've had the opportunity to talk about [infertility], we rarely talk about it"- (Dierickx et al., 2021, p. 8).

"It's not ok for men to share": Isolation and barriers to accessing support

The literature represents a complex relationship between men's self-perception of masculinity and the implications for help-seeking and accessing support. Having an awareness of narratives around gendered stereotypes towards help-seeking behaviour are intrinsic to a growing understanding of men accessing fertility related support and potential blocks, barriers and resistance.

Hanna and Gough (2020) explored men's help-seeking behaviours on an online forum. The themes that emerged from some of the users highlighted a deep connection with themes consistent with traditional perspectives of masculinity. Users of the online forum reflected on their role as men in their relationship and in society, emphasising the narrative that men do not seek help. Men discussed behaviours that infer prioritising stoicism and emotional restraint in order to promote the wellbeing of others and to remain congruent with social perceptions of masculinity.

However, some men shared an alternative perspective of help-seeking online. Some shared their attraction to the anonymity of online forums and the 'permission' this gives them to seek support under a guise. Others' posts reflect their suppression of emotions and motivation to trivialise their experience, relative to that of their partner, which is perpetuated by overarching narratives that it is not ok for men to share in visible forums (Hanna, & Gough, 2018).

As well as anonymity, men shared several benefits of online help-seeking and learning that you are not "the only one" (Hanna & Gough, 2020, p. 472). This was also represented elsewhere in the literature where men suggested that finding forums of support helped establish a sense of normality and helped to create a context where they can share stories, tell intimate details of their fertility journey and feel empowered, offering a relief from their internalised stigmatisation (Patel et al., 2019). This narrative was weaved through several of the papers, suggesting that men use online forums to share authentic experiences of their journey with infertility and to represent and normalise these experiences. However, the method of using online forums, similar to other papers employing the same methods, raises questions about the robustness of the methods used to interpret themes, and the resulting discrepancy in the representation of the population being studied.

While the majority of papers included in this review represent UK-based populations, several papers in the literature represent diverse cultural perspectives. Culturally normed practices in the UK, for some, are experienced to increase barriers to accessing fertility care and support provisions. For some men, requests for sperm samples or attendance to clinics deviate from their culturally derived expectations around the role of men in healthcare and expectations around men's help-seeking behaviour (Dyer et al., 2004). Western health care settings and expectations of men were experienced as uncomfortable or embarrassing within the cultural context of the participants, creating isolation and stigma around men accessing fertility care.

Additionally, men also discussed that Western discourse around marriage and intimacy has led to miscommunication and incongruence regarding expectations of practitioners around men's involvement with fertility care. For example, Blell reported that clinicians viewed men's lack of attendance to clinic appointments as a signal of problems in the relationship (Blell, 2018). For men who were unable to speak English, this language barrier was another obstacle in seeking support and accessing fertility care for men, creating isolation and a sense of exclusion.

Isolation in the context of fertility-care was a theme across several papers. Men shared experiences of feeling excluded from their care, for example, with letters being solely addressed to "Mrs", and services providing "female centric-care" (Malik & Coulson, 2008, p. 24). Others reflected on damaging narratives about men's role in fertility which positions them as a purely practical element – or a mechanical "solution" – as opposed to an emotionally invested participant in the fertility journey in their own right. This led to men reporting feeling like the "passive observer", perpetuating a reluctance to disclose their own emotions, or seek support for distress (Hanna & Gough, 2020, p. 474).

Discussion

This paper is the first to synthesise a narrative review of the literature exploring perceptions of masculinity in the context of male infertility. Across four overarching themes: multiple perspectives of masculinity; infertility's impact on self-perception of male identity; masculinity as an influence on coping with infertility; and "It's not ok for men to share": isolation and barriers to accessing support, the review draws together research which rebuts the perspective that, within an evolving and increasingly liberal social context, traditional perspectives of masculinity are diminishing. However, it also introduces alternative perspectives and begins to create a nuanced understanding of the evolution of perceptions of masculinity through the lens of male infertility and the application of this new understanding to clinical settings.

The literature represents complexity in the intersectionality of gender, culture, and infertility and its impact at different stages in the infertility journey (Malik & Coulson, 2008; Blell, 2018; Dierickx et al., 2021). Experiences consistent with pervasive narratives about stereotyped perspectives of masculinity are both outlined and contradicted in the literature about male infertility. The myriad of perspectives of masculinity permeate into the experience of infertility for men and closely influences their self-perception on their journey with infertility (Webb & Daniluk, 1999; Dyer et al., 2004; Hanna & Gough, 2016; Dolan et al., 2017; Patel et al., 2019; Pearson, 2021). This review is sensitive to cultural difference in experiences of infertility and the integration of these different contexts in understanding the impact of these narratives on self-image. There is a recognition that the variation is widespread and represent cultural, social and temporal differences.

The synthesis of the literature explores many influences on men’s help seeking behaviour; it represents inconsistencies in men’s motivation, action, and apprehension towards sharing their emotional experience through constructing a narrative about the influence of perspectives of masculinity (Webb & Daniluk, 1999; Dyer et al., 2004; Hanna & Gough, 2016; Dolan et al., 2017; Dierickx et al, 2021; Pearson et al., 2021). The review also begins to shape an understanding of the subsequent implications for help-seeking through exploring barriers to help-seeking for men, represented at an individual, relational and systemic level (Dyer et al., 2004; Malik & Coulson, 2008; Patel et al., 2019). It highlights the relevance of context for understanding men’s motivation for accessing help, as well as outlining what enables help-seeking and support (Webb & Daniluk, 1999; Dyer et al., 2004; Hanna et al., 2018 & 2020).

What emerges is a contrast between the perception of maleness within modern Western ideas of parenthood (and the prioritisation of it) and the perception of fatherhood among non-Western groups. One perspective suggested that both individual and systemic narratives in modern Western societies, in some instances, position men and their role in fertility care and parenthood as secondary to that of women (Dolan et al., 2017; Pearson at al., 2021). The outcome of this is reports of Western men experiencing less of a drive to become a father than non-Western men. These narratives reinforce the expectation that men with a strong desire to parent, or men who are emotionally impacted by infertility, are different or have experiences which are incongruent. The implications of this narrative, which reflects exaggerated and traditional stereotypes of hegemonic masculinity (Connell & Messerschmidt, 2005), creates isolation, as well as rigid expectations of men around conception and parenthood, without an understanding of what infertility represents for them as an individual.

Viewed as a whole, the literature represents and outlines the influence of complex systemic influences on the interaction between perceptions of masculinity and the experience of male infertility. This can be understood within the framework of Bronfenbrenner's socio-ecological model (Bronfenbrenner, 1979, as cited in Darling, 2007) which explores the interaction of complex factors in maintaining a narrative, or pattern of experience; it offers a framework for providing insight and an evaluation of the complex web of systemic influences relating to a man's experience of infertility. Pervasive narratives of hegemonic masculinity can distract from the pain, emotion and lived experience of infertility for men and are therefore harmful in obscuring (and narrowing) our perspective of men's experience of infertility. The resulting impact is isolation, disguise, and fear of disclosure (Malik & Coulson, 2008; Hanna & Gough, 2020), matching findings by Fisher and Hammerberg (2012) and Hanna and Gough (2015) in their reviews, which further perpetuates social and cultural narratives that men do not need help, or to be offered support, due to concealing their emotional experience.

However, the review highlights significant contradictions within this and other narratives, illustrating that men are challenging this ingrained stereotype (Hanna & Gough, 2020). The narratives that emerge represent an alternative perspective, in which there is the need to explore the experience of infertility by men in the context of modern re-definitions of masculinity (Hanna et al., 2018). Moreover, it represents a landscape where the expression of emotional experiences linked to infertility is not mutually exclusive with identification with traditional perceptions of masculinity.

Limitations

There was variability in the quality of the papers included in this review (Appendix H). Discrepancy in methodologies - particularly differences in recruitment and choice of analysis – impact the trustworthiness of the contribution of different papers to the results. However, the representation of different cultural groups, temporal contexts and lived experience is broad and the overall strength of the evidence is rich in offering new understandings and perspectives about perceptions of masculinity in the context of male infertility.

However, it is limited in the inclusion of only papers written in English and therefore there are stories that remain untold and absent in the synthesis of this review. The literature selected for inclusion in this review is also reflective of the wider literature pool which is primarily heteronormative and restricted in exploring diversity. This means that the review is unrepresentative of the non-heterosexual experiences of infertility. The literature included in this review therefore does not fully consider all groups and draws its main conclusions from heteronormative experiences.

Another limitation arises from the narrative approach taken to this review. The review seeks to synthesise and represent a complex literature base in a succinct narrative; in this case, the whole is greater than the sum of its parts and the themes, inevitably, cannot capture every detail. The nature of narrative synthesis means that some details, or stories, have been left out, or overtaken by other more prominent stories in the literature and does not adopt the necessary steps to mitigate bias.

Implications and future research

The knowledge synthesised in this review introduces new perspectives to understanding perceptions of masculinity in the context of male infertility and stimulates thoughts and ideas towards promoting wellbeing and normalising the challenges faced by men living with infertility.

A key theme that emerged through the review is the importance of validation of men's experiences of emotions pertaining to their experience of infertility. The review illustrates that men's experiences of infertility are diverse and highlights that the experience of distress, connection to emotions and challenges associated with the experience of infertility are not exclusively experienced by women, contradictory to many sociocultural expectations and gendered stereotypes (Fisher & Hammerberg, 2012; Hanna & Gough, 2015). Therefore, wider sociocultural narratives and traditional perspectives of masculinity contradict the lived experiences of many and act as a barrier to more men confronting these experiences 'head on' and seeking support .

Acknowledging this, this review introduces ideas about how clinicians could adapt their model of service delivery to create a space where men feel able to explore the different layers of their experiences of infertility and be met with compassion and validation, without judgement, based on an understanding of how perspectives of masculinity impact men's experiences of infertility. While most of these suggestions are applicable to heterosexual couples, they also provide a basis for future thoughts on the infertility journeys of non-heterosexual couples as well.

Within a typically female-orientated context, services and clinicians should aim to acknowledge that the depth of emotion experienced by men on their journey with infertility can parallel the experiences of women. Normalising this experience and naming that it is not uncommon may support the breakdown of barriers and stigma towards men asking for help or beginning conversations on the topic (Connell & Messerschmidt, 2005). The power of validation can be seen in models of therapy which emphasise the importance of validation in the therapeutic relationship; validation signifies that people are being listened to and heard and that their experiences within their current context are being understood (Kocabas & Üstündağ-Budak, 2017).

The review outlines several simple and tangible solutions to normalising the inclusion of men throughout the journey. For example, addressing letters to both prospective parents and including men alongside their partners in conversations about care-planning and treatment plans (Malik & Coulson, 2008). As in any health context, the provision of a service should be individualised, however the core foundations of relationship building, trust, communication and curiosity about the service-users experiences and expectations is also important.

Acknowledging men's motivation to support their female-partners through this journey, health services should seek to identify ways of empowering men to support their partners through offering self-care and compassion towards themselves. This could be framed within the context of motivating men to identity their own challenges and seek support so they can subsequently offer better support to their partners from a position where their own concerns are being met, rather than trying to nourish their partner's wellbeing from a 'half empty cup.' This fits within psychological perspectives of compassion and the evolutionary origins of compassion and caregiving (Gilbert, 2014). This perspective of compassion outlines the motivational systems that underpin human instinct for caring for others being socially rooted and in this context illustrates how listening to our own need for self-compassion can create capacity to show compassion and care to others.

The review also highlights the importance of cultural sensitivity in the context of fertility care. The diversity and subjectivity in experiences of infertility suggests that services and clinicians should operate from a person-centred perspective (Rogers, 1951, as cited in Joseph & Murphy, 2012). They should show curiosity and validation of differing expectations of infertility care and the role of men in this process. Clinicians should reflect on their position relative to the service-users and be mindful that Western practices may or may not match the myriad of expectations of culturally diverse populations accessing fertility services. This careful mindedness can help to create an atmosphere of safety and comfort for service-users, where they are aware their cultural differences are being considered and respected within the provision of care.

This naturally stimulates wider reflection about the accessibility of fertility services, the impact of Western-values and principles on clinical practice and the improvement of therapeutic relationships in the UK health system. It raises questions about whether there needs to be a paradigm shift towards the way that support is offered to incorporate perspectives from a culturally responsive lens. This might take shape as the offering of spiritual care alongside biomedical care; providing options in care planning and involvement in care; and creating a context where there can be effective communication, for example through the provision of interpreters.

The review is limited in its omission of diversity in representing non- heteronormative experiences and raises subsequent questions about the applicability of the outcomes to other groups of people. As such future research should seek to reach these marginalised communities. Specific questions that might guide these studies might be: what are service perspectives on male help-seeking behaviour? What are the experiences of LGBTQ+ individuals through fertility challenges and help-seeking for them? How do men's experiences of perspectives of masculinity shape their experience of fertility-care and services?

The review makes recommendations that accommodate the need for more research - acknowledging omissions and shortcomings of this review – and the broad context that this review is summarising. It offers a new understanding of male-experiences relative to our understanding of female-fertility and access to fertility care, emphasising the need for the use of creative, and non-prescriptive sources of support for men. It reflects the need for a shift in attitude towards signposting men to support and encouraging help-seeking. The benefits observed in men who have accessed support online anchor the suggestion that fertility services (as well as other clinical settings that might encounter men experiencing infertility, such as adult mental health services) should recommend existing online forums for men to access support from. These can include active and high-profile networks like 'HimFertility' and 'Andy's Man's Club'. Additionally, these services could explore opportunities within their own capacities to offer this type of forum. If not online support groups, alternative methods of reducing isolation and exclusion of men could adopt these strategies to enable men to access anonymous support, meet other individuals going through similar experiences, or access education about their fertility journey, options and choices.

Conclusion

The stories of men with lived experience of infertility, told through the research summarised in this review, indicate that ingrained discourse about expectations of masculinity are significant in perpetuating fears and barriers to speaking out and seeking support. However, more recent literature represents a shift and reflects modern re-definitions of masculinity where men feel able to navigate their experience more openly and authentically, when the appropriate scaffolding is provided. The review emphasises the importance of service users' voices, choice in decision-making and their inclusion in fertility care. Clinicians and services should seek to model and normalise men's experience of distress and show equality in their provision of support to men and women.

By asking the question: what can be learned from understanding perceptions of masculinity in the context of male infertility, we invite a new perspective to understanding men's experiences of infertility. The review has synthesised an understanding of key themes related to men's experiences of infertility and their role and relationship to perceptions of masculinity. There is not a straightforward answer to the review question. However, what the synthesis represents is a framework in which to reflect and be curious about the nuance of male experience of infertility. It demands that services and clinicians should adopt curiosity towards understanding the male perspective, inviting men to engage and be a part of the infertility journey and should seek to normalise and validate diverse and myriad experiences. Future research should continue to explore underrepresented groups in the literature and research around infertility and represent their experiences.

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*NB * indicates the papers included in this review.*

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Part Two: Empirical

This paper is written in the format ready for submission to the *Journal of Psychology of Men and Masculinities.*

Please see Appendix C. for the submission guidelines.

Exploring the Experiences of Compassion in Men Living with Infertility

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Abstract

The experience of infertility for men is often extrapolated from experiences of women, yet growing research in this field recognises the nuance of the experience of infertility for men. Men's reports of a desire for greater support and visibility in their experience of infertility motivates this research which seeks to derive an understanding of men's experience of compassion in the context of infertility, in order to inform recommendations for clinicians and services. Interpretative phenomenological analysis (IPA) was used as an in-depth study of a small sample of men living with infertility. Three themes emerged which are described under the broad headings: self-perception; relationships; and 'It's opening that Pandora's Box again', with six subthemes developed from the data. The findings suggest that relationships between infertility and compassion for men are complex. Men both seek to receive and cultivate compassion, but in attempting to do so face clear obstacles and barriers. This research outlines recommendations for more compassion-orientated healthcare and inclusion of men on their journey with infertility to seek to validate the emotional, and medical, experience of infertility.

Introduction

The clinical understanding of the male experience of infertility tends to extrapolate from research about women, despite the prevalence of male infertility affecting 1 in 10 men in the UK (Joja et al., 2016; Datta et al., 2016). The last decade has seen a growth in the recognition of the importance of understanding experiences of male infertility explicitly (Fisher & Hammarberg, 2012; Fieldsend & Smith, 2022). The impact of infertility for men is far-reaching and can create significant vulnerabilities for mental health difficulties (Chen at al., 2004), however there is a consensus in the research suggesting that men ‘disguise’ this and are influenced by psychosocial factors and gender stereotypes (Sherrod, 2006; Fisher & Hammarberg, 2012, 2017).

Definitions of infertility through a social constructivist lens reflects a change from the medical understanding of infertility- a phenomena affecting the primary individual with a medical diagnosis - and instead sees infertility as an experience affecting a couple and/or the individual regardless of what, if any, the functional impairment may be (Greil et al., 2011). This definition broadens the perspective from the medical definition which is often female-centric, to account for a range of experiences.

With infertility treatment typically focused on the outcome of achieving pregnancy, men are often excluded due to the attention being on the female partner (Stevenson et al., 2021). The range of experiences of men living with infertility are complex with a variety of psychosocial factors (Hart, 2002; Cousineau & Domar, 2007) driving challenges and immobilising access to resources, research and support (Fisher & Hammerberg, 2012; Hanna & Gough, 2015).

Compassion and infertility

There are multiple theories of compassion, each bringing a different perspective, and offering alternative parameters. A review by Strauss et al (2016) draws-together key theories of compassion (Neff, 2003; Gilbert, 2010, 2014) and proposes a summary of the main concepts offering an overarching definition of compassion: the recognition of suffering as part of the human experience; the ability to tolerate distress; and the motivation to alleviate suffering.

Specifically, Gilbert's model of compassion (Gilbert, 2014) situates compassion in a relational context and identifies multiple flows of compassion: compassion to self, compassion to others, and receiving compassion from others. This understanding is particularly relevant for exploring the experience of infertility for men as it provides a framework for an exploration of experiences of infertility for men exclusively, while also extending the understanding to their social-contexts and relationships. More broadly, compassion is defined by Gilbert (2014) as the human capacity to nurture and for wellbeing; this definition is supported by Neff's (2003) definition of compassion which reflects warmth and understanding, rather than self-criticism or denial as central to defining compassion.

In the UK compassion is strongly established in the National Health Service (NHS) discourse (NHS England, 2013; The King's Fund, 2022). Across healthcare settings research evidences how integrating compassion in the clinical approach improves clinical outcomes and patient satisfaction (Epstein et al., 2005).

In the context of infertility, research has begun to explore applications of compassion (Galhardo et al., 2013; Afshani et al., 2019), though the focus continues to be on the female experience. This is despite men who are affected by infertility reporting a desire for greater support and expressing that their emotional needs are often neglected by the female-centric focus of services and professionals, creating feelings of detachment and uncertainty (Hinton & Miller, 2013; Hanna & Gough, 2016; Stevenson et al., 2021).

This research seeks to explore the experience of compassion for men experiencing infertility. It will create space for men to share their stories in order to contribute to a growing body of research aimed at understanding experiences of male infertility (Fieldsend & Smith, 2022). The influence of gender-based stereotypes contribute to the rationale for more research into the male experience of infertility (Greil et al., 1988; Halcomb, 2018), to guide recommendations for services and clinicians (Jirka et al., 1996), without assuming best-practice from research with women.

This research seeks to ensure the male experience of infertility is neither minimised or considered to be less significant by asking the question ‘What is the experience of compassion for men living with infertility?’

Method

Ethical approval was granted by the Faculty of Health Sciences Research Ethics Committee at the University of Hull (REF: FHS431) (Appendix D). All documents were reviewed with independent representatives from both Andy’s Man’s club and HIM Fertility to check their suitability for the intended demographic.

Participants

Interpretative phenomenological analysis (IPA) supports the selection of a small sample and is purposeful in enabling in-depth insight and experiential understanding of individual experiences (Smith, 2009).

Participants were recruited based on the criteria of being a man aged over 18 years, living in the United Kingdom, identifying as living with infertility (not required to be a medical diagnosis) and fluency in English.

Six men were interviewed. The mean age of men in this study was 33.6 years (range 30 – 38). Due to the focus being on men who identify as living with infertility, the context and parameters of infertility were not stipulated, therefore the participants’ stage on their fertility journey varied, as did the length of time they had actively been trying to conceive. All participants (either personally or as a couple) had or were currently seeking treatment through the NHS or privately. All but one participant had conceived a child through their journey with infertility at the point of interview; and at the point of interview all participants were living in the UK though they represent diverse cultural groups.

Procedure

Recruitment was carried out from July 2022 to September 2022 using platforms such as Twitter and was supported by national online male support-groups such as Him Fertility and Andy's Man Club. Interviews were completed over Microsoft Teams by the first author and lasted between 60 and 120 minutes.

The emotive quality of the research was identified as was the potential risk of personal distress. Prior to each interview the protocol for withdrawal was discussed with participants and each participant was provided with a debrief document containing information about additional sources of support (Appendix J). The remit of confidentiality was discussed with participants, and all were audio recorded, transcribed and pseudonymised to protect confidentiality. Each participant signed an online consent form before participating.

Semi-structured interviews were used to explore an experiential understanding of compassion in the context of the participants' experience of infertility. The interviews were structured around two sections: (1) experience of infertility, and (2) the presence of compassion throughout this journey. Questions were asked to guide participants to share their story of their experience. Flexibility in the interview structure allowed space for personal-reflection and narratives about their experiences to emerge (Appendix K).

All interviews were transcribed. As well as verbatim transcription, non-verbal qualities of the interview were noted to provide additional dimension to the content of the interview.

Analysis

IPA was used to explore in detail the lived experience of men and allow close insight into experiences of compassion in the context of infertility. The analysis was completed according to IPA processes (Larkin et al., 2021).

Transcripts were re-read and the audio-recordings listened to simultaneously to achieve familiarity with the data (Larkin et al., 2021). The first author's reactions, initial descriptions and concepts were noted on the first transcript, and this was repeated for each transcript. On the second iteration transcripts were revised and initial themes were examined and collected in a summary of key words and themes. Only once transcripts were studied individually did the researcher begin drawing connections between transcripts and organising them into clusters (Larkin et al., 2021). Super- and subordinate themes were derived, with care being taken for the wording of these themes to remain close to the words of the participants (Yardley et al., 2017).

Researcher position

IPA reflects the double hermeneutic perspective (Larkin et al., 2021), therefore reflexivity was integral to the process. The researcher kept a reflective journal and participated in regular supervision to reflect on their position and its influence on their interpretation. The first author is a white-British female, employed as a Trainee Clinical Psychologist in the NHS; therefore, their own biases and position, as peripheral relative to the participatory group was identified (see the authors epistemological statement (Appendix B) and reflective statement (Appendix A)).

The researcher, in their professional context, has not worked with men experiencing infertility but has particular interest in perinatal psychology and a motivation for holistic service-provision.

Results

Three over-arching themes were identified which have been distilled into six subordinate themes summarised in Table 1. While it is not always clear that there is a rigid delineation between these themes, they seek to capture the nuance of the men's stories.

Table 1
Experiential themes and subthemes

Superordinate themes	Subordinate themes
Self-perception: "I always saw myself being good with children…I always saw myself having a family"	Identity and masculinity Autobiographical shift
Relationships: "Creates stress, creates tension, creates pressure"	Support and strain in social relationships Spouses and partners
"It's opening that Pandora's Box again"	The paradox of social media Hope as a double-edged sword

1. Self-perception: "I always saw myself being good with children…I always saw myself having a family,"

This first theme illustrates the impact of infertility on self-perception and sets the scene for those which follow, articulating the participants' deconstruction of their identity in the context of infertility.

1.1 Identity and masculinity

Participants shared how their experience of infertility conflicts with their earlier expectations of their role as a man.

> "I can't do the most simplistic thing my body should be able to do" (William)

William shared that he feels that he is “failing” in his “job” to be able to father children, criticising his body for its role in infertility.

Oliver shares this sentiment, and both go on to acknowledge that wider discourse about the social roles of men established their expectations of what they “should be able to do” as a man, emphasising their sense of loss and failure and subsequent negative self-perception.

> “What’s the one thing a bloke should be able to do? Father children, you know, that’s the most basic fundamental thing.” (Oliver)

> “The one job of a bloke that he’s got to do, and that’s natural, makes you feel like of less of a bloke” (William)

Oliver and William’s view demonstrates a perspective that the idea of infertility contradicts narratives that are ingrained in the social conversation about the expectations of men; Oliver specifically identifies how the implications of this are painful and impact his self-perception of his identity as a man, and how he believes others view him.

> “You’re not a proper man, people will see you differently” (Oliver)

For William, he identifies that for him “self-confidence was a big hit”. The impact of his perception of being “less of a bloke” is visible when he elaborates that this was far-reaching into his life at work and other roles.

> “Even when I went back to work, I felt like I was, I felt like less of a person…confidence got to me, and obviously self-worth” (William)

This sense of alienation and shift in self-perception was compounded by participant’s account of their experience of the NHS and its failure to provide holistic support that validates not only the medical context of infertility but also the emotional experience. William reflects on its limitations beyond this explaining that he often felt excluded and “pushed to one side,” due to the presumption that a diagnosis of infertility would primarily impact his wife.

> “My treatment was being discussed with my wife first because she becomes the primary individual listed on that case… it’s a system that’s designed to fail by default”. (William)

These responses articulate the complexity of infertility and tension of the desire to conceal and not-confront the experience of infertility in personal life and simultaneously the desire for visibility and inclusion in health services. It clarifies that exclusion of men in health services might inadvertently reinforce their sense of isolation.

Elijah corroborates this reflecting on the tension he felt between his grief and emotional pain, and his simultaneous motivation to conceal this from the outside world.

“I feel like a I want to break down…usually when I don’t talk about it…that’s when I hold it in, I tend to kind of view myself as a second issue that can be dealt with later” (Elijah)

Reflecting on his experience of confronting painful emotions, and evaluating this, he went on to share: “I probably should talk about it more, but just trying to end [conversations] so I can just be alone and kind of get past that gut wrenching feeling in my stomach… so I don’t have to show that I’m feeling terrible and I’m on the verge on crying..” (Elijah)

Though acknowledging his experience of pain and grief and simultaneously “holding it in”, Elijah infers that he perceives his experience as less significant, or less of a priority that his female partner. This reflects one way in which wider male-stereotypes create an obstacle to accessing compassion, with men not providing themselves with permission to confront or explore their emotions.

However, Aadesh and Adam share that through their journey with infertility they have grown an alternative perception of their strengths; they suggest that their vulnerability creates space for a new self-awareness. Aadesh shared how his experience enables keener insight of his own strengths and capabilities.

“You’re learning a lot about yourself…pain endurance, resilience…it is intriguing to go through, to learn a lot more about my body, what my body can withstand.” (Aadesh)

He goes on to discuss how this journey enabled him to disentangle his experience of infertility from his identity and self-perception.

"It's a massive part but it doesn't define who I am…I am more than just my fertility problems; I am a human being." (Aadesh)

Adam also reflects on his own relationship with infertility and its impact on his self-perception and identity: "A person wouldn't say they are a birthmark, rather they would identify as a person who has one." (Adam)

1.2 Autobiographical shift

As well as identifying a shift in self-perception, participants explained how their experience of infertility is incompatible with their expectations of their future, including being a father. Adam shared his sense of "not having a lot of things that [my partner and I] wanted or would have expected at this point in life." His account compares his expectations of his life (established by social narratives and expectations around having family) with the reality enforced by infertility. Matt shared this sentiment and specifically identifies a lack of awareness – and his unwavering expectations of the trajectory of his life events - towards the prevalence of infertility: "I always assumed for me it was just one of those things that was gonna happen, you get married, you have kids."

Adam identifies that the implications are to feel "heavily disappointed, ranging to devastated to not end up being parents in some capacity," reflecting a sense of being forced to relinquish his expectations of the past and grieve the loss of the future.

Both Matt and Adam's stories illustrate how wider social narratives play a vital role in shaping expectations of fatherhood; the experience of infertility represents a deep grief personally and socially. This is echoed by Aadesh who reflected on infertility diminishing his hopes to 'carry on his name' and raising questions and uncertainty about the future and what happens next: "Sometimes it's scary, it's scary because it's like 'will I ever have kids, is it supposed to happen for me?'"

Oliver also shared his worries about the future, and the fear that is instilled by his experience of infertility: “What happens when I get old? Is somebody going to come and visit me in a nursing home?”

Reflecting on how infertility creates shifts in his own life, Matt shared a consciousness of the impact on his close family. In particular he identified grief as multigenerational: “I remember afterwards apologising to my mum and dad like I couldn’t give them a grandchild,” illustrating his awareness of other people’s suffering within the context of his own experience.

However not all autobiographical shifts were entirely negative. Matt went on to articulate that the extensive emotional pain experienced facilitated a re-evaluation of his motivations to be a father, stating: “it’s made me think actually how to be a good dad, and it’s made me want it more.” Aadesh also identified that his experience of infertility has made him alter his perception of family, and what this means to him:

> “It’s important to have a family rather than just having a child…it’s ok to have a child that’s not biologically yours…being a dad and being a father are two different things.” (Aadesh)

Aadesh identifies what constitutes fatherhood, happiness and fulfilment for him; he reflects that this resolution has not been straightforward, or without its challenges, but has reconciled some of these challenges, offering an alternative perspective that “there’s different paths for different people in life”.

Both Matt and Aadesh illustrate their efforts towards changing the discourse around infertility and fatherhood. In doing so they introduce stories of hopefulness and power in re-claiming their own autobiography.

2. Relationships: “Creates stress, creates tension, creates pressure.”

As well as changing men’s self-perception, the strain of infertility also impacts relationships to a significant extent.

2.1 Strain and support in social relationships

Friendships were one form of relationship that was changed by infertility. In particular, Oliver observed an increasing desire for isolation: “[You] start going out a bit less…become distant from your male friends.”

Continuing on, he also reported on the way in which stereotypical perceptions of masculinity – and how this manifests as “banter” – could be harmful, either by diminishing the chances that he will go on to seek their support regarding his distress in the future, compounding the sense of isolation that participants report is a consequence of infertility, or could develop into a sense of resentment. While he suggests that humour can be helpful in other circumstances, when discussing infertility and being compared to the other men around him, it provoked anger.

> “It’s lads’ banter, “oh you’re firing blanks, do you want me to have a night with your missus”…I know they’re only having a laugh, but you do want to punch your best friends in the face at the same time.” (Oliver)

One explanation for the behaviour described by Oliver is an awkwardness (potentially masked by humour) as a method of avoiding emotionally in tune conversations about infertility. This is supported by the stereotypical idea that men should “get on with it” (Aadesh), with this being at odds with having such conversations. However, Elijah suggests what emerges is a vicious cycle: “People don’t want to hurt your feelings” – so these conversations are not had – “but by doing that they’re isolating the person even more so”.

These conversations reflect a friction between the capacity to share in the suffering of others and the taboo – and trepidation of having conversations – around infertility: Elijah reports how he experiences his friend’s awareness of his own grief, “You can just see he feels like gut wrenchingly bad for me, but what do you say, like how do you know what to say” and William shared in this observation too: “It’s not really a topic that people talk about, even though they know you’re going through it, they still don’t talk about it.” (William)

This helps to untangle the tension between the participants' need for compassion and support from their peers, and their concurrent desire to withdraw and resist help. This complexity was addressed by Aadesh, who acknowledged the line between helpful and unhelpful behaviour was not binary and would shift depending on where he was in his journey and his needs at that given time: "there's only so much you can do for me at the moment…how you can help me mentally is to not ask silly questions, is not to put me under pressure…it's not to show me that it is the worst thing that is ever going to happen."

However, he does articulate that others making space to connect and understand his experience, offering action alongside words, is helpful and appreciated.

> "When it's meaningful it's nice…when they really want to understand what's going on, when they really want to help, like ok, 'shall I come to your appointment with you?'"(Aadesh)

Beyond friendships, approaching relationships with family had an additional dimension. William became aware of his own reduced capacity for compassion towards others through engaging in the grief and loss of family members.

> "I was kind of like: well, that's their emotion to deal with, I've got enough on my plate to not have to deal with that…I'm not going to deal with the emotional baggage that they've got because we've got our own to deal with."

2.2 Spouses and partners

All participants identified shifts in their close relationships, with participants observing that this shift was multifaceted: "creates stress, creates tension, creates pressure" (William)

Adam and Elijah both identified – with unease - that, in some ways, learning about the diagnosis of infertility prevented projecting unconscious blame onto their partner: "learning that we both had infertility…prevented us from unconsciously placing blame on the other.' (Adam)

> "We both have an issue so there's no blame"(Elijah)

Within these statements, it’s clearly implied there would be a sense of blame if the source of infertility could be isolated to one individual.

Matt’s experience supports this idea. He shared feeling a sense of responsibility, saying that his diagnosis of infertility was immobilising and impacted his own self-worth: “I felt like there was nothing I could do about it…there’s nothing I can do, so that’s where my self-worth came in”. He also would share how this “felt like it was very much my fault” rather than laying any blame onto his spouse.

Matt goes on to identify how these feelings were integral to their decision making and planning of their next steps, leading to tangible consequences.

> “I didn’t want adoption because I felt like I was taking away…my wife can still use her egg and I didn’t want to take that away from her” (Matt)

Within the choice of language here, Matt begins to expand on the idea that he is inadvertently depriving his partner of something of huge importance and with this comes a perceptible weight of guilt. Aadesh shared this sentiment but presented it in a different way, in the form of an ultimatum: a binary choice between living with him or having a child.

> “You can’t have kids, so you go and live your happily ever after. Or do we ride this through and see what the outcome is…I do want to be with you but it’s like, if you want kids more than being with me then I think it’s important for you to go and search for that.” (Aadesh)

By acknowledging and reflecting on the restraints of infertility and by being candid about that, Aadesh signalled an attempt to relieve pressure on himself around having a child, instead placing the burden of decision making on his partner.

Participants identified other ways in which they attempt to distract or distance themselves from the painful experience. Adam shared that becoming engulfed by work kept him busy and simultaneously distracted him from the noise surrounding infertility; while acknowledging the benefits – or apparent benefits – for himself, he shared that in hindsight this inadvertently negatively impacted his partner.

"Neglecting maybe what she needs or what she is expecting from me…she had felt hurt that I hadn't asked her [about her scan] and I felt terrible about that" (Adam)

William shared the sentiment that work offered a distraction and was a knee-jerk reaction to wanting to "push away" any difficult emotions: "I don't do emotion very well because I try to process it in my own way whether it's helpful or not…the job situation was probably a reaction to that". He went on to reflect that in preserving his own wellbeing he perhaps neglected that of his spouse and identified that "what's impacting me is also impacting everybody in different ways", signalling that this could simultaneously have been experienced as unhelpful by his spouse. Matt also reflected this sense of having a tunnel vision for coping with his own experiences, and shared that he struggled to support his partner, because he believed he was "feeling worse."

This build-up of pressure and declining self-worth reported by participants led to negative outcomes within their romantic relationships. For Oliver, his "marriage broke down." William's relationship had not yet reached that point, however, he acknowledged that the pressure "could make or break us as a couple"; and for Aadesh, the emotional challenges meant he "wasn't really being open with how [I'm] feeling" leading to "quite a few disagreements" with his partner.

However, reflecting on his experience of reaching the other end of their journey and having a child, William acknowledged that through these challenges and conflict – "You've had to go through hell and back to get there" - it creates strength. He described that for him and his wife, this journey and experience 'creates a deeper bond within the relationship.'

William identifies tangible examples of where the experience of infertility, and its impact on relationships, is not exclusively negative, though caveats this with knowing he has reached a point in his journey where he has had children. However, Adam highlights where in the midst of the challenges and conflict, strength and compassion can emerge:

"One of the biggest things for me that has helped me to deal with things is supporting and helping my wife…being able to provide care to her makes me feel better." (Adam)

3. “It’s opening that Pandora’s Box again.”

Pandora’s Box represents a metaphor for the emotional experience of infertility. Like the hidden contents of Pandora’s Box, experiences of infertility are multifaceted and unpredictable, and once unleashed cannot easily be controlled. There is capacity for experiences that are simultaneously perceived as negative – such as isolation and suffering- as well as those that are positive, such as connection and hope, though the two are often entangled and not mutually exclusive.

3.1 The paradox of social media

Like Pandora’s box which unleashes unpredictability, participants’ experiences of social media are filled with unexpected complexity. The experience of using social media is paradoxically helpful and unhelpful; simultaneously capable of creating positive outcomes and generating pain and exclusion.

For some, social media provided a space for them to access information about infertility while also allowing them to meet others going through similar experiences. As Adam explains, these forums facilitate the sharing of stories and the variety of experiences, and act as a place where members use their experiences to advise and support others.

> “You can go on the internet and find as many different stories with as many different viewpoints as possible but it’s still more helpful to know a more personalised version ‘how did it work out for them?’ It’s you know, do they have a very easy time of it, was it a challenge, that kind of thing”
>
> (Adam)

Participants also reflected on the sense of connectedness from meeting people online. Matt suggests online spaces create a context where he can reach out to other men and in doing so, feel less isolated in his experience. He shared that this connectedness “makes you feel normal,” and that this prevented him from “feel[ing] alone.”

However, within this connectedness, there is also a clear sense of distance. While participants may have been uneasy about having such conversations with people they know, there can be a sense of security in knowing that, while discussing infertility online, "anonymity" (Oliver) can be preserved.

Social media creates a shared space for others experiencing infertility, helping to provide a space for community and friendship while maintaining the security of distance. Elijah's view evidenced this, saying he "created an Instagram" to track his "journey", and the subsequent support received online "has been insane".

For William similar support from conversations on social media allowed him to break down barriers around discussing infertility more broadly and this was a sentiment echoed by Aadesh.

> "I think until you know somebody who either understands this topic, has empathy and compassion that goes with it…or somebody who's gone through it, that's when you can suddenly talk about it, and once you've broken that barrier once, you feel like you can have that conversation" (William)

> "The more people talk about it, and lead the conversations, more and more people will feel comfortable talking about male factor fertility problem" (Aadesh)

Aadesh and other participants discussed how their experiences online has translated into a motivation to offer their own insight and compassion to others.

> "I want more men to feel comfortable talking about these types of problems… I'm going to help other men talk about their fertility problems so that we can come together and kind of combat, and make people aware" (Aadesh)

Conversely, there are also significant challenges faced by men experiencing infertility stemming from social media. Oliver reflected that accessing social media reinforced grief, saying it was "like someone dangling a carrot on a stick."

Elijah corroborated this, adding that social media could lead to a sense of exclusion as he was unable to share in the joy from news about children or pregnancy on social media. Instead, such news prompted feelings of jealousy: “it’s thrown into your face a lot…it’s the green-eyed monster flaring it’s head.”

These reported consequences of social media use come from Oliver and Aadesh, who also shared the many positives. That contradiction highlights how social media is paradoxical in its impact; simultaneously capable of creating unpredictable feelings of support and inclusion, and jealousy and exclusion.

3.2 Hope as a double-edged sword

While the concept of ‘hope’ is often seen as something exclusively positive, the participants also illustrated that this is not always the reality: while it can be a source of optimism, hope can lead to greater feelings of disappointment and loss. Like social media, this is another example of how the idea of ‘Pandora’s box’ – where experiences are not simple and are filled with unexpected complexity – is intrinsic to the experience of infertility for men.

In speaking about infertility, it was clear that language was foundational in a lack of hope with the words ‘infertile’ and ‘infertility’ creating their own barriers. The implication from the conversations had was that the language was paralysing and there was no room within the word ‘infertility’ for any other outcome than always being unable to have a child. Oliver explicitly reflected this, explaining “infertility is quite a final word,” and he interpreted the word itself as being, “the final no.”

The implications of a diagnosis of infertility and the finality of the language on the experience of hope was also reflected on in the context of interacting with health care professionals.

Oliver shares his experience comparing receiving the diagnosis of infertility to “a bloody sledgehammer,” and reporting that the appointment was brief failing to validate the deep implications of infertility: “it is 5 minutes, there’s not a lot we can do. Bosh; your whole world’s gone.” He identifies that through this interaction, and the uncertainty it creates, hope is minimal and difficult to preserve.

William supported this, going on to discuss how the uncertainly of infertility, matched with the uncertainty of COVID-19 created a context of 'constant stress'. He reflected that this sense of ambiguity led to anxiety, contributing to a sense of hopelessness: "going into a dark place of 1I don't know what's going to happen.'"

Despite their interpretation of the language, and the context of uncertainty, participants also reported that they were able to experience a sense of hope in some instances across their journey. However, an interpretation that this hope led to an uncomfortable sense of vulnerability (potentially leading to more emotional pain) was strongly supported from the responses.

"The more you go through those kinds of things, the more it kind of builds and every missed opportunity just hits a little bit harder cus you've got all of those previous ones compounding on top of it" (Elijah)

Reflecting candidly on the impact of this, Elijah shared that **"**every time you go through a round of IVF [you] open your heart up to a child then that never happens…that space is always there."

Though this hope could lead to grief with "every missed opportunity", this experience did not prevent the participants from continuing to invest hope in the potential for success.

"I hadn't realised how much hope I had been placing on getting that treatment…I've had hope generally every cycle." (Adam)

Recognising this relationship between hope and disappointment, Adam shared: "having the hopes dashed after the first one really set back in terms of positive thinking". The impact of this led to Adam denying himself hope, pre-empting the sense of loss that it could contribute to: "I'm trying not to put hope into it…trying to insulate myself from the bad feelings afterwards."

From the participants responses, the experience of hope in the context of infertility is clearly complicated and multi-layered. It leads to vulnerability and disappointment, even compounding loss or grief. But it can also be the only lifeline.

“I still hold out the hope that one day, but I do realise that that hope’s minimal… just give me something, something I can pin a hat on.” (Oliver)

Hope acts as a raft at sea: a lifeline just as you were giving up or going under. While the raft alone cannot prevent waves and challenges, it gives you a platform to keep afloat.

Aadesh illustrates this idea emotively, highlighting the positive power of hope even when it can also be precarious. “If it’s not the end of the story, then the story is not done.”

Discussion

The results of this study provide insight into the experience of compassion through the lens of male infertility. Considering Gilbert’s (2010) definition of compassion, as the courage and willingness to confront suffering it becomes possible to identify participants’ attempts to seek and cultivate compassion, subsequently revealing the obstacles to compassion (Gilbert & Mascaro, 2017).

This research shows men will - within the right context and when on their terms - speak openly and emotionally about their infertility, contradicting literature about gendered stereotypes and disguise (Sherrod et al., 2006; Fisher & Hammarberg, 2012, 2017). These results support the idea that even men who appear hesitant to speak about their emotions may simultaneously have the desire to have these conversations. Acknowledging the challenges, the results support the broad definition of compassion outlined by Strauss (2016) as men illustrate their capacity for vulnerability and willingness to reflect on their distress, creating space for self-awareness and emotional insight.

Regarding the influence of infertility on identity, the impact of self-criticism and subsequent negative self-perception is clear. Consistent with Neff’s (2013) understanding of self-compassion, self-criticism presents a key barrier to self-compassion (Gilbert & Mascaro, 2017) and this is evidenced by men’s accounts in this research.

Men shared how experiences of infertility contribute to self-perceptions of low self-worth and negative self-image; they hold their own distress as second priority (in order to preserve the wellbeing of those around them and their self-perception of endurance). This clarifies the complexity of experiences of compassion in the context of infertility and makes room for understanding the influence of narratives of gender-stereotypes (and how this manifests for the self, in relationships, and socially) on barriers to self-compassion (Neff, 2013), inadvertently reinforcing participants' tendency to shut down, and not disclose their own distress (Strauss, 2016).

Framing infertility in its interpersonal and social context, the results illustrate that the potential for compassion shifts in different contexts. Participants identified that compassion is not an infinite resource, sharing that when experiencing their own distress, their capacity for compassion to others was, at times, limited (Gilbert, 2014).

The social cost of compassion is also acknowledged by Eisenberg (2018) who found the capacity for compassion is reduced when also witnessing the distress of others. This can result in highly emotional experiences being dismissed in order to protect from that pain. The broader effect is conflict and ruptures in relationships through unacknowledged pain or lack of communication, or a minimisation of the impact of male infertility socially which prevents access to support needed.

The same is true of platonic relationships. Participants articulate a tension between their desire for social-connection and the simultaneous threat of social relationships. The results indicate a sense of safety in concealing emotions, defaulting to humour or becoming consumed in distractions. Therefore, in the context of male-to-male relationships barriers to self-compassion (Neff, 2003) (influenced by self-criticism and shame) for some men, interrupt the flow of compassion within social relationships (Gilbert, 2014). Participants explain that in these relationships even if compassion is implied, it is not always explicit or articulated, despite a desire for more overt acts of compassion between friends.

This finding is inconsistent with research about compassion which illustrates how the potential for the flow of compassion between people is greater for those we have a close relationship with, than for those we do not (Gilbert, 2010). The results of this research suggest for men experiencing infertility, this distinction is not straightforward, demonstrating how in the context of infertility boundaries for compassion may be more permeable and fluid. Contrary to research by Gilbert and Mascaro (2017), it suggests how closeness and emotional proximity can exacerbate barriers to compassion. Consistent with findings by Cousineau and Domar (2007) men in this study identified gender-stereotypes and emotional-proximity (embedded in expectations to be strong and supportive) to be an obstacle to receiving compassion, due to a desire to preserve the image of their own masculinity. Instead, this research argues that men found it easier to access and share compassion (Gilbert, 2014) with men with similar experiences.

Therefore, acknowledging it being paradoxical in nature, participants identified positive outcomes for compassion of social media, as it offered space to connect to others with similar experiences, consequently reducing threats of isolation and shame (which create barriers to compassion (Gilbert & Mascaro, 2017)), and at the same time inspiring hope. Research by Goetz et al (2010) supports this finding suggesting the capacity for compassion is greater towards people we perceive as having similar values to us. This research, embedded in this understanding, offers insight into alternative ways men can engage with compassion; it illustrates the importance of connection to others with shared experiences, and its role in ameliorating threats associated with infertility, and fostering common humanity (Neff, 2003; Gilbert & Mascaro, 2017).

However, the extent to which engagement with social media promotes self-compassion is unclear (Neff, 2003). For some participants one of the characteristics of social media that enables connection and emotional disclosure is anonymity. What this unravels is a tension between perception of self-identity, visibility, and self-compassion. It raises the question: does the anonymity of social media reinforce individual blocks to compassion by not permitting men to confront their distress in a way that is fully transparent. In doing so it contradicts Strauss' (2016) definition of compassion as a willingness to confront distress as part of the human experience (Strauss, 2016). However, it also precipitates an alternative interpretation. Through engaging with social media, men are confronting their distress, but in doing so with the protection of anonymity they seek to avoid negative repercussions experienced in close relationships.

Issues of visibility were also discussed in the context of experiences of health services. However, anonymity in this context was not desired, instead participants shared the need for inclusion and holistic care.

Interactions with health services and professionals were seen as foundational to men's experiences, specifically through the power of language. Reflecting on this, what was identified as most significant was care that validates not only the medical context of infertility but also the emotional experience. For some men a key experience in their journey was hope. While hope had the capacity to lead to greater vulnerability and distress, men's accounts and stories of hope are consistent with broad theories of compassion with men evidencing their willingness to turn towards their distress and demonstrate a motivation to alleviate their suffering (Strauss, 2016).

In sharing their stories about their suffering, men demonstrated their capacity for compassion for themselves on their journey with infertility through confronting their experience of pain, grief, and isolation (Gilbert, 2010). They demonstrated their motivation to reassess assumptions about their roles and their identity, in a way that preserves a sense of coherence and safety but also that validates their lived experience. In doing so they establish their motivation towards changing the discourse around infertility and introducing stories of hopefulness (Neff, 2011) and illustrate the multi-functionality of compassion in the context of infertility.

Clinical implications

The results of this study guide several recommendations for services and clinicians encountering men on their journey with infertility through offering insight into the men's relationship with compassion and potential blocks and resistances.

Research suggests that compassion is the prerequisite of any environment which aims to nurture hope, create community, and maintain positive relationships (Rogers, 2013), however participants identified several ways in which the NHS was unable to provide the necessary validation and compassion.

Acknowledging resource constraints, at a minimum professionals should be transparent and compassionate (able to normalise distress as part of the human experience (Strauss, 2016)) in their offer of support. They should facilitate dialogue that invites men, alongside their partners, to arrive at a position where they feel able to have conversations about their experience of infertility without fear of judgement or invalidation (Stevenson et al., 2021). They should not assume the impact of infertility for men is lesser, or that men do not want to engage in support (even if an offer of support is declined in the first instance) as this can reinforce men's feelings of isolation (Hinton & Miller, 2013).

It is important to socialise individuals and couples to the range of emotional distress that might be experienced through infertility, as well as expose the potential challenges that closeness and emotional proximity can bring to compassion (Gilbert & Mascaro, 2017). Knowing the importance of connection in reducing isolation and cultivating compassion and hope, alternative resources of support should be explored and offered. Information about male support groups, or online communities should be made available to all men.

The stories told by men stress the need for balancing pragmatic decision making and patient involvement, with the tangible emotional harm derived from a sense of exclusion and invisibility. This research emphasises the importance of keeping sight of the individual, providing more holistic care, and nurturing the emotional needs of all person's included in the experiences of infertility.

Conclusion and future research

While acknowledging that this research only included a select participant group, it reveals detailed insight into the male experience of compassion in the context of infertility.

Participants' desire for greater emotional support, validation and compassion is evident, albeit frontloaded with trepidation and complexity. The results are clear in suggesting that a compassionate approach taken by individuals, social networks, and clinically by professionals and services can lead to positive psychological outcomes.

The more we understand about blocks to compassion (Gilberts & Mascaro, 2017), the more able we are to promote compassion. Future research should continue to share stories of men through their experience of infertility and explore the effectiveness of appropriate interventions for men experiencing infertility. To do so, it should prioritise the exploration of non-heteronormative participants, recognising that same-sex partnerships can have their own unique journeys of infertility and experience of compassion within that context. Simultaneously, the influence of different cultural backgrounds or beliefs may intersect with experiences of compassion in the context of male infertility. In understanding the impact of these influences to a better extent, clinical implications can aim to be inclusive and representative of the population at large.

The role of language also has its own distinct relationship to men's experiences with infertility, and this presents itself as an area worthy of more research. While the parameters of this research could not permit explicit exploration of this, men disclosed the term 'infertility' upholds stigma. It may be necessary to consider how the language around the topic can evolve to reflect this.

This research highlights the need for greater emphasis on the inclusion of male-partners in research and in fertility and perinatal services. Through acknowledging this, the notion of compassion that is embedded in guidance and NHS discourse can begin to meet the needs and expectations of service-users.

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Part Three: Appendices

Appendix A: Reflective Statement

The Japanese art of Kintsugi involves putting together broken pieces of pottery using gold-bonding. It is a metaphor for reconstruction, growth, and creativity. The practice embraces challenges and imperfections holding them integral to creating new meaning and storytelling.

On this research journey the art of Kintsugi, and the message that it carries, feels particularly pertinent and reflecting on Kintsugi has equipped me with adaptability and flexibility. Starting with my initial ideas for a research topic, to reflecting back on my own journey now, I have learned to not be wed to my initial expectations, hopes and aspirations for this research. Instead, I've learned to be flexible and open to reshaping my ideas and expectations as the research has evolved.

Understanding the metaphor of Kintsugi has supported me on this journey to know that the challenges, decision-making and obstacles I have come up against in completing my portfolio thesis all contribute to the finished piece. These imperfections - stitched together with golden moments of joy, pride, and motivation - help the research to find new meaning, tell a new story and contribute to greater understanding of men's experiences of infertility.

On a thematic level Kintsugi and its meaning resonates with exploring compassion in the context of experiences of infertility. The stories told through this research emotively capture the lived experience of infertility in all its complexity. While the stories illustrate vulnerability, pain and grief, the participants' rawness, honesty, and courage to share and reflect on their experiences parallels the metaphor of reconstruction and growth to generate new meaning and insight. It has been a privilege to be trusted with these stories and to have the opportunity to share the stories of these men through this research.

Systematic literature review (SLR)

At first trying to hone a topic for my SLR felt challenging. While my empirical topic (once it began to take shape) felt clearer, I felt more challenged identifying a meaningful and relevant question for my review. However, once I began strengthening some initial ideas - and its relevance for my empirical paper became clear - I enjoyed the process of completing my SLR and learned a lot along the way.

My initial question for my review was ‘what is the psychosocial impact of infertility for men?’ Acknowledging that the literature exploring male experiences of infertility was limited, at first I was keen to complete a review with scope to incorporate all of the relevant literature. However, as I began my initial searches, and came head on with the literature that was published, this began to feel like an impossible task. Through reflective conversations with my supervisors and the library support team – as well as the need to be pragmatic - what became clear was the priority to select a review question that was specific, and which had clinical relevance.

I continually came across the theme of ‘masculinity’ when reading around experiences of infertility for men, and its relevance to understanding men’s experiences of infertility; and to an extent their relationship with compassion. This emphasis drew me to my final review question: ‘what can be learned from understanding perceptions of masculinity in the context of male infertility?’

When approaching this review and selecting my included papers, the importance and relevance of social, cultural, and temporal contexts and their influence on the construct of ‘masculinity’ became abundantly clear. Similarly, the construction and meaning attributed to language around infertility was important. With this in mind my position and experience (influenced by my professional identity as a Trainee Clinical Psychologist; Western, female lens; and liberal perspective), were particularly relevant. It was useful to think about this early on in the process of completing my SLR and the relevance of this guided my choice of quality assessment tool. The NICE assessment tool (NICE, 2012) draws specific awareness to the researcher’s position and it was useful to be as attentive and reflexive of my own transparency and self-awareness approaching my review, as I was when assessing the quality of my included papers.

The scope of papers included in my review was varied and inherently this meant that there was diversity in the disciplines, methodology and assumptions they contributed. With this in mind it was not immediately clear which methodology was most relevant to answering the review question. I spent time looking at various papers, reviews and recommendations about different qualitative methodologies to understand their differences and similarities.

I came across meta-narrative synthesis and it immediately felt relevant for answering my question and for effectively synthesising my included papers. This methodology is particularly suited to exploring nuance and tension in literature, as well as heterogeneity in research approaches, perspectives, and assumptions. However, as it was not a methodology that we had been introduced to in our SLR teaching, I was initially hesitant to begin and unsure where to start. After conversations with my supervisors – and their support in helping me identify and think about its relevance for my review question - I felt reassured by my choice of methodology and excited to begin my analysis.

Reflecting on my portfolio thesis as a whole - although not linear – my SLR has played a significant role in informing my thinking, position and approach towards my empirical paper, and vice versa. Firstly, it drew my attention to the importance of language and how meaning is socially constructed within the context in which it is shared. The diversity of perceptions of ‘masculinity’ across papers in my review meant that when approaching my empirical I was reflective of my interpretation and prior assumptions of language around infertility and compassion. This had a tangible impact on the way I planned my interview schedule and included revisions and input of services in designing my interview schedule.

Secondly, specific themes such ‘self-perception of male identity’ generated in my SLR paralleled experiences summarised in the sub-theme of ‘identity and masculinity’ in my empirical paper. Confirming my assumptions coming into this research, the influence of constructs such as masculinity on experiences of infertility for men is palpable. However, there were exceptions to this across both my SLR and empirical paper and evidence to suggests that there are multiple perspectives that challenge traditional perceptions of masculinity. The alternative narratives offer other perspectives that are compatible with more fluid, diverse and self-ascribed definitions of masculinity.

Finally, the themes generated in my SLR offer insight into broader systemic narratives that have the potential to influence the experiences of infertility for men. The wider literature provides a framework in which to contextualise these experiences and illustrate how narratives about infertility - which are embedded systemically - impact lived experience, shape participants storytelling, and subsequently my interpretation; as well as influencing (even if subconsciously) my own assumptions and expectations approaching this research. The myriad perspectives of infertility confirm my position that experiences do not occur in isolation. The relevance of relationships, systemic influences, and broader social and cultural narratives in shaping experiences was clear in my SLR, and its significance for exploring how meaning is created, and ensuring space for multiple narratives, was central to my empirical research.

Empirical

My research topic and subsequent research question evolved over time. During my undergraduate degree I completed research about the experience of fathers, drawing my attention to the lack of research and understanding about male experience and male perspectives in this field of research.

Knowing this, the topic of infertility – where experiences of men are disproportionately underrepresented - specifically sparked my interest and motivation for using research as a tool to amplify the voices of less visible groups of people in research. As well as this, my connection to the topic was influenced by my own narrative and autobiographical aspirations: to be a mother, to parent, to have a child (and my reflections of the implications of this not being a given or assumed).

As the research question began to take shape, what also became apparent was the relevance of this research in its place in time, specifically in the context of COVID-19. Through talking to and connecting with local infertility support groups, the impact of COVID-19 was indisputable. Specifically, its impact on loss of connection and community. What particularly struck me was the lengths of creativity that people went to in order to maintain connection during this time. Learning from the HIM Fertility support group and from Andy’s Man’s Club - for some men living with infertility - the use of online groups accelerated, while for many the deep challenges of infertility and the presence of ingrained gender-stereotypes continued to create barriers to connection and support. This motivated me to ask the question as to how (if at all) men experiencing infertility seek to engage with care and compassion and subsequently nurture the emotional distress of infertility, to build an understanding of how this is facilitated or blocked within clinical contexts.

My decision to explore experiences of infertility through the lens of compassion was informed by this, as well as being influenced by my experiences through training and interest in the CFT model. Therapeutically compassion-based approaches emphasise the relational component of distress, specifically in Gilbert’s (2014) model of the flow of compassion; this emphasis felt particularly compatible and relevant to infertility and exploring the myriad influences on men’s experiences.

I was excited and motivated approaching this research while being apprehensive about its challenges, specifically relating to recruitment. However, my anxiety – mostly influenced by literature discussing issues of ‘disguise’ with men, as well as my own bias and hesitation of men’s willingness to volunteer to discuss such a personal and emotive topic – was allayed and the initial interest and momentum in this research was reassuring and reinforced my motivation for this project.

One of the biggest challenges that I came up against – and that was much more time (and thought!) consuming that I could have imagined - was designing and planning my interview schedule. The most important thing that I learned is that there is not necessarily a ‘right’ way of doing it and instead adaptability and flexibility (and the ability to be guided by my participants) was most fruitful.

There were times where I felt challenged by the emotion and rawness of the conversations around infertility and had to encourage myself to take a step back from my usual position as a trainee clinical psychologist (and resist being pulled in to offer support) and reflect on my purpose and motivation for this research and the necessity to approach it from a different angle and perspective. With that being said, the emotive nature of this topic required thoughtfulness and care, particularly when making decisions about language. An example of this was the use of word ‘infertility’ and my navigation of how to define this in the context of the research. Specifically, it was important not to assume a shared understanding of what infertility meant and to instead adopt an interview guide and approach that was flexible to integrate and be influenced by the participants’ own definition of the word and their experience.

Language was also important when I was designing my interview schedule and framing questions about ‘compassion’. My initial approach was to explicitly ask participants about their experience of ‘compassion’, though with feedback from reviewers of my interview material taken on board, it became clear that this language was inaccessible and ambiguous. Instead, what was more important – guided by a more holistic and broad understanding of compassion as: a recognition of suffering; ability to tolerate distress; and motivation for alleviating suffering (Strauss, 2016) – was to explore ‘compassion’ in a more nuanced and flexible way. Therefore, the questions I asked looked more like: ‘we talked about how your experience of infertility has affected you. Could you tell me about anything that you do that helps this/ changes how you feel?’ and ‘what gets in the way of doing this all the time?’ These questions enabled participants to share their own stories and narratives about nurturing (or barriers to nurturing) their distress in the context of their experience of infertility.

On reflection, as the interviews progressed, the interview-schedule evolved and the conversations become more organic and candid, guided by which questions elicited rich conversation, and where questions were stickier, or closed down dialogue.

On this journey, for me, it was important to ‘unlearn’ the notion that speed, productivity and accuracy on the first attempt correlates with success. Instead, I learned that the journey of writing my thesis was a marathon not a sprint and that every part would take time (planning the interview schedule offered a deep insight to this). Even though my recruitment was quick off the starting blocks this did not mean that the rest would, or would need to, follow in this way. On reflection, I am grateful for the time that I have had at each stage of this journey, particularly the chance to sit with and get to know my data before beginning analysis, and the time and space this gave me to show myself compassion, demonstrate patience and self-care and to tolerate any uncertainty along this journey.

A final, but crucial reflection central to this research was about my position relative to the research; and my self-perception as an ‘outsider’. Through reading about IPA methodology, I learned about double hermeneutics and the importance of putting myself and my interpretation into the analysis while simultaneously privileging the participants’ stories.

My position, and perspective as a female trainee clinical psychologist, and the potential for its influence at each stage of my research was important. Specifically, my identity as a female exploring men’s experiences, raised several questions about what permissions being an ‘outsider’ granted me, as well as its limitations. In my professional role as a trainee clinical psychologist, I meet people with a myriad of experiences, and my ability to build relationships, connection and trust is imperative. I have grown confidence and skills in my clinical work to build trust and facilitate conversations with people who may, or may not share characteristics with me, as well as an awareness of my blind-spots and ability to be reflective and transparent about this.

Approaching my research, I had discussions in supervision about my expectations going into my research and how my identity as a female could either promote openness or be a barrier to conversations. While the implication of this was something I reflected on – and even worried about – during the recruitment process, my conversations with participants eventually allayed those concerns. Though some men may have found it challenging to speak to a female researcher about their infertility (perhaps due to concerns that the researcher might not be able to relate and empathise with their experience), the participants I spoke to were of the opposite view.

Specifically, in one conversation at the end of an interview a participant shared his ‘relief’ at being able to express himself freely and speak openly about his experience without worrying about judgment or embarrassment which could stem from talking to male-peers. Of course, this may not have been the case in all instances and there may be a significant proportion of men who would find it easier to have such conversations with a male researcher. However, considering my identity as a female researcher and the impact of this on my research did provide me space to reflect on how such dynamics had the potential to impact this research.

More broadly, throughout the research process my position as a female researcher had the potential to impact my interpretation of the male participants’ experiences. From the offset, I was aware that I would be seeing their experiences through the lens of my own position. Therefore, I attempted to come to terms with the importance of making conscious attempts to recognise when my own perspectives could impact the way in which I analysed the words and stories of the participants. In doing so, I was careful to pay attention to where I was particularly drawn to certain information, themes and ideas, and why. This wasn’t always straightforward; however it did mean I was continuously evaluating how my own life experience might leave its mark on my research in ways which were difficult to predict. Being aware of my own thoughts and feelings allowed me to preserve the intended meaning which was articulated by participants, and not unintentionally fuse the two.

Approaching my analysis I had both an eagerness to begin, as well as a sense of being overwhelmed when confronted with the amount of data in front of me. I recall many conversations at this point in the research journey with my supervisors about the tension of wanting to do ‘justice’ to the stories of my participants – while acknowledging my limits as a researcher and the constraints of my project - and feeling paralysed by the fear of not doing a ‘good-enough’ job or knowing where to begin.

Like Pandora’s box, there was the sense of not knowing what might be unleashed when I began the analysis and subsequently how I could organise and communicate the complexity and nuance in an accessible way.

Final thoughts

Through this journey, I have learned the importance of remaining flexible and adaptive to change. While sticking close to my initial motivation and intentions set out for this this project, my ability to shift my attention and approach my thesis from the perspective of wanting to tell the stories of the participants has allowed me to approach the research with greater curiosity and self-compassion.

While there have been obstacles en route to completing this thesis, there have simultaneously been moments of joy and gratitude. As in Kintsugi, the project as a finished piece wouldn’t be what it is without the challenges and learning that came with it.

Looked at together, the SLR and empirical paper give first hand insight into the experience of infertility for men. My own exploration of my experience in relation to this research, the stories offered by the men who participated in this research, and the background noise of wider cultural and social narratives all contribute to this project. They illustrate how both at an individual level and systemically, assumptions about the experience of infertility for men (or how this *should* look) are deep rooted. However, through this research, I have learned that there is not a single-world view of infertility. Instead, the experiences of infertility for men are complex and comprehensive.

In my current placement in an NHS maternal mental health service, which offers psychological services to women who’ve experienced baby loss, including those experiencing fertility challenges, the significance of this research in real-time is clear. While not currently a provision, the importance of extending support to partners and families, to provide a more holistic service has been identified. Anecdotally, women what I have been working with have stressed the challenges in their relationships and their hopes for the offer of support for their partners and spouses as well. This research acknowledges that the challenges associated with infertility are not isolated to an individual. Instead, the challenges of infertility are relational and systemic; this research, and the confirmation of the clinical need in NHS services, suggests that where partners can be involved there can be more growth, restoration, and compassion.

I hope that this thesis, in some way, furthers our understanding of the experiences of men living with infertility and their relationship with compassion.

References

The National Institute for Health and Care Excellence. (2012, September 26) *Methods for the development of NICE public health guidance (third edition) https://www.nice.org.uk/process/pmg4/chapter/appendix-h-quality-appraisal-checklist-qualitative-studies*

Strauss, C., Taylor, B. L., Gu, J., Kuyken, W., Baer, R., Jones, F., & Cavanagh, K. (2016). What is compassion and how can we measure it? A review of definitions and measures. *Clinical Psychology Review, 47*, 15-27. https://doi.org/10.1016/j.cpr.2016.05.004

Appendix B: Epistemological statement

The researcher's position and perspective on how they see and interpret the world around them is significant to this portfolio thesis.

Epistemology refers to the theory of knowledge; and how we seek to arrive at the destination of knowledge and understanding (Ritchie et al., 2013). While ontology is defined as the "nature of the world" (Ritchie et al., 2013, p. 5), within which there are two dominant positions: realism (the belief of a single truth) and relativism (the existence of 'multiple truths').

The researcher takes an interpretivist epistemology, subsumed by a relativist ontology. From this position, the researcher's selected methodology is compatible. Interpretative Phenomenological Analysis (IPA) (Smith et al., 2009) is an interpretivist endeavor looking at individual lived experience - as opposed to generalisable outcomes - in doing so privileging multiple truths and experiences. IPA is also interested in the double hermeneutic and the role of the researcher in co-constructing meaning through their sense-making of participants shared experience. Knowing this, the researcher's position and transparency about their perspective is integral to understanding the bias, assumptions, and perspective of the researcher; and the choices that guide the research methodology and subsequent interpretation.

The researcher participated in regular reflection and was active in seeking opportunities to be reflexive about their position and these processes. They were reflective of their potential to influence and shape this research, but to a greater extent to ensure their awareness of these biases and blind spots (see Appendix A for reflective statement).

Both the empirical paper and SLR are compatible with this epistemological and ontological position and hold the perspective that people's experiences are complex and reflective of the mirrors that social, cultural, and political contexts hold up. The researcher felt that IPA was applicable to exploring lived experience of compassion for men living with infertility - acknowledging the complex and evolving contexts that prevail around this topic – to capture detailed insight, experiential understanding, and manifestations of compassion in the context of infertility. The SLR explored literature which detailed heterogeneous experiences cross-culturally and across social and temporal contexts. While this presented the potential for discrepancy in definitions and construction of masculinity and infertility; the researcher’s epistemological and ontological position means that they seek meaning from individual lived-experience and do not assume a one-world view or perspective.

References

Gilbert, P. (2014). The origins and nature of compassion focused therapy. *British Journal of Clinical Psychology, 53*(1), 6-41. https://doi.org/10.1111/bjc.12043

Ritchie, J., Lewis, J., Nicholls, C. M., & Ormston, R. (2013). Qualitative research practice: A guide for social science students and researchers. (2nd ed). Sage Publications.

Smith. J. A, Flower. P & Larkin, M (2009). *Interpretative Phenomenological Analysis: Theory, Method and Research (4th ed).* Thousand Oaks, CA: Sage Publications.

Appendix C: Notes or Guideline for authors for the Systematic Literature Review and Empirical study: Psychology of Men and Masculinities

Submission

To submit to the Editorial Office of Y. Joel Wong, please submit manuscripts electronically through the Manuscript Submission Portal in Microsoft Word (.docx) or LaTex (.tex) as a zip file with an accompanied Portable Document Format (.pdf) of the manuscript file."

Prepare manuscripts according to the *Publication Manual of the American Psychological Association* using the 7th edition. Manuscripts may be copyedited for bias-free language (see Chapter 5 of the *Publication Manual*). APA Style and Grammar Guidelines for the 7th edition are available.

SUBMIT MANUSCRIPT

General correspondence may be directed to

Y. Joel Wong, PhD
Indiana University Bloomington
Counseling and Educational Psychology
107 S. Indiana Avenue
Bloomington, IN
47405-7000
Email

Manuscripts for *Psychology of Men & Masculinities* may be regular-length submissions (7,500 words, not including references, tables, or figures) or brief reports (2,500 words, not including references, tables, or figures). **Please include your submission's word count on the title page.**

If Microsoft Word Track Changes was used in preparing the manuscript, please execute the "accept all changes" procedure, and remove all comments prior to submission.

Psychology of Men & Masculinities is now using a software system to screen submitted content for similarity with other published content. The system compares the initial version of each submitted manuscript against a database of 40+ million scholarly documents, as well as content appearing on the open web. This allows APA to check submissions for potential overlap with material previously published in scholarly journals (e.g., lifted or republished material).

If you are submitting a literature review, please read the Literature Review Guidelines.

Manuscripts for *Psychology of Men & Masculinities* may be regular-length submissions (7,500 words, not including references, tables, or figures) or brief reports (2,500 words, not including references, tables, or figures). Please include your submission's word count on the title page.

Psychology of Men & Masculinities requires all manuscripts to comply with guidelines on equity, diversity, and inclusion (EDI). Read our EDI guidelines before submitting your manuscript.

Masked Review Policy

Psychology of Men & Masculinities uses a masked review process.

Each copy of a manuscript should include a separate title page with author names and affiliations, and these should not appear anywhere else on the manuscript. The first page of the manuscript should include only the title of the manuscript and the date it is submitted. Footnotes containing information pertaining to the authors' identity or affiliations should be removed.

Every effort should be made to see that the manuscript itself contains no clues to the authors' identity.

Please ensure that the final version for production includes a byline and full author note for typesetting.

Manuscript Preparation

Prepare manuscripts according to the *Publication Manual of the American Psychological Association* using the 7th edition. Manuscripts may be copyedited for bias-free language (see Chapter 5 of the *Publication Manual*).

Review APA's Journal Manuscript Preparation Guidelines before submitting your article.

Double-space all copy. Other formatting instructions, as well as instructions on preparing tables, figures, references, metrics, and abstracts, appear in the *Manual*. Additional guidance on APA Style is available on the APA Style website.

Below are additional instructions regarding the preparation of display equations, computer code, and tables.

Display Equations

We strongly encourage you to use MathType (third-party software) or Equation Editor 3.0 (built into pre-2007 versions of Word) to construct your equations, rather than the equation support that is built into Word 2007 and Word 2010. Equations composed with the built-in Word 2007/Word 2010 equation support are converted to low-resolution graphics when they enter the production process and must be rekeyed by the typesetter, which may introduce errors.

To construct your equations with MathType or Equation Editor 3.0:

- Go to the Text section of the Insert tab and select Object.
- Select MathType or Equation Editor 3.0 in the drop-down menu.

If you have an equation that has already been produced using Microsoft Word 2007 or 2010 and you have access to the full version of MathType 6.5 or later, you can convert this equation to MathType by clicking on MathType Insert Equation. Copy the equation from Microsoft Word and paste it into the MathType box. Verify that your equation is correct, click File, and then click Update. Your equation has now been inserted into your Word file as a MathType Equation.

Use Equation Editor 3.0 or MathType only for equations or for formulas that cannot be produced as Word text using the Times or Symbol font.

Computer Code

Because altering computer code in any way (e.g., indents, line spacing, line breaks, page breaks) during the typesetting process could alter its meaning, we treat computer code differently from the rest of your article in our production process. To that end, we request separate files for computer code.

In Online Supplemental Material

We request that runnable source code be included as supplemental material to the article. For more information, visit Supplementing Your Article With Online Material.

In the Text of the Article

If you would like to include code in the text of your published manuscript, please submit a separate file with your code exactly as you want it to appear, using Courier New font with a type size of 8 points. We will make an image of each segment of code in your article that exceeds 40 characters in length. (Shorter snippets of code that appear in text will be typeset in Courier New and run in with the rest of the text.) If an appendix contains a mix of code and explanatory text, please submit a file that contains the entire appendix, with the code keyed in 8-point Courier New.

Tables

Use Word's Insert Table function when you create tables. Using spaces or tabs in your table will create problems when the table is typeset and may result in errors.

Equity, Diversity, and Inclusion

Psychology of Men & Masculinities requires all manuscripts to comply with equity, diversity, and inclusion guidelines.

Participant description

Authors are encouraged to include a description of the study participants in the Method section of each empirical report, including (but not limited to) the following:

- Sex/Gender
- Race/Ethnicity
- Age
- Nativity or immigration history
- Socioeconomic status
- Any other relevant demographics (e.g., disability status; sexual orientation)

In the discussion section of the manuscript, authors are encouraged to discuss the diversity of their study samples and the generalizability of their findings.

Academic Writing and English Language Editing Services

Authors who feel that their manuscript may benefit from additional academic writing or language editing support prior to submission are encouraged to seek out such services at their host institutions, engage with colleagues and subject matter experts, and/or consider several vendors that offer discounts to APA authors.

Please note that APA does not endorse or take responsibility for the service providers listed. It is strictly a referral service.

Use of such service is not mandatory for publication in an APA journal. Use of one or more of these services does not guarantee selection for peer review, manuscript acceptance, or preference for publication in any APA journal.

Submitting Supplemental Materials

APA can place supplemental materials online, available via the published article in the APA PsycArticles® database. Please see Supplementing Your Article With Online Material for more details.

Abstract and Keywords

All manuscripts must include an abstract containing a maximum of 250 words typed on a separate page. After the abstract, please supply up to five keywords or brief phrases.

Public Significance Statements

Authors submitting manuscripts to *Psychology of Men & Masculinities* are required to provide 2–3 brief sentences regarding the public significance of the study or meta-analysis described in their paper. This description should be included within the manuscript on the abstract/keywords page, but in a separate paragraph from the abstract and keywords. It should be written in language that is easily understood by both professionals and members of the lay public.

When an accepted paper is published, these sentences will be boxed beneath the abstract for easy accessibility. All such descriptions will also be published as part of the Table of Contents, as well as on the journal's web page. This new policy is in keeping with efforts to increase dissemination and usage by larger and diverse audiences.

Examples of these 2–3 sentences include the following:

- "A brief cognitive–behavioral intervention for caregivers of children undergoing hematopoietic stem cell transplant reduced caregiver distress during the transplant hospitalization. Long-term effects on caregiver distress were found for more anxious caregivers as well as caregivers of children who developed graft-versus-host disease after the transplant."

- "Inhibitory processes, particularly related to temporal attention, may play a critical role in response to exposure therapy for posttraumatic stress disorder (PTSD). The main finding that individuals with PTSD who made more clinical improvement showed faster improvement in inhibition over the course of exposure therapy supports the utility of novel therapeutic interventions that specifically target attentional inhibition and better patient-treatment matching."
- "When children participated in the enriched preschool program Head Start REDI, they were more likely to follow optimal developmental trajectories of social–emotional functioning through third grade. Ensuring that all children living in poverty have access to high-quality preschool may be one of the more effective means of reducing disparities in school readiness and increasing the likelihood of lifelong success."

To be maximally useful, these statements of public health significance should not simply be sentences lifted directly from the manuscript.

They are meant to be informative and useful to any reader. They should provide a bottom-line, take-home message that is accurate and easily understood. In addition, they should be able to be translated into media-appropriate statements for use in press releases and on social media.

Prior to final acceptance and publication, all public health significance statements will be carefully reviewed to make sure they meet these standards. Authors will be expected to revise statements as necessary.

Constraints on Generality

In a subsection of the discussion titled "Constraints on Generality," authors are encouraged to include a detailed discussion of the limits on generality (see Simons, Shoda, & Lindsay, 2017). In this section, authors should detail grounds for concluding that results are specific to characteristics of the participants and address limits on generality not only for participants but for materials, procedures, and context. They should also specify which methods the authors think could be varied without affecting the result and which should remain constant.

References

List references in alphabetical order. Each listed reference should be cited in text, and each text citation should be listed in the References section.

Examples of basic reference formats:

Journal Article

McCauley, S. M., & Christiansen, M. H. (2019). Language learning as language use: A cross-linguistic model of child language development. *Psychological Review*, *126*(1), 1–51. https://doi.org/10.1037/rev0000126

Authored Book

Brown, L. S. (2018). *Feminist therapy* (2nd ed.). American Psychological Association. https://doi.org/10.1037/0000092-000

Chapter in an Edited Book

Balsam, K. F., Martell, C. R., Jones. K. P., & Safren, S. A. (2019). Affirmative cognitive behavior therapy with sexual and gender minority people. In G. Y. Iwamasa & P. A. Hays (Eds.), *Culturally responsive cognitive behavior therapy: Practice and supervision* (2nd ed., pp. 287–314). American Psychological Association. https://doi.org/10.1037/0000119-012

Figures

Preferred formats for graphics files are TIFF and JPG, and preferred format for vector-based files is EPS. Graphics downloaded or saved from web pages are not acceptable for publication. Multipanel figures (i.e., figures with parts labeled a, b, c, d, etc.) should be assembled into one file. When possible, please place symbol legends below the figure instead of to the side.

Resolution

- All color line art and halftones: 300 DPI
- Black and white line tone and gray halftone images: 600 DPI

Line weights

- Adobe Photoshop images
  - Color (RGB, CMYK) images: 2 pixels
  - Grayscale images: 4 pixels
- Adobe Illustrator Images
  - Stroke weight: 0.5 points

APA offers authors the option to publish their figures online in color without the costs associated with print publication of color figures.

The same caption will appear on both the online (color) and print (black and white) versions. To ensure that the figure can be understood in both formats, authors should add alternative wording (e.g., “the red (dark gray) bars represent”) as needed.

For authors who prefer their figures to be published in color both in print and online, original color figures can be printed in color at the editor's and publisher's discretion provided the author agrees to pay:

- $900 for one figure
- An additional $600 for the second figure
- An additional $450 for each subsequent figure

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Open Science Badges

Starting in August 2017, articles are eligible for open science badges recognizing publicly available data, materials, and/or preregistration plans and analyses. These badges are awarded on a self-disclosure basis.

At submission, authors must confirm that criteria have been fulfilled in a signed badge disclosure form (PDF, 33KB) that must be submitted as supplemental material. If all criteria are met as confirmed by the editor, the form will then be published with the article as supplemental material.

Authors should also note their eligibility for the badge(s) in the cover letter.

For all badges, items must be made available on an open-access repository with a persistent identifier in a format that is time-stamped, immutable, and permanent. For the preregistered badge, this is an institutional registration system.

Data and materials must be made available under an open license allowing others to copy, share, and use the data, with attribution and copyright as applicable.

Available badges are:

Open Data:

All data necessary to reproduce the reported results that are digitally shareable are made publicly available. Information necessary for replication (e.g., codebooks or metadata) must be included.

Open Materials:

All materials necessary to reproduce the reported results that are digitally shareable, along with descriptions of non-digital materials necessary for replication, are made publicly available.

Preregistered:

At least one study's design has been preregistered with descriptions of (a) the research design and study materials, including the planned sample size; (b) the motivating research question or hypothesis; (c) the outcome variable(s); and (d) the predictor variables, including controls, covariates, and independent variables. Results must be fully disclosed. As long as they are distinguished from other results in the article, results from analyses that were not preregistered may be reported in the article.

Preregistered+Analysis Plan:

At least one study's design has been preregistered along with an analysis plan for the research — and results are recorded according to that plan.

Note that it may not be possible to preregister a study or to share data and materials. Applying for open science badges is optional.

Publication Policies

APA policy prohibits an author from submitting the same manuscript for concurrent consideration by two or more publications.

See also APA Journals® Internet Posting Guidelines.

APA requires authors to reveal any possible conflict of interest in the conduct and reporting of research (e.g., financial interests in a test or procedure, funding by pharmaceutical companies for drug research).

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Authors of accepted manuscripts are required to transfer the copyright to APA.

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  Publication Rights (Copyright Transfer) Form (PDF, 83KB)
- For manuscripts funded by the Wellcome Trust or the Research Councils UK
  Wellcome Trust or Research Councils UK Publication Rights Form (PDF, 34KB)

Ethical Principles

It is a violation of APA Ethical Principles to publish "as original data, data that have been previously published" (Standard 8.13).

In addition, APA Ethical Principles specify that "after research results are published, psychologists do not withhold the data on which their conclusions are based from other competent professionals who seek to verify the substantive claims through reanalysis and who intend to use such data only for that purpose, provided that the confidentiality of the participants can be protected and unless legal rights concerning proprietary data preclude their release" (Standard 8.14).

APA expects authors to adhere to these standards. Specifically, APA expects authors to have their data available throughout the editorial review process and for at least 5 years after the date of publication.

Authors are required to state in writing that they have complied with APA ethical standards in the treatment of their sample, human or animal, or to describe the details of treatment.

- Download Certification of Compliance With APA Ethical Principles Form (PDF, 26KB)

The APA Ethics Office provides the full Ethical Principles of Psychologists and Code of Conduct electronically on its website in HTML, PDF, and Word format. You may also request a copy by emailing or calling the APA Ethics Office (202-336-5930). You may also read "Ethical Principles," December 1992, *American Psychologist*, Vol. 47, pp. 1597–1611.

Other Information

Visit the Journals Publishing Resource Center for more resources for writing, reviewing, and editing articles for publishing in APA journals.

Appendix D: Ethical and approval

PRIVATE AND CONFIDENTIAL
Emily Wallis
Faculty of Health Sciences
University of Hull
Via email

11th May 2022

Dear Emily

REF FHS431 - Exploring the Experience of Compassion of Men Living with Infertility

Thank you for your responses to the points raised by the Faculty of Health Sciences Research Ethics Committee.

Given the information you have provided I confirm approval by Chair's action.

Please refer to the Research Ethics Committee web page for reporting requirements in the event of any amendments to your study.

Should an Adverse Event need to be reported, please complete the Adverse Event Form and send it to the Research Ethics Committee FHS-ethicssubmissions@hull.ac.uk within 15 days of the Chief Investigator becoming aware of the event.

I wish you every success with your study.

Yours sincerely

Professor Liz Walker
Chair, FHS Research Ethics Committee

UNIVERSITY
OF HULL

Liz Walker | Professor of Health and Social Work Research |
Faculty of Health Sciences
University of Hull
Hull, HU6 7RX, UK
www.hull.ac.uk
e.walker@hull.ac.uk | 01482 463336

Appendix E: Information sheet

INFORMATION SHEET FOR PARTICIPANTS

Title of study: Exploring the Experience of Compassion of Men Living with Infertility

I would like to invite you to participate in a research project which forms part of my thesis for the Doctorate in Clinical Psychology course at the University of Hull. The sponsor for this research is the University of Hull.

We would like to invite you to participate in this research. Before you decide whether you want to take part, it is important for you to understand why the research is being done and what your participation will involve. Please take time to read the following information carefully and discuss it with others if you wish.

Please contact the researcher by emailing E.c.wallis-2020@hull.ac.uk if there is anything that is not clear or if you would like more information.

What is the purpose of the study?

This research is interested in exploring the experience of compassion for men living with infertility and/or fertility difficulties. We know that infertility can create significant psychological difficulties and can be emotionally challenging for many individuals.

Research has looked at strengths-based constructs such as compassion to support emotional distress in women experiencing infertility, however very little is known about its impact for men.

This research is interested in hearing the voices and stories of men living with infertility. We hope to be able to understand more about the role of compassion for men living with infertility to contribute to a growing insight into more inclusive and better-informed access to perinatal aftercare for men.

Who can take part?

There are several criteria that you must match to be able to participate in the study. This is to ensure I am reaching the group of people I am aiming to study. Please read the following questions carefully. If you can answer yes to all these questions, then you will be eligible to take part in the study.

- Are you a man aged 18+?
- Do you currently live in the UK?
- Is English you first language and/or can you speak English fluently?
- Do you identify as living with infertility and/or having fertility issues? (you do not require a medical diagnosis of infertility to participate in this research).

What is involved?

If you choose to take part in this study, you will be asked to attend an interview with the researcher either face-to-face or online depending on the feasibility of meeting in person. The interview will last approximately 1 hour.

During the interview you will be asked to discuss your experience of living with infertility and your experience of compassion. The interview will be audio-recorded, transcribed, and analysed. Audio-recordings will be stored safety whilst in use and discarded after use to ensure the participants confidentiality. Only anonymised quotes from the interview will be used in research reports.

Do I have to take part?

Participation is completely voluntary. You should only take part if you want to and choosing not to take part will not disadvantage you in any way. Once you have read the information sheet, please contact us if you have any questions that will help you decide about taking part. If you decide to take part, we will ask you to sign a consent form and you will be given a copy of this consent form to keep. Alternatively, you can contact the researcher to ask any questions that will help you decide about taking part and if you decide to take part the researcher will send you a consent form to sign and send back and you will be given a copy of this consent form to keep.

What are the possible risks of taking part?

Participating in the study will require you to discuss your experience of infertility and tell you story which some participants might find difficult or distressing. If you choose to participate in this research, you are free to withdraw at any point until the interviews have been transcribed (2-weeks post interview), at which point interviews will have been anonymised and not identifiable, without giving any reason. All participants will be sign-posted to a list of resources to access that can provide further advice or support if needed.

Completing the interview should take no longer than 1 hour.

What are the possible benefits of taking part?

There may not be any direct benefits from taking part in this research. However, it is hoped that the information that you provide in your interviews will help us to be able to understand more about the experience of compassion of men living with infertility. We hope to be able to contribute knowledge to an under-researched field to support other men also living with infertility, and support professionals working in this setting to deliver practical and useful interventions for men living with infertility.

How will we use information about you?

In this study we will only use information provided by yourself. This information will include your email address (to set up the interview), demographic information, information about your experience of infertility and your interview audio-recording. We will only use information that we need for the research study.

All information that you provide will be kept confidential and contact details will be paired with a unique participant number to protect participant anonymity. Data will be held on an encrypted file. Only the researcher and her research supervisor will have access to the information.

The interviews will be transcribed and analysed by the researcher. The audio-recordings will be deleted once the interviews are transcribed though anonymised transcripts will be stored securely for 10 years before being destroyed.

The analysis will then be written up and submitted for publication in an appropriate professional journal. All this data will be anonymous. Direct quotes from the stories may be used in the write-up of the research and subsequent publication but you will never be personally identified.

Where can you find out more about how your information is used?

You can find out more about how we use your information:

- At www.hra.nhs.uk/information-about-patients/ and https://www.hra.nhs.uk/planning-and-improving-research/policies-standards-legislation/data-protection-and-information-governance/gdpr-guidance/templates/template-wording-for-generic-information-document/
- By asking one of the research team using the contact details below
- By contacting the University of Hull Data Protection Officer by emailing dataprotection@hull.ac.uk or by calling 01482 466594 or by writing to the Data Protection Officer at University of Hull, Cottingham Road, Hull, HU6 7RX
- By reviewing the University of Hull Research Participant privacy notice: https://www.hull.ac.uk/choose-hull/university-and-region/key-documents/docs/quality/research-participant-privacy-notice.pdf

Data Protection Statement

The data controller for this project will be the University of Hull. The University will process your personal data for the purpose of the research outlined above. The legal basis for processing your personal data for research purposes under GDPR is a ‘task in the public interest’.

If you are not happy with the sponsor's response or believe the sponsor processing your data in a way that is not right or lawful, you can complain to the Information Commissioner's Office (ICO) (www.ico.org.uk or 0303 123 1113).

What will happen to the results of the study?

The results of the study will be summarised in a written thesis as part of a Doctorate in Clinical Psychology. The thesis will be available on the University of Hull's on-line repository https://hydra.hull.ac.uk. The research may also be published in academic journals or presented at conferences. If you want to hear about the results of the study then do contact the researcher, Emily Wallis, who will be happy to provide you with a written summary of the research.

Who has reviewed this study?

Research studies are reviewed by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and been given a favourable opinion by the Faculty of Health Sciences Ethics Committee, University of Hull.

Who should I contact for further information?

If you have any questions or require more information about this study, please contact the researcher via email using the following contact details. Due to Covid-19 restrictions access to the university campus or postal system is very limited, consequently if you send anything via the post there will be a delay in responding to you, please use email for all correspondence.

Emily Wallis
Dept. of Psychological Health, Wellbeing & Social Work
Faculty of Health Science
The University of Hull
HU6 7RX
E-mail: E.c.wallis-2020@hull.ac.uk

What if I have further questions, or if something goes wrong?

If you wish to make a complaint about the conduct of the study, you can contact the University of Hull using the research supervisor's details below for further advice and information, due to COVID-19 restriction contact via email is preferred:

Dr Philip Molyneux
Room 128 Aire Building
Dept. of Psychological Health, Wellbeing & Social Work
Faculty of Health Science
The University of Hull
HU6 7RX
Tel: 01482 464008
Email address: P.Molyneux@hull.ac.uk

Thank you for reading this information sheet and for considering taking part in this research.

Appendix F: Consent forms

CONSENT FORM

Exploring the Experience of Compassion of Men Living with Infertility

Please read the statements below carefully and put your initial in the box to indicate that you agree with the following:
Name of Researcher: Emily Wallis

Please
initial box

1. I confirm that I have read the information sheet dated 20.01.2022 (version 1.0) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. *Required.* ☐

2. I understand that my participation is voluntary and that I am free to withdraw up until the point of interview transcription (up to 2-weeks after the interview) without giving any reason. *Required.* ☐

3. I understand that the data I have provided up to the point of withdrawal (two weeks after interview completed) will be retained. *Required.* ☐

4. I understand that the research interview will be audio recorded and that my anonymised verbatim quotes may be used in research reports and conference presentations. *Required.* ☐

5. I understand that the information collected about me may be used to support other research in the future and may be shared anonymously with other researchers. *Required.* ☐

6. I give permission for the collection and use of my data to answer the research question in this study. *Required.* ☐

7. I have considered all the information provided and I agree to take part in the above study. *Required.* ☐

_______________________	_______________________	_______________________
Name of Participant	Date	Signature
_______________________	_______________________	_______________________
Name of Person taking consent	Date	Signature

Appendix G.

Table 1. NICE Quality Assessment Tool

<table>
<tr><td colspan="2">Study identification: Include author, title, reference, year of publication</td><td></td></tr>
<tr><td colspan="2">Guidance topic:</td><td>Key research question/aim:</td></tr>
<tr><td colspan="2">Checklist completed by:</td><td></td></tr>
<tr><td colspan="3">Theoretical approach</td></tr>
<tr><td>1. Is a qualitative approach appropriate?
For example:
• Does the research question seek to understand processes or structures, or illuminate subjective experiences or meanings?
• Could a quantitative approach better have addressed the research question?</td><td>Appropriate
Inappropriate
Not sure</td><td>Comments:</td></tr>
<tr><td>2. Is the study clear in what it seeks to do?
For example:
• Is the purpose of the study discussed – aims/objectives/research question/s?
• Is there adequate/appropriate reference to the literature?</td><td>Clear
Unclear
Mixed</td><td>Comments:</td></tr>
</table>

• Are underpinning values/assumptions/theory discussed?		
Study design		
3. How defensible/rigorous is the research design/methodology? For example: • Is the design appropriate to the research question? • Is a rationale given for using a qualitative approach? • Are there clear accounts of the rationale/justification for the sampling, data collection and data analysis techniques used? • Is the selection of cases/sampling strategy theoretically justified?	Defensible Indefensible Not sure	Comments:
Data collection		
4. How well was the data collection carried out? For example: • Are the data collection methods clearly described? • Were the appropriate data collected to address the research question?	Appropriately Inappropriately Not sure/inadequately reported	Comments:

• Was the data collection and record keeping systematic?		
Trustworthiness		
5. Is the role of the researcher clearly described? For example: • Has the relationship between the researcher and the participants been adequately considered? • Does the paper describe how the research was explained and presented to the participants?	Clearly described Unclear Not described	Comments :
6. Is the context clearly described? For example: • Are the characteristics of the participants and settings clearly defined? • Were observations made in a sufficient variety of circumstances • Was context bias considered	Clear Unclear Not sure	Comments :
7. Were the methods reliable? For example:	Reliable Unreliable Not sure	Comments :

• Was data collected by more than 1 method? • Is there justification for triangulation, or for not triangulating? • Do the methods investigate what they claim to?		
Analysis		
8. Is the data analysis sufficiently rigorous? For example: • Is the procedure explicit – i.e. is it clear how the data was analysed to arrive at the results? • How systematic is the analysis, is the procedure reliable/dependable? • Is it clear how the themes and concepts were derived from the data?	Rigorous Not rigorous Not sure/not reported	Comments:
9. Is the data 'rich'? For example: • How well are the contexts of the data described? • Has the diversity of perspective and content been explored? • How well has the detail and depth been demonstrated?	Rich Poor Not sure/not reported	Comments:

• Are responses compared and contrasted across groups/sites?		
10. Is the analysis reliable? For example: • Did more than 1 researcher theme and code transcripts/data? • If so, how were differences resolved? • Did participants feed back on the transcripts/data if possible and relevant? • Were negative/discrepant results addressed or ignored?	Reliable Unreliable Not sure/not reported	Comments:
11. Are the findings convincing? For example: • Are the findings clearly presented? • Are the findings internally coherent? • Are extracts from the original data included? • Are the data appropriately referenced? • Is the reporting clear and coherent?	Convincing Not convincing Not sure	Comments:
12. Are the findings relevant to the aims of the study?	Relevant	Comments:

	Irrelevant Partially relevant	
13. Conclusions For example: • How clear are the links between data, interpretation and conclusions? • Are the conclusions plausible and coherent? • Have alternative explanations been explored and discounted? • Does this enhance understanding of the research topic? • Are the implications of the research clearly defined? **Is there adequate discussion of any limitations encountered?**	Adequate Inadequate Not sure	Comments:
Ethics		
14. How clear and coherent is the reporting of ethics? For example: • Have ethical issues been taken into consideration? • Are they adequately discussed e.g. do they address consent and anonymity?	Appropriate Inappropriate Not sure/not reported	Comments:

- Have the consequences of the research been considered i.e. raising expectations, changing behaviour? - Was the study approved by an ethics committee?		
Overall assessment		
As far as can be ascertained from the paper, how well was the study conducted? (see guidance notes)	++ + −	Comments:

Appendix H:

Table 2. Table of values: Quality Assessment

Paper	NICE Checklist															
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	Total	Overall Rating
Dyer et al (2004)	2	2	-	-	2	2	2	-	2	-	2	2	2	-	18	+
Pearson et al., (2021)	2	2	2	2	2	2	-	2	2	-	2	2	2	2	24	++
Blell (2018)	-	2	-	-	1	2	-	-	1	-	2	2	-	2	12	-
Hanna & Gough (2016)	2	2	1	1	-	2	1	2	2	2	2	2	2	2	23	++
Hanna & Gough (2018)	2	2	1	1	-	2	1	2	2	2	2	2	1	2	22	++
Dolan et al (2017)	2	2	2	2	2	2	2	2	2	1	2	2	2	2	27	++
Dierickx et al (2021)	2	2	2	2	2	2	2	2	2	2	2	2	1	2	27	++
Malik & Coulson (2008)	2	2	1	1	-	2	1	1	2	1	2	2	2	2	21	+
Webb & Daniluk (1999)	2	2	2	2	-	2	2	2	2	2	2	2	1	-	23	++
Hanna & Gough (2020)	2	2	1	1	-	1	2	2	2	2	2	2	2	2	23	++
Patel et al (2019)	2	2	1	1	-	1	1	2	2	2	1	1	2	2	20	+

2 = Satisfactory
1 = Unsatisfactory
0 = Not reported
(Max score = 28)

Appendix I: Qualitative analysis extract

Autobiographical shift; sense of not having what want/ what expected/ what hoped for

World view and subsequent self-perception shifts

- Role
- Identity
- Purpose

P: I suppose I did at one point I spoke to the fertility network like counsellors really, I won't lie got a bit upset really a bit down in the dumps and what not, not wouldn't say depressed or taking your life or anything like that but but I didn't see the point in much really so I suppose I'm a bit old fashioned, I'm brought up on old war films and stuff like that where every family has an heir and a spare there's big families and the family names carried, you know carried on type of thing where I suppose you know I'm in a lucky position financially where I don't need to progress in my career if I don't need to you know I can just kind of plateau to a certain extent and I was into my politics and changing the world and everything like that and making it a better place for the kids but then when I suppose my head then though well what's the point, well you know I meant as well sell the 3- bedroom house that I've got, buy a little bungalow somewhere you know there's no point pushing myself really at work, so I suppose it was a form of depression really. So, I spoke the fertility counsellors a little bit but yeah that was the end of it it yeah, professional involvement.

Tradition; expectations personally and socially. Impact of education, intergenerational expectations and scripts?

Sense of loss if this isn't possible. What are the implications?

Sense of self; identity; and role. Without expectation of children, next generation what are intentions, purpose, goal?

Grief. Feeling of stagnation.

Hopelessness

I: I guess, thinking sort of, you've sort of explained like when you found out, or when you first learnt that you were having difficulties with fertility, I guess sort of moving on from that so sort of present-day X I guess how does hat that experience, how does your experience of living with fertility difficulties impact you day to day would you say, if at all?

Isolation

Isolation and exclusion. Barriers to compassion.

From others.

Conflict in showing self-compassion: openness about 'internal battle' but pushing emotions away

Isolation

P: I think it does, I mean I suppose I the marriage broke down, because of I wouldn't say all of fertility, erm but I think that played its part as well, erm then I got with new a new partner after a while found out that you know she couldn't have children of her own due to her own physical issues so I think there's this internal battle in your head of desperately wanting children but then also parking it as well erm I suppose day to day you know my friendship group whore all of a similar age, about 5 of us they've all got children now or over the past 5 years erm you know 2, or well 1 or 2 children kind of each really, so I suppose you miss out on you miss out a lot in a way I think your friends

Resentful. Sadness, parallel processes of loss and grief.

Images: a literal battle in your head. Bloodshed, tears, injury.

What are the pressures to 'park it' and to move on?

Feeling excluded; isolation; not a part of the in-group then get new friends, other parents at nurseries, at the BBQ you're slightly alienated to a certain extent and I probably, if I'm honest probably still think about it daily you know its er not constantly but there'll always be that odd little thought of in your head, erm I think that at start I think I got to think to myself as well now that when I'm at work, when people say of I'm pregnant you know and people expect you to say ah congratulations. I think you know I've said to you before, I didn't become a nice person in my head to a certain extent because I just thought, can I swear? Bloody wankers, type of thing, bloody hell, not again, I've got to put up with another pregnancy and at work and watch the pregnancy develop and so on and so forth, which I know it isn't but when you're in that frame of mind is a bit like rubbing your bloody face in it so where now I think when there's the internal barriers in your head, you I try to be a lot, even though I don't particularly think it though sometimes, I must admit, I still I think I've got to be, I try and say ah congratulation rather than, where before, ah right, well done, (laugh), right you know when you going off, when do I need to get cover for when you know and there being a very clinical work orientated, that's to protect yourself isn't it, when now I you know I consciously got to think well yeah congratulation, well, you know, well done I think ahhaa, yeah if that's what you say

Negative self-perception.

Self-criticism a barrier to self-compassion

Exclusion/ isolation. Challenges and ruptures in social relationships

Maladaptive self-compassion. Pushing away emotions/ distraction conflicts definition of confronting distress

Socially there is a pressure; an expected dialogue around conception/pregnancy.

Identity; perception of self. Self-judgement?

Jealousy/ resentful. Confronted with it daily.

Compassion to self to preserve on wellbeing, but also denying connection to emotions. Timing? Location? In whose company?

Preference to be pragmatic ad practical. Practice-based coping, rather than connecting emotionally.

I: Whatever you say, yeah

P: But yeah, so, yeah it does, it does, I suppose I you know I live near to 2 primary school, we deliberately bought a house near 2 primary schools I still live I the same house, you still see those kids, you know, so you still effected day to day it's just suppose learning to cope with it

Autobiographical shift. The experience conflicts hopes and plans.

Frustration. Grieving an alternative future.

A pressure to just get on with it, to cope

I: And I guess it sounds like, the degree to which, but sort of the degree to which it impacts you changes erm and there, would you say it changed over time, since when you first found our to now

P: Yeah, I think like I say, when I first found out erm you know then the marriage broke down I think the combination of the 2 because they were very close together like I say I lost interest in you

Autobiographical shift

And self-perception

Barriers to compassion

Hope – the paradox of hope.

Hope = vulnerability

Expectations of life; what *could* have been. Pressures for what he *should* have achieved.

Autobiographical shift. Change in motivation. Identity, beliefs about self, world, and future.

Is this self-protective to not say ‘depressed’

Identity; challenging the script of expectations; incongruence with expectations and reality

Hope is a tightrope

Risk of hope?

know lost interest in everything, really. And I didn’t not see the point of living, as in not suicidal, but what you know well what am I working for now, so if I’m if I’m pushing myself and working hard and I’m earning more money but like I said, without being big headed, I’m comfortable, I aren’t passing anything on to the children the grandchildren, not you know, why should I do the politics, an want to create a better world, so I’m not passing anything on to my children, why am I in a 2 bedroom house, why don’t I sell up and just get a little bungalow somewhere, so there was a very , again I wouldn’t say depressed, but a very down in the dumps you know depression to me you know I know there’s different levels, to me it’s not functioning, not caring for yourself, a very clinical , bare in mind where I work, it’s a very clinical level of depression, some people describe it as a functional depression where people still function and what not, I would say it was more just like a adjustment, kind, high level, for me, to start with, quite a high level adjustment where I didn’t like myself as in how I would speak to some people, erm how I would act sometimes no act but how how you come across. Erm but as time goes hold out the hope one day, but I do realise that hopes you know minimal at the same time so its yeah, if that answers your question

I: Yeah, absolutely that more than answers my question thank you. I guess my next sort of question sort of it is you’ve talked about your ex-partner and sort of partners since then, but I guess I’m curious about in your sort of social circle, if there anybody else that you feel has been impacted by your experience of fertility difficulties, do you feel like it’s sort of extended into friends and family and others around you?

Intergenerational grief/barriers to compassion

Life expectations; autobiography.

Fear of disclosing – influenced by gender, culture, generation? Taboo subject; congruent with broader social stereotypes of masculinity.

Shame?

P: Yes, to a certain, but I suppose il have to articulate my argument as I’m thinking about it really but I think you know I didn’t talk to my dad a great deal about it but I did speak to my mum eventually erm you know because you’re getting divorced, you know it’s a, we were only married 2 years it a you know erm it’s difficult really and questions get asked don’t they so erm but going questions get asked don’t they so erm but going back what’s useful is I think as well when you get married – are you married?

The flow of compassion. Complexity.

I: No, I’m not

P: If you get married a little warning for you, everybody will say it to you, right when you having kids, that’s the next step in in the thingy now when hen you’ve been married 2 years and kids still haven’t come along then you start, not from a lot, but especially if you are a male, you’ve got to bare in mind the male culture that we have don’t get me wrong, I’m the first to take the mick out of my friends with different things, with lads banter, and to be honest I wouldn’t have it any other was cus that’s just lads for you, yeah couldn’t be a woman, Jesus it’d be boring, (laugh), but I’ll get onto my argument, is that you start getting the little oh are you firing blanks, is there something wrong, do you want me to have a night with your missus types of thing, I’ll sort it type of thing, and I know they’re only having a laugh and a joke an what not but you do want to punch your best friends in the face at the same time. Erm you know so I think then you start going out a bit less, not meeting up with them a little bit more, if you know what I mean, so again it your just a way to protect yourself er so I spoke to my mum I mean I think I think my parent would like grandchildren erm so that’s difficult at times never really had that discussion but they would always say ah as long as you’re happy they would do, but my feeling s that they probably would, erm friendships with others, like I say we that’s probably it is your friends and your mum really you become distant from your male friends and there’s difficult conversations with you mam really. Is erm I think there was one lady that I worked with that was going through similar similar things, it was her issue at that point erm and they’d had a number of IVF’s, lost a child and what not and we became very friendly because those issues erm and again you know it’s sounds awful but then actually she was successfully conceived and then had a child so that one person that you had that understood everything, that you could talk to, that she would cry her eyes out at you , that you could talk to her

Impact of sociocultural narratives/ pressure/ expectations and how this informs self-perception

Interpersonal relationships

The flow of compassion in male- to- male relationships

Isolation/ distance/ exclusion and simultaneous desire for closeness and connection.

Normalisation and validation

Relating to the researcher.

Perception of experience of men and women. How does he experience being male?

Humour in male friendships; harmful in the context of fertility. Defending that humour appropriate in different contexts?

Implicit pressure from parents; or self-induced pressures – how he expects he should feel?

Impact on relationships. Pressure on self for children but also to provide grandchildren.

Isolation

A shared experience; a short hand for communication. Offers comfort and friendship.

about, suddenly is then a mum, is then you know not you don’t have those deep meaningful conversations that you once had you know everyone so that’s but then you start disliking yourself, and disliking her, which is not her you know, I should but extremely happy for her, which I am now, but at the time, you think your head kind of goes well you fucking left me, well you were the one person that understood, not you’ve got a when say I used to dislike myself there the type of things that I knew I was doing it but I couldn’t help myself so therefore disliked myself for it, I don’t, I’ll be honest with you, I don’t think it’s gone

Negative self-perception/ self-criticism a barrier to compassion?

Isolation

Unfairness; resentfulness; jealousy. Anger.

Comparison.

Grief, and loss of connection. Isolation. Left behind.

Sense of self, self-appraisal is critical but honest. Vulnerability.

Appendix J: Sources of support

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Sources of Support and Information Regarding Distress Associated with Infertility and/or Difficulty with Fertility.

Fertility Network UK

Offers information, support and advice for individuals trying to conceive, going through fertility treatment, or living without children.

https://fertilitynetworkuk.org

Free and confidential support line: 0121 323 5025 | 07816 086694

Email: support@fertilitynetworkuk.org

Andy's Man Club

Offers support, community, and free talking- groups for men

https://andysmanclub.co.uk

Email: info@andysmanclub.co.uk

For urgent help or assistance, contact **The Samaritans**

Free and confidential support line: 116 123

Should you have any specific issues regarding taking part in this study, then you can contact the **Researcher**.

Contact number: X

Appendix K: Interview schedule

Focus	Possible questions and prompts
Opening/ introduction	• Introduce interview • Check understanding of information sheet • Review consent, and consent for audio-recording
Infertility	• Could you tell me about your experience of infertility/ difficulties with fertility? (Prompts: *When did you first know that you were having difficulties? What was happening at the time? What has happened since?)* • Can you tell me about how this experience impacts you day-today? (Prompts: *physically, mentally, emotionally; can you tell me a bit more about that? Can you tell me about how this has changed, if at all?)* • Can you tell me about anyone else who has been impacted by this experience? *(Prompts: can you tell me a bit more about that? friends, family)* • We've talked about your experience of infertility/ fertility difficulties. Can you

	reflect on what this experience means to you? *(Prompts:* Can you reflect on what this experience means to you in your current life circumstances? ; *If you had to describe what infertility means to you, what would you say; How does it feel when you reflect on this aspect of your life; How does this experience 'fit' with your other roles and relationships).* • We talked about how your experience of infertility has affected you. Could you tell me about anything that you do that helps this/ changes how you feel? *(Prompts: When you feel (whatever they described they felt), what happens/ what do you do?)*
Compassion	• Compassion is often talked about in the context of infertility for women?; what I am interested in your experience of compassion and how you relate to other people in the context of this. • The next set of questions will help us to explore that.

Compassion: self to self	• Can you tell me about how, if at all, your experience of infertility has impacted how you see yourself? *(Prompts: can you tell me more about that? what sort of things are you thinking about?; what feelings might you associate?; ask for clarification- what do you mean by '….'?)* • When you feel *INSERT FEELING* what do you do? • What helps the most in these situations? • What gets in the way of doing this all the time?
Compassion: others to self	• Can you tell me about how, if at all, your experience of infertility has impacted how you think how others view you? • When you feel *INSERT FEELING* how do you think others think about you? • What is it that other people do that helps in these situations?
Compassion: self to others	• Can you tell me about how, if at all, your experience of infertility has impacted on your relationships with other people? *(Prompts: what sort of things are you thinking about? ; what feelings might you associate?;family/ friends/ partner etc.)*

	• When you see others upset/angry/etc about your experience of infertility (either as a couple or as an individual), what do you do? *(Prompts: can you tell me a bit more? Can you tell me what it makes you think?)* • Can you describe any way that you get involved in these situations? *(Prompts: What makes these situations better or worse? how does this make you feel?; how would you like to change this in anyway?)* • What, if anything, gets in the way of doing this all the time?
Ending	• What beliefs of yours have changed through this time? What new beliefs are emerging; what (if anything) have you learned from your experience of infertility? • Draw research interview to close • Express gratitude • Provide space for questions from participants; opportunity to answers and/or add to discussion