GENDER DIFFERENCES IN INFERTILITY AND THEIR IMPACT ON MALE COUNSELLING NEEDS

Dr. Paul A. Entwistle

Journal of Fertility Counselling (2020), Vol. 27 (2) pp.16-18

I would like to thank McEleny and Stevenson for their recent, insightful paper, *All about Fertility - helping people to help themselves*, which featured in the latest issue of the Journal (j. Fertility Counselling, Spring, 27.1, 22-23). Also for their proposed "All-About-Fertility" website. I was nevertheless somewhat saddened to hear that men with fertility related problems are continuing to be reluctant to discuss these with counsellors or other agencies, or indeed with anyone outside their relationship (and frequently not even within this). I came to much the same conclusion many years ago when working with men in a range of fertility situations, but assumed (and hoped) that with the increase in public and media awareness of the frequency of male infertility over the past 10 years, men were starting to feel more empowered about admitting to and talking about their infertility problems. Unfortunately, it appears from McEleny and Stevenson's research that this is still not the case.

Part of the problem still may be the difficulty that some *male* doctors and medical professionals have about talking honestly and frankly to their *male* patients about their infertility, along with the disempowerment that some men might feel when receiving such information from what they assume to be fully fertile men. But of course, even talking to a *female* medical or counselling professional, no matter how warm and diplomatic they may be, can generate similar discomfort and embarrassment. I would surmise therefore that, despite the frequently acknowledged inadequacies and inaccuracies of the information obtainable from the internet, "Doctor or Counsellor Google" has become a further means whereby men with concerns regarding their fertility can seemingly obviate the need for face-to-face discussions and counselling, and instead can explore their problem from the privacy of their living room or bedroom.

Over a career of forty years I have had many hundreds of conversations with men of all ages, about their diagnosis (or possible diagnosis) of male infertility, and how they are managing (or think they might manage) this. Such discussions often included their partners who were concerned about how their men were dealing with, or avoiding dealing with their infertility assessment. These conversations have taken place in the context of my various roles as a clinical scientist and as a fertility counsellor. In the former role, I spent four years as a researcher into sperm function and fertility, which necessitated talking regularly to men about their semen results. I have also worked as a fertility scientist providing a private semen analyses service, as a laboratory manager running a pre-vasectomy and pre-radiotherapy sperm banking service, and as a recruiter and assessor of potential donors for a donor insemination service.

For most of that time I have also been a fertility counsellor and mind-body therapist and researcher in infertility, and was one of the very earliest of the *voluntary* counsellors working in an IVF Unit. I also worked as consultant fertility counsellor primarily seeing individuals and couples with

unexplained infertility. During the time I have spoke to many couples and to individual men about fertility counselling at local and regional infertility support groups, formal and informal, large and small. Coincidentally, in my current role as a Primary Care medication counsellor, I have realised that a significant percentage of the patients I have seen in GP practices over the past 15 years had been prescribed long-term antidepressants or tranquillisers for infertility related issues. These were prescribed either because of the stresses imposed upon them as a result of their investigations or treatment, or later, as a means of helping them to come to terms with their infertility, their ultimate childless status or even their consequential marital breakdown.

From these varied encounters and conversations, with so many lovely men, women and couples, I feel that I have learnt a little at least of how they feel/felt about being labelled as "infertile". Also about some of the differences in how fertility and infertility is perceived by men and women, and how therefore an infertility diagnosis affects, and is managed, differently by men and women. These differences I believe arise in part from three mitigating factors that influence the impact of an infertility diagnosis on women when compared to men, and which need to be taken into account when counselling men and women in the fertility unit.

The first of these factors is the difference in expectations that women and men have about of the likelihood of their having a fertility problem. Many women with fertility problems, when setting out to try for their baby and their family, will have some prior hint or expectation that they might have a problem or delay, or may require help with conceiving. Such indications as irregular or absent menstrual cycles due to hormonal problems; irregular, abnormal or excessive intra-menstrual bleeding or pain suggestive of fibroids or endometriosis; or recurrent vaginal discharge and/or episodes of pelvic pain hinting at possible pelvic inflammatory infection with potential for tubal occlusion. All of these problems can give some women prior warning of a potential fertility issue.

A second and equally important factor is that, for most women experiencing a delay in conceiving, the consequent investigations and trials of treatment options conventionally take place over a period of many months from simple ovulation testing and induction, through to more invasive approaches using laparoscopy and surgery. The results of these and the growing awareness of their potentially serious implications accrue over a similarly long time scale with only a gradual realisation of the impact of each diagnosis on the women's chances of achieving a successful conception and baby. The third mitigating factor applicable to female infertility and which is increasingly becoming understood amongst medical and non-medical populations is that conception is a series of linked steps, many of which can be bridged, by-passed or obviated. The identification of a problem in one of these specific steps, might not therefore be a total bar to her becoming pregnant and achieving a baby.

Contrast this with the situation with which men in their first ever, potential or actual infertile relationship, may be having to deal. Other than what they would brush off as natural (and groundless!) fears, most such men would have little or no prior suspicion or any real expectation of there being any degree of a sperm problem, let alone of their being infertile. Any prior self-appraisal they might have made is likely to have been based upon the generally perceived attributes of maleness such as erectile potency, volume of ejaculate, sexual libido or even penis size. Even today I suspect that these are still commonly seen as portraying a picture of real "manliness" alongside which fertility is therefore assumed axiomatic. Indeed, with this assumption in mind, many men will have spent much of their prior years taking care to *avoid* an unplanned or unwelcome pregnancy, whether with their current or with earlier partners. Just as most women from childhood upwards have expectations of their being able choose to have or not have a baby when the time comes, the

vast majority of men I would guess, will have always seen themselves as fertile and therefore fully capable of "getting my partner pregnant" when the time came.

For the majority of men therefore, the revelation of discovering that they have an infertility diagnosis will come as a cataclysmic shock. This is an impact that would not have been ameliorated or softened over a series of tests and months, through the gradual accruing of knowledge and information and the exploring of options. Within as short a time as one month and two semen examinations, they can be given the news that they are sub-fertile or even infertile. Even the former, a report that labels a man as not *fully* fertile is disrupting to his self-confidence. This report tells him that he is not the "fertile superman" that he may have always supposed himself to be, it can rob him of his emotional potency as well as his fertility, losing something that he had always implicitly if not explicitly believed about himself. This is why too rapid a male diagnosis, whilst useful for an older couple trying for a family, can perhaps be so damaging to the male partner.

This damage is further compounded when he learns that there is no cure for his problem, except perhaps for those men with hormonal conditions such as idiopathic hypogonadotropic hypogonadism, where hormone treatment can sometimes restore fertility. More usually the couple have to resort to some form of assisted fertility treatment such as IVF, sperm/egg micro-injection (ICSI) or sperm retrieval. If these are quickly successful in achieving fertilisation and embryo replacement, then his fertility is seemingly restored even if this does not lead to a full-term pregnancy. But where this is not the case then his infertility is reaffirmed and remains visibly and painfully in the public, or at least in the clinical domain, for as long as the couple are in the infertility treatment arena.

This can be why many men with major irretrievable infertility have told me that they preferred to move to adoption rather than to Donor Insemination (DI). They admitted (often with some guilt) that they saw this as an escape route for them in dealing with their infertility problem as it would get him out of the infertility clinic environment, so reducing his private and public ego-damaging pain and distress. It would also hide the true nature of their problem from friends and family, as well as adoption being an easier and more acceptable conversation than DI to have with the couple's future children. Some men also saw it as a way of sharing their infertility problem as a couple, in that neither partner would have a biological child in their relationship.

The use of donated semen can sometimes be portrayed as a solution to male infertility, which clearly it is not. It can certainly be an appropriate option for treating childlessness, and for satisfying the couple's need for a family and the female partner's understandable need to experience conception, pregnancy and delivery of their baby. However, using donor sperm does not cure the male partner's infertility, physically, publically and even psychologically. In practice, where a pregnancy is achieved in the first cycle of DI after several or many attempts using the male partner's sperm, via AIH or ICSI, this conception can serve to further reinforce the male partner's feelings of inadequacy and failure. One man's thoughts to me were that – "all she needed was some decent sperm instead of my rubbish, and she was pregnant".

Difficult though it is for the couple to commence DI and then for this to take a while to achieve a pregnancy, in some cases this delay can be helpful. Such a delay gives both partners the chance to see how they might feel if she became pregnant with donor sperm, and a chance therefore to reconsider their decision if necessary. It also suggests the possibility that perhaps she also was not super fertile, and that their infertility had truly been a couple issue rather than solely due to his low fertility sperm. Although I have worked with very many totally happy and fulfilled couples whose families were conceived through DI, for some male partners I have spoken to, the couple's use of

donor sperm to achieve their family has seemingly glossed over his infertility problem, making counselling feel irrelevant, and leaving him to cope with his personal pain alone, and for all time.

Male partners would often tell me that they felt obliged to appear whole heartedly supportive towards their partner's need to experience a pregnancy and to the DI clinic's desire to be helpful, and have felt inhibited in expressing their own true feelings and reservations even to the counsellor, who is clearly one of the clinic team. Any such hesitancy admitted on his part to the counsellor, behind his partner's back as it were, can raise real fears for him that they will be refused treatment, taking away the chance of his partner experiencing a pregnancy, and possibly undermining the security and future of their relationship.

As a result of my time spent with men in these and allied situations, I have come to realise that fertility can have a different meaning for many men from that of their female partners. For many, although I am sure not all women, fertility is primarily a route to conception, pregnancy and their family and therefore only really becomes important when they choose to have a family. For men however, fertility can be an important attribute in its own right throughout their lives, and independent of conception and paternity. It is something that contributes to their inner picture of who they are and of how they feel the world sees and feels about them, whether or not they ever want to have a family. A diagnosis of male infertility or even subfertility takes away that important part of whom they are.

As an illustration of this - I once saw a man in his late-30s who told me he had never wanted children and was planning to have a vasectomy as a permanent means of ensuring his future birth control needs. However he felt that he would like to become a semen donor for a few months leading up to his surgery, for what he emphasised were altruistic reasons. Whilst being a little uneasy about this conflict of plans, I agreed to undertake some preliminary semen analyses with him before discussing this further. His two initial semen specimens showed an extreme sperm problem with regard to both sperm numbers and quality. His fertility whilst not actually nil, was of a very low order, and he certainly could not be a donor, in fact he probably did not even need to have a vasectomy. When I began to explain this to him, it was immediately apparent that he was devastated at the thought that he had probably always been an involuntarily infertile man, this despite his plans now to render himself infertile. I realised that I needed to change the focus of our discussion towards his principally not having the very high sperm count and activity that I could use as a donor, but stressing that he did have some active sperm and was clearly fertile. He therefore required a vasectomy in order to ensure his future infertility. When we last spoke he was planning to see a urology consultant to explore his unexpected and innate sub-fertility.

From working with so many men and women in infertility situations over so many years, I have come to believe the following. If I were to say to many of these men - "I have done my own special fertility tests and these have shown that you are fertile, even though you are not going to be able to have a baby with your partner", for most, their response would be – "that is so sad, but It's a relief at least just to know that I am fertile". However, were I to say the same thing to the women – "My special tests have proved that you are fertile, although you are not going to be able to have a baby". The response would – "What good is fertility to me if it doesn't get me a baby". It all sounds like common sense but it does reflect a major difference in attitude and emotional focus that I believe needs to be considered when providing gender appropriate counselling support to men and women in infertile settings, and when trying to persuade each to utilise fertility counselling services.