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“It’s such a pathetic little operation”: Men, masculinities and vasectomy in New Zealand

Gareth Terry

A thesis submitted in partial fulfilment of the requirement for the
degree of Doctor of Philosophy in Psychology, The University of
Auckland, 2010

Abstract

This thesis examines vasectomy as a gendered practice of (non)reproductive masculinity. Taking the New Zealand context as my domain of focus, I will discuss the socio-cultural meaning of the operation both within Western society, and for individual (heterosexual) men in the ongoing production and reproduction of their identities. This project reports on interview and survey based data, in which a number of New Zealand men made sense of the operation. It is social constructionist in nature, critical realist in orientation and also draws upon poststructuralist feminist theory and critical masculinities theory. This thesis will rely on various forms of quantitative, discourse and thematic analysis to highlight the ways in which men talked about having a vasectomy and its impact on their relationships with their partner, themselves, their own body and others. It will examine the potential use of these in “disrupting and displacing dominant (oppressive) knowledges” (Gavey, 1997, p. 53) and producing inclusive expressions of masculinity, which will have material benefit for women (and men).

Acknowledgements

This thesis, while the product of my own reading, ruminations and really quite awful typing skills, would not have been possible without the influences, time and support of the following people:

The men who shared their experiences of vasectomy with me, their willingness to be open about their sexual and reproductive decision making. Thank you.

My supervisors, Virginia Braun and Nicola Gavey, who both having schedules that defy normal definitions of busyness, still managed to help provide the direction, enhancement and enthusiasm that helped make this thesis possible, all the while not making me feel awful for the disruptions the thesis had to the operating of *Feminism and Psychology*. Thank you both! Ginny in particular, thanks for keeping me on track when I needed it, giving me slack when I needed that more, and for reminding me time and time again (in the best possible way) that there is *always* something to improve!

The Gender and Critical Psychology Group (Jeff Adams, Melanie Beres, Nicola Gavey, Jade Le Grice, Sue Cowie, Bernadette Guerin, Virginia Braun and Pani Farvid). Thanks for the questions, insights and for putting up with my cynicism. In particular I would like to thank Melanie, for coffee and conversations, for helping me with the stats, and for introducing me to the 'delights' of child friendly cafes (20 children under three!).

Thanks to the Department of Psychology at the University of Auckland for providing me with such great supervisors, an up to date computer and an office space in the Dungeon. Thanks to those in the Department who made the research for, and writing of, this thesis easier. This thesis was also made possible by a University of Auckland Doctoral Scholarship.

My Friends – Special thanks to the Pancake Posse and the Yoga and Pizza Collective: Jody and Miriam for taking my work seriously, Julian for pretending (or at least I hope so!) not to. Thalia who made me put all my ideas into two sentences of layperson’s language even when she *well* understood the jargon. Mike for reminding me to (indirectly) of the need to spell and grammar check and for ‘goodtimes’. For all my friends who have never really got what I do, but love me anyway, put up with my ranting and like to introduce me as a sexologist. Thanks guys!

Brazilian Jiu Jitsu, despite it being particularly inconsistent that a critical masculinities researcher is also a martial artist, I have finally found a sport that makes sense to me (although I’m aware, not to others). Thanks to my coaches and club mates, who often didn’t even try to understand my work, but allowed me an avenue to think about something other than vasectomies, and to burn off calories and stress. Special thanks to the Garage and the Hulk for helping me become a halfway passable blue belt.

My family – you’re mostly all half crazed, but I wouldn’t be where I am (and I quite like where I am) if not for my formative years and all the stuff after that. Thanks especially to Dad, not only for being supportive and taking me as I am, but also for being the first guy I knew of that had had a vasectomy. However that came about, you’d be surprised how much those sorts of decisions have helped shaped me.

Nicola – This thesis would have been impossible without you (as you well know!). Thanks for challenging me, questioning me, agreeing with me, talking with me, listening to me, laughing at me, laughing near me, and encouraging me. For doing the cooking (and washing up!) when I was too stressed to leave the security of the computer. For being the primary breadwinner in our home for over six years. For keeping me sane(ish) and stable...

Chocolate Fish!

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Chapter 1: To snip or not to snip? Is there even a question?

I first heard about vasectomy when I was about ten or eleven. Why (or even how) I was involved in conversations about vasectomy at such a young age is a little beyond me, but it may have had something to do with my family structure. My parents, having divorced when I was a child, had both remarried, and in the process created two new blended families. This meant I was inundated with older (and informative) stepbrothers and stepsisters, and the later addition of a new brother and sister much younger than myself. Various conversations about the different dynamics in each family, and the large age gap between my newest siblings and myself, meant I was able to catalogue the differences between parenting styles, sibling interaction and the relationships my parents had with their new partners.

I did not have (as I do now) the benefit of a number of years of critical masculinities theory under my belt, but I still remember being able to distinguish between the types of men my father and step-father were. I identified more with my father (despite his absence), and much less so with my step-father, who I can (now) recognise as being strongly invested in a particularly traditional expression of masculinity. While I have no real interest in trying to determine how this identification came about (though perhaps one of my psychotherapist friends might want to give it a stab), I was able to (in a fashion) recognise some connection between the masculinities my father and step-father were invested in and how these impacted upon their decision-making processes.

One of those decisions, it turns out, was their involvement in sharing the contraceptive burden with their partners. Somehow, in the midst of these disruptions, redefining of family boundaries and identifications, I either overheard (or was perhaps even party to) conversations about sterilisation. The overall gist of these conversations was that my father had had a vasectomy and my step-father had not. Although this had very little meaning for me as a child, my increasing awareness of the

differences between my father and step-father meant I catalogued their choices in such matters as indicative of who they were and who I wanted to be like. Having a vasectomy in a heterosexual relationship seemed like an inevitable consequence of being a certain type of man.

While the issue of vasectomy and the men in my life who have had them (or not) faded into the background for quite some time, it became salient again several years ago. This was largely due to my partner and I undergoing the process of deciding whether we want to have children. While we still have not resolved this question (tending toward *not* having them currently), the issue of vasectomy has become, not only inevitable, but also somewhat immanent for me. As an outcome, this thesis has been more than a simple academic project; it has been a significant part of my working through the implications of being a heterosexual identified male, in a long term relationship, and thinking of making a permanent decision about not having children.

A key factor that sparked my *academic* interest in vasectomy was a *60 Minutes*¹ special on the operation. In this segment, Willy De Wit (NZ comedian/radio broadcaster/TV personality) had a vasectomy performed on camera, with all its 'gory' detail demonstrated for the edification of viewers. Built around the claim that men in Aotearoa/New Zealand have one of the highest rates of vasectomy in the world,²³ it also drew attention to New Zealand being one of a small number of countries where vasectomies were performed at higher rates than tubal ligations. These claims sparked my interest, especially as I was already academically interested in the critical examination of men and masculinities, and had begun to tentatively think about vasectomy as a part of my own future. This seemed like the perfect avenue to continue researching men's 'masculine sense-making'

¹ A current affairs show

² There are some questions about the collection of comparable statistical data around contraception use (particularly male contraception use) in other countries; however, this still seems to be as accurate an assessment of vasectomy rates currently possible.

³ Canada, as of 2008 projections (Clifton, Kaneda, & Ashford, 2008) may be about to overtake us in this matter, so we wait with baited breath.

(Wetherell & Edley, 1999), and so I began the process to find out more, launching myself into the public eye with a press release (see Appendix A) calling for participants.

“Ah mate... nuthin’”: How to ‘explain’ the high vasectomy uptake in New Zealand?

‘Explaining’ the high rates of vasectomy was an integral part of my early experience in researching the topic. As a newly minted doctoral student, with only general reading on the subject, I was very early on asked (by a number of different people and organisations), to give some rationalisation for New Zealand men’s high uptake. The press release had provoked (somewhat incredible) national interest in the issue and soon national radio stations, newspapers, television news providers and even Australian radio stations were lining up to hear what I had to say. As a consequence of this exposure, I also received more than three hundred emails from men wanting to be involved in the study. These men, as well as wanting to offer their stories, also inevitably wanted some sort of explanation as well.

The subject had apparently hit a nerve (excuse the pun) nationally, and it is not surprising then that the stalwarts of talkback radio soon contacted me to ‘ask my opinion’ (read: tell me theirs) about New Zealand’s high vasectomy uptake. One of these hosts (Michael Laws, who also happened to be Mayor of Whanganui, a (conservative) ex MP and ex-‘spin doctor’ for various other political figures), ended our interview (see Appendix B for transcript of full interview) with the following ‘question’:

Laws: listen the other things that comes out about this is um this remarkable stat about the forty to forty nine age group that over half of New Zealand males have had a vasectomy [GT: yeah] do you think that perhaps there’s a critical mass that builds up that enough men talk to each other and say “ahh mate (.) nuthin’” that that gives if you like the green light for other men that age group in that peer group to go ahead themselves

GT: yeah yeah In think that that’s a an important um factor I also think it’s um I mean the biggest surge of vasectomies happened in the nineteen seventies and that’s also around

the time that the uh the peak of or one of the big kicks for the feminist movement began as well um

Laws: (overlaps) (outbreath) mmn you see I don't like that correlation

[cuts me off line]

For Mr. Laws the question of women's groups and their advocacy for reproductive rights did not seem to be something worth investing time in discussing, and the possibility that couples make such decisions together was absent. Laws, as a talkback host, appeared to have a very fixed idea of the sorts of social arrangements that make a high uptake in vasectomy possible and they certainly did not involve feminists! Admittedly, some research evidence seems to suggest that men *do* rely on other men who had had vasectomies as a source of information in the decision making process (Amor et al., 2008; Mumford, 1983). However, whether the answer for high uptake in New Zealand is as simple as men being more engaged in each other's lives and thus having raised the profile of vasectomy for one another is another matter.

The interest in offering simple explanations for high rates of vasectomy is certainly not a new one. In the 1970s in the United Kingdom, Wolfers and Wolfers (1974) referred to certain periods of time, characterised by significant rises in vasectomy uptake, as experiencing 'vasectomania'. Critiquing 'vasectomania', Wolfers and Wolfers (1974) put the 'blame' at the feet of providers and overzealous 'vasectomarketing': "we are fully convinced that no good for anyone is served by employing the pressure sales techniques appropriate for the promotion of canned soup and soap powders to solicit irredeemable decisions" (Wolfers & Wolfers, 1974, p. 153). Concerned that men might feel pressured into having a vasectomy, Wolfers and Wolfers (1974) argued that reduction of 'vasectomarketing' would create uptake rates reflective of greater consideration in the decision-making process. Such a simplistic analysis of a highly complex social phenomenon, let alone its lack of regard for the pressures women are placed under to manage their reproductive bodies, is only one of many examples (which includes Laws' interview) of attempts to theorise the uptake of

vasectomy in ways that perpetuate male privilege. While concerns about vasectomania from academic sources such as Wolfers and Wolfers seem to have faded, giving way to a much more positive view of the promotion of the operation, there remains an interest in easily digested explanations.

To add to the tropes of contemporary talkback hosts and (conservative) scholars of the 1970s, were the lay explanations that filled my email inbox. Alongside the large number of men expressing interest in participation in the study and the media calls were angry references to men wanting to have affairs without risk of making 'mistresses' pregnant, and somewhat contradictorily, the growing 'feminisation of New Zealand' with vasectomy being touted as yet another example of men being thrust 'under the thumb' of women.

Theoretical approach to the thesis

In contrast to these simplistic explanations, suggestions and accusations, my interest in the number of men choosing to take up vasectomy in New Zealand was (and is) less invested in seeking individual traits of particular men, or even in New Zealand men as a collective. Instead my interests lie in the social structures that make such uptake possible, the cultural resources that men draw from in the formation of their identities, and the ways these cultural resources are deployed as they interact with others. This thesis examines vasectomy as a gendered practice of (non)reproductive masculinity. Taking the New Zealand context as my domain of focus, I will discuss the socio-cultural meaning of the operation both within Western society, and for individual (heterosexual) men in the ongoing production and reproduction of their identities. This project reports on interview and survey based data, in which a number of New Zealand men made sense of the operation. It is social constructionist in nature, critical realist in orientation and also draws upon poststructuralist feminist theory and critical masculinities theory. It locates vasectomy within the gendered arena of contraceptive and reproductive responsibility, which, to all intents and purposes, has unfairly

burdened women. I will now briefly introduce the different theoretical influences of the research and, following this, give an overview of the rest of the thesis.

Social constructionism

No longer contentious within academic psychology (Edley, 2001c), social constructionism offers insight into the ways people make sense of the world around them. Fundamental to social constructionism is the notion that human production of knowledge (i.e. our ideas, labels, concepts, experiences) does not merely reflect the way the world is, but also helps to constitute it (Burr, 2003; White, Bondurant, & Brown-Travis, 2000). Also important to social constructionist theory is the suggestion this is also true of knowledge about people themselves. What we 'know' about ourselves is both historically and culturally specific, socially *produced* rather than 'uncovered' (Parker, 2002).

Generally within Western society, the individual has been understood as "a natural locus of beliefs and desires, with inherent capabilities, as the self evident origin of actions and decision, as a stable phenomenon exhibiting consistency across different contexts and times" (Rose, 1996, p. 22). The 'turn to language' or 'discourse' across the social sciences (Burr, 2003; Wetherell, Taylor, & Yates, 2001) has challenged these assumptions, and has meant that gender (and particular to this thesis, masculinities) can be understood as products of the social environment, rather than inherent qualities. Gender is not a simple manifestation of an internal state, but a *performance* (Butler, 1999). It is something that men (and women) *do* or achieve rather than *are*. It is a process of constantly and consistently maintaining and reinforcing this performance in order to be ascribed one gender or the other (Courtenay, 2000).

How we understand masculinity (or more properly masculinities (Connell, 2002, 2005)) within this framework, tends to ride against the current of the commonsensical location of masculine activity *within* the self. Edley (2001a) has explained this 'different' way of understanding masculinity :

So where traditional psychological analyses have seen men tinkering with their cars and their repeated conversations about beer and football as *footprints* and set out to track the animal that produced them, the discursive psychologist insists that these words and deeds *are the beast itself*. Masculinity is viewed as a consequence rather than a cause of such activities (p. 191, emphasis in original).

This thesis is also influenced by poststructuralist feminist theory (Gavey, 1989, 2005) and I identify as (pro)feminist in orientation to this. I am invested in the value of adding to liberatory discourse and positive material outcomes for women and reducing the negative impact of orthodox versions of masculinity upon women and men. I am interested in seeing reproductive responsibility equalised between men and women, with more emphasis on increasing knowledge about men's choices and involvement in contraception. This is because: "a lack of information on men [has] implicitly overemphasise[d] female responsibility for contraceptive use, pregnancy and child bearing" (Greene & Biddlecom, 2000: 84). This research project, therefore, has material as well as theoretical implications, particularly where publication can contribute to research making men's reproductive bodies more visible, and therefore more able to be discussed and critiqued. A critical realist stance allows scope to begin the project with these concerns in mind.

Critical realism

Within the wider framework of social constructionism, the predominant position for the research reported in this thesis was critical realist. "Critical realism acknowledges the 'social construction' of reality, the reality described by discourse analysis, but embeds such descriptions of relatively enduring structures of talk, conceived of as the interlacing of power and ideology" (Parker, 2002, p. 60). Critical realism stands between relativist and realist approaches, highlighting the mediating

power of language and its potential to determine people's experience and knowledge of the world, without the denial that this language is built upon and into material realities.⁴

Important within a critical realist position is the tendency to be informed by themes of justice and material equality and by so doing has the potential to challenge structures and systems in society that marginalise, label and pathologise groups with less power (Parker, 2002). Historically (as I will discuss in Chapters 2 and 3), vasectomy and its impact on men's psychology has been theorised within a positivist framework, which has tended to reinforce, rather than challenge men's privileged status. This reinforcement has largely been located within the 'personalities', 'predispositions', or individual 'traits' of men (see Chapter 2 and 3) and done so through appeals to scientific rigour. Parker (2002) has referred to this generation of ideas about people, and their location within a humanistic construction of the self as psy-discourse, and has argued that it is both powerful and prevalent. Critical realism, however, has the potential to expose "positivist psychology's pretensions to model itself on what it imagines the natural science to be, and it grounds discursive accounts of mentation in social practices" (Parker, 2002, p. 57). In this way, a critical realist analysis of the accounts and survey responses of men in this project attempts to go beyond the "psychology of the vasectomised man" (Wolfers & Wolfers, 1974, p. 227), and instead investigate the social practices and structures that make possible (and at times constrain) certain ideas about vasectomy. Critical realism chooses to define a certain level of 'reality' as a foundation, in order that one can position oneself subjectively. It is this 'groundedness that makes for an appealing stance in which to do social constructionist research in an area where women continue to be marginalised.

⁴ Edley (2001c) has pointed out that much of the concern with 'pure' relativism relates to misunderstanding the differences between its ontological and epistemic expressions, or at least the conflation of the two. While I wholeheartedly agree, I would suggest that taking a critical realist position prevents the potential for such confusion, and allows for research to take 'realist' stance on injustices.

Aims of the research

This research has four primary aims: First, to introduce and explore New Zealand men's accounts of vasectomy. Second, to identify the discourses of family, sexuality and masculinity evident in and around men's accounts. Third, to consider the ways in which vasectomy is constructed as a desirable, viable, or even necessary, contraceptive choice for (heterosexual) men. Fourth, to examine the potential for men's accounts of vasectomy to disrupt dominant constructions of masculinity and sexuality that are oppressive, through its associations with care, reproductive responsibility and egalitarianism.

Chapter Outline

The next chapter in this thesis (**Chapter 2**) is a review of literature specific to research on vasectomy. In it I will discuss research that has been key to understanding the "psychology of the vasectomised man" (Wolfers & Wolders, 1974, p. 227). The research and theory covered within this review will extend from the late 1960s (when an upsurge of vasectomy research began, leading to Wolfers and Wolfers' (1974) concern about 'vasectomania'), through to more recent research, which with only a few exceptions, tends to be focussed upon developing countries. Themes of previous research will be highlighted and questions about the current 'wave' of 'vasectomania' will be raised.

Chapter 3 will review literature on the subjects of men, masculinities, embodiment, particularly as they pertain to understanding reproduction. It is in effect the project's 'intellectual home' I will discuss the social constructionist framework of men and masculinities that the rest of the thesis will rely upon (with some mention of masculinities specific to New Zealand), and then seek to embed the research and theorisation of vasectomy within this. Some of the history of men's involvement in reproduction will be discussed, with some focus on a major 'turning point' in the recent history of reproduction, the 1994 International Conference on Population and Development in Cairo.

Chapter 4 will outline the methodologies used in the rest of the thesis. Beginning with an explanation of the mixed methods approach taken in the thesis, I will locate the forms of analysis used as both *pragmatic* and *appropriate*. I will then discuss the data collection and analysis in both their quantitative and qualitative forms. A description of the different forms of data analysis will follow. The analysis of qualitative data, which made up the primary form of data collected, will be discussed in light of the ‘spectrum’ or ‘pool’ of different forms of discourse analysis. Later chapters will be then located within this spectrum.

The first analytic chapter (**Chapter 5**) is based upon the quantitative data that were collected from an online survey. It is largely made up of descriptive data and two examples of exploratory factor analysis (EFA) based on men’s responses to questions about their reasons for, and concerns about, having a vasectomy. It provides an important link to previous research, which has been (historically) almost entirely quantitative in nature.

Chapter 6 is the first qualitative analytic chapter, and presents a thematic analysis of the interviews with the men who had undergone a ‘typical’ vasectomy (i.e. had children and were in a long term relationship at the time of the interview). It discusses the primary themes of responsibility and heroism and how they fit within a context of a growing rhetoric of ‘men’s involvement’ in contraceptive/reproductive tasks. I will suggest that, similar to the subject position of the ‘new father’, talk of being responsible fits within an ‘economy of gratitude’ (Hochschild, 2003).

The second qualitative chapter (**Chapter 7**) draws upon the conclusions of Chapter 6 and will develop the finest grained form of analysis in the thesis. While fitting within the scaffolding of critical discursive psychology, the analysis will *tend* more toward a discursive psychology influenced by conversation analysis. In saying this, it is still influenced by poststructuralism and relies on concepts such as ‘cultural resources’ and ‘imaginary positions’ (Wetherell & Edley, 1999). In the chapter I will

examine two extracts of interview data from one participant 'Chad' and focus on the ways he makes sense of the notions of 'responsibility' and 'heroism'.

The third qualitative chapter (**Chapter 8**), while still falling within the 'landscape' covered by critical discourse psychology, is much less fine grained than Chapter 6 and follows closer to Wetherell and Edley's (1999, 2009a, 2009b) synthetic approach to discourse analysis. Its focus is the decision making process and ways in which men refer to themselves, their bodies and other men in order to 'make sense' of themselves as masculine.

The final qualitative chapter, **Chapter 9**, will reflect upon the cultural resources men who do not have children, yet have vasectomies, draw upon and are 'answerable' to. This chapter will be much more poststructuralist in orientation, highlighting the power of pronatalist and neoliberal discourse in the subject positions men with 'pre-emptive' vasectomies take up. It will discuss 'marginalised' or 'deficit' identities (Reynolds & Taylor, 2005; Reynolds, Wetherell, & Taylor, 2007) and their intersection with discourses that provide men with 'choosing power'.

Last, in **Chapter 10**, I will discuss the contributions this thesis has made to understanding vasectomy and the men who have it performed on them. I will also discuss its contribution to critical masculinities theory and the connection between the cultural resources men draw upon and their involvement in reproduction/contraception.

The goal throughout these chapters is, using various forms of analysis, to theorise the place of vasectomy in the formation of men's identities. This project is premised upon the assumption that masculinities, as with all gender categories, can be shifted, challenged, built upon and enhanced.

Chapter 2: “The psychology of the vasectomised man”: A literature review

This chapter reviews literature important to critically evaluating the status of vasectomy. It will set out and discuss the patterns of research that have developed over the last few decades in order to understand vasectomy’s relationship to masculinities, men’s psychology and men’s participation in contraceptive choices.

Vasectomy research

Research on vasectomy has gone through clear periods of interest and development and can be broken up into distinct themes. As vasectomy is a medical procedure, much of the literature tends to focus within the area of prevalence, side effects and ways to improve its efficacy, both in terms of the surgeon’s knowledge and improving outcomes in the men receiving the operation. Wolfers and Wolfers (1973) argued that since vasectomy was first performed on human males in 1893, the operation has gone through ‘waves’ of interest (e.g. initially high due to its eugenic value) and such varying interest is reflected in the foci of research that have developed. This pattern seems to have persisted, with broader interest in the social and psychological connotations of the operation and the men who have it performed on them, being broken up into three clear periods. The first contemporary ‘wave’ of interest occurred in the 1960s and 1970s, following this, two distinctly different ‘waves’ occurred, divided by the Cairo conference of 1994 (see Chapter 3).

This section will first, briefly compare vasectomy with its ‘opposite’, tubal ligation. In order to fully make sense of vasectomy as a gendered practice, and within the scope of my critical realist position, the bare ‘facts’ of vasectomy versus tubal ligation need to be understood. Second, I will broadly discuss some of the medical concerns that have been raised in research on vasectomy. Third, I will address the different lenses that social and psychological researchers have viewed vasectomy

through historically, from the first 'wave' of vasectomania in the 1960s and 1970s. Much of the research that studies a "psychology of the vasectomised man" (Wolfers & Wolders, 1974, p. 227) occurred in the late 1960s and early 1970s, with a much slower trickle of psychological research occurring through the decades since. Production of medical data and prevalence statistics has been relatively consistent over this period, however, and I will give a broad and relatively recent overview of that research as far as it pertains to our understanding of men's uptake of vasectomy.

Whose tubes to tie? The 'snip' versus tubal ligation

World-wide, sterilisation makes up almost half (43.8%) of all contraceptive uptake, with the vast majority of these forms of contraception being 'female controlled' (Clifton, et al., 2008). Vasectomy (at 4% of total contraceptive use) and condom use (at 6%) barely register against total contraception use, and even when contrasted more specifically with tubal ligation (at 21%), there is still a significant discrepancy (Clifton, et al., 2008). Why contraception is so heavily weighted toward women's bodies will be more fully developed in Chapter 3, however at this point I will suggest that there is nothing about the procedures themselves which would suggest tubal ligation should be the preferred option when sterilisation is being considered.

Vasectomy (also known as male sterilization, or 'the snip'), is a simple, 15-30 minute operation, in which the vas deferens (more commonly referred to simply as 'the vas') is cut (or occluded) and cauterised under local anaesthetic (Anderson & Baird, 2002). It is highly effective, with failure rates recorded around 1/400 (failure likelihood is highly dependent on the skill of the surgeon) (Jamieson, et al., 2004; Sparrow & Bond, 1999). It requires men to avoid any heavy lifting for a few days, but they can return to sedentary work after a full day's rest. It has been suggested that recovery time to return to 'normal activity' may be reduced by men opting for the now more popular non-scalpel technique, which involves puncturing rather than incising the scrotum (Alderman & Morrison, 1999; Sparrow & Bond, 1999). Complications post-vasectomy are both rare and minor (Adams & Walde,

2009). Infertility (azoospermia) occurs after approximately 3 months, although in some cases this can be expedited by the performance of at least 20 ejaculations (Bartz & Greenberg, 2008)

In contrast, tubal ligation (female sterilisation) is a more serious operation that generally involves general anaesthetic (and thus increases risk of death). It is usually performed relatively soon after childbirth and in many cases, especially in Catholic countries, immediately following a caesarean section (Anderson, 2005), which has been shown to increase chances of complication. Recovery time for tubal ligation is significantly longer than vasectomy (sometimes taking weeks) and the failure rate higher, with 1 in 300 women becoming pregnant. Ectopic pregnancies (pregnancy outside the uterus, usually in the fallopian tubes) are a high risk for women who have been sterilised, when a man has a vasectomy there is no such risk (Kubba, 2005). Overall, vasectomy is 30 times less likely to fail and 20 times less likely to result in complications than tubal ligation (Adams & Walde, 2009).

Purely from a financial standpoint tubal ligation is a much more expensive procedure. Within the North American context its cost has been estimated at US\$2978, compared with vasectomy at US\$647 (Grimes, 2009). In New Zealand, a review of vasectomy related websites indicates that vasectomy is covered by health insurers, and ranges in cost between \$333 and \$700.

When comparisons like this are made, whether they be financial, impact related or ethical, it seems somewhat nonsensical that tubal ligation would ever be more 'popular' than vasectomy worldwide. As researchers Bumpass, Thomsen and Godecker (2000) have commented from the US context: "one of the major puzzles in the adoption of sterilization is that tubal sterilization has become so much more common than vasectomy, when the latter is safer, less expensive, and equally effective in preventing birth" (p. 938). *Sterilisation anxiety*, or the factors that prevent people from taking up sterilisation as an option, has been studied in order to understand this imbalance (Groat, Neal, & Wicks, 1990). As a part of this study Groat et al. (1990) considered the relationship between

pregnancy anxiety, regret (or fertility) anxiety and sterilisation anxiety. Reporting from a sample of 338 couples, they argued that men were more likely to be concerned about a loss of sexual performance (particularly 'erectile dysfunction) than loss of fertility or about pregnancy. The implication of this research was that as long as women are willing to continue shouldering the contraceptive/reproductive burden within their relationships, men may not necessarily feel any pressure to change the status quo. Thus in many relationships worldwide, women continue to take oral contraceptives or have tubal ligations when a couple has decided not to have any more children.

Decision making is not always limited to couples' or even individuals' processing of options, traits or concerns. However, Bumpass et al. (2000) note: "Regional variations in physicians' attitudes toward sterilization or in the medical care delivery system may also limit or facilitate sterilization for those who have achieved their desired family size" (p. 944). They argue that in many cases the greater number of tubal ligations in the US may be heavily influenced by the advice and information provided by health professionals.

Despite there being such a worldwide imbalance in the sterilisation of men and women, not all countries follow this pattern (particularly, it seems, in New Zealand). I will now discuss the prevalence of vasectomy in specific countries, with a particular focus on New Zealand.

The prevalence of vasectomy

Much of the current information about vasectomy comes from medical journals with a large emphasis on providing statistical and demographic information about men who have chosen to have a vasectomy (e.g., Holden, et al., 2005; Sandlow, Westefeld, Maples, & Scheel, 2001; Sneyd, Cox, Paul, & Skegg, 2001). Even these rather limited types of studies are relatively new – for instance, prior to Sneyd et al.'s (2001) study, there were: "no historical, national population data about numbers of sterilization procedures done in New Zealand" (p. 155). This paper's explicit concern was

with being the foundation for a study on side effects associated with vasectomy (Cox, Sneyd, Charlotte, Delahunt, & Skegg, 2002), and was one of the first papers to rely on reports from *men* about their contraceptive practices. This stands in contrast to much of the data on contraceptive practices collected prior to the 1990s, which came from surveys of women (Holden, et al., 2005; Sneyd, et al., 2001).

According to Sneyd et al.'s study (which had a sample size of 1225 men), it is claimed that Aotearoa/New Zealand has one of the highest rates of vasectomy in the world.⁵ Eighteen percent of all adult men and more than 25 percent of married men opt to have vasectomies (Sneyd, et al., 2001; Sparrow & Bond, 1999). When adjusted for age, the prevalence of men between 40 and 74 was 44%. This captures a large percentage of straight couples and individual men who either have finished having children, or who are not interested in having them at all. These numbers also easily outstrip those of all but a small number of developed countries (also including Canada, Australia and the United Kingdom).

The uptake numbers in New Zealand were highest at the traditional end to childbearing age (i.e. 40-49), where the percentage of men having had the operation was 57% (Sneyd, et al., 2001). This age group is considered 'key', not only because of its place in life course theorisation of the issue (i.e. when couples are generally choosing to stop having children), but also due to its significance in terms of where vasectomy prevalence becomes progressively smaller in each of the following age brackets (i.e. approximately 48% for ages 50-54, and approximately 15% for ages 70-74 (Sneyd, et al., 2001)), suggesting a strong cohort effect (see Schwingl & Guess, 2000 for a similar effect in the United States). New Zealand is also one of the few countries where numbers undergoing male sterilisation are greater than their female counterparts (the other two notable countries being the

⁵ There are some questions about the collection of comparable statistical data around contraception use (particularly male contraception use) in other countries; however, this seems to be as accurate an assessment of vasectomy rates as currently possible.

United Kingdom and the Netherlands). Only six developed countries (USA, New Zealand, Australia, Great Britain, Canada, and the Netherlands) and three developing countries (China, South Korea and India) consider vasectomy a primary contraceptive method.

More recently Holden et al.'s (2005) study on contraceptive practices in Australia showed Australians are aligning with the New Zealand prevalences, with a similar uptake of vasectomy among men in general with an age adjusted rate of 25.1%. Australia fell behind New Zealand in the 'important' 40-49 age bracket with 31% (Holden, et al., 2005), although there was a similar cohort effect to the New Zealand data. With the Sneyd et al. (2001) study, these are considered among the two most comprehensive of recent studies focussing on vasectomy as a phenomenon.

Prevalence rates in the US range between 11 and 13% (Holden, et al., 2005; Sandlow, et al., 2001). In Great Britain 30% of couples over 35 take up vasectomy, and approximately 1% in France (Sandlow, et al., 2001) (this was primarily due to its illegality and limited number of clinics able to perform the operation (Heiliger, 2001; Toulemon & Leridon, 1998)).

Gandy (1978) commented that, in the UK, vasectomy was initially associated with the "upper social classes" (p. 131). However, his research showed that this has a 'trickle-down' effect to other classes, reflected an increase in growing cultural knowledge and acceptance of the operation. Philliber and Philliber (1985, p. 1) have noted in agreement that "the procedure appears first to be adopted in upper socioeconomic groups and then these groups are emulated later in the lower classes". In contrast, Dassow and Bennett (2006) in a more recent review on vasectomy in the United States, have commented that that this class distinction has not changed, with little evidence that lower socioeconomic groups or non-white ethnicities are significantly increasing uptake. They comment that "men who undergo vasectomy... tend to be non-Hispanic whites, be well educated and have private health insurance" (Dassow & Bennett, 2006, p. 2069). Furthermore, Sandlow et al (2001)

argued that men who had vasectomies in their US based sample “showed more effective problem-solving capability, as well as higher self-concept” (p. 547) than their control groups, associating this with higher education.

Side effects studies

Since the voluntary uptake of vasectomy first rose significantly in so-called developed countries in the late 1960s, there have been a series of health concerns associated with it, with a new one appearing almost at the rate of once a decade (e.g., prostate and testicular cancer, erectile dysfunction, forms of dementia etc.). Many of these concerns have been associated with “autoantibody response against sperm antigen” (Goldacre, Wotton, Seagrott, & Yeates, 2005, p. 1438). This is the premise that the body’s immune response to sperm being absorbed into the body (rather than ‘released’ into semen) results in antibodies against those sperm forming (a factor which can have an impact on the reversibility of vasectomy as well (Chavezbadiola, 2008; Clarke & Gregson, 1986; Nagler & Jung, 2009; Nowroozi, Radkhah, Keyhani, Ayati, & Jamshidian, 2008)). Sperm have autoantigenic properties (often becoming targets of the immune system) due to their post-puberty formation, well after the body’s immune responses have been calibrated (McDonald, 1997). There has been a longstanding question of immune response to sperm resulting in autoimmune conditions (see Shahani, Hattikudar, Mehat, & Bordekar, 1983; Wolfers, 1970), attacking healthy tissue or even crossing the blood brain barrier (Nagler & Jung, 2009).

Prostate Cancer

Increased risk of prostate cancer is perhaps the most commonly raised of these potential health concerns (Cox, et al., 2002; McDonald, 1997), largely it seems because the “aetiology of prostate cancer remains poorly understood” (McDonald, 1997, p. 381). However, a number of relatively recent empirical studies, database studies and reviews (e.g., Cox, et al., 2002; Dennis, Dawson, & Resnick, 2002; Holt, Salinas, & Stanford, 2008; James, 1994; Köhler, Fazili, & Brannigan, 2009;

McDonald, 1997; Schwingl, Meink, Kapp, & Farley, 2009) have consistency shown no link with prostate cancer. The most comprehensive of these from New Zealand, reported that even up to 25 years after the operation there was no increased risk of prostatic cancer (Cox, et al., 2002). A more recent study which explicitly studied men who 1) had a family history of prostate cancer, 2) had vasectomy at a young age or 3) had a long period of time elapse since the vasectomy, also highlighted the lack of association between prostate cancer and vasectomy (Holt, et al., 2008). Less common health concerns such as cancer of the testis and increased risk of cardiovascular disease have also been discounted (Goldacre, et al., 2005; McDonald, 1997). Schwingl and Guess (2000) have noted in fact, research evidence which suggests men who have vasectomies have a *lower* mortality rate than control groups.

'Erectile dysfunction'

Another 'side effect' of vasectomy has been the presentation of men at clinics complaining of post-vasectomy 'erectile dysfunction' (Buchholz, Weuste, Mattarelli, & Woessmer, 1994; Dias, 1983; Dilbaz, et al., 2007). Approximately one to three percent of men are described as having "sexual and psychological problems" post-vasectomy (Buchholz, et al., 1994, p. 759), with men often most concerned about loss of erectile function . This is somewhat ironic, as vasectomy's first occurrences in humans was due to its claim to *treat* this very issue ('father of psychoanalysis' Sigmund Freud and the poet W.B. Yeats having it done for this purpose)(Drake, Mills, & Cranston, 1999). While there is no biological basis for a claim in either direction, it is more common for men to report improvement in sexual satisfaction than the opposite (e.g., Bertero, Hallak, Gromatzky, Lucon, & Arap, 2005).

When the potential for post-vasectomy erectile dysfunction is raised in research, reference is inevitably made to Buchholz et al.'s (1994) Swiss study . Questionnaire based, it had a sample of 18 men who presented at the researchers' urology clinic attributing their erectile difficulties to their vasectomy (called 'Group 2'). This group was compared with a control of 45 men ('Group 1') chosen

randomly from patients vasectomised at the same clinic. Buchholz et al. (1994) attributed post-vasectomy erectile 'dysfunction' to men having a vasectomy decision 'made for them' (22% identified their partner as primary motivator versus 4% in the control). Of the men who presented with concerns about erectile dysfunction, all of them were able to achieve erections and orgasm through masturbation, which Buchholz et al. (Buchholz, et al., 1994) argued was indicative of a psychological rather than physical issue. They suggested the erectile dysfunction was more to do with dissonance between a man's sense of masculinity and the 'imposed' nature of the operation than any physical problems. They concluded:

Patients requesting vasectomy should always be asked systematically about their motivation and the manner in which the decision was reached. The female partner should be included in the preoperative evaluation. Whenever the decision is imposed by the partner and not based on the patient's own wishes, a risk of possible sexual dysfunction later must be considered (p. 762).

This sort of positioning, rather than questioning the way masculinities are constructed, worked in a 'blame the partner' fashion. In fact, the researchers posited men in 'traditional' relationships (i.e. which they described as ones where the male partner was 'dominant') would be less likely to have to deal with such dissonance (Buchholz, et al., 1994).

Moreover, missing from the study's conclusions was the significance of difference in mean ages in each of their groups. Group 1 (the control) had a mean age of 39.1, and, as mentioned earlier, was drawn randomly, in contrast, Group 2 had a mean age of 56.4 years and were self-selected (Buchholz, et al., 1994). Some consideration of the age of the men in the group complaining of 'post-vasectomy erectile dysfunction' would be appropriate, considering Group 2's mean age is higher and therefore more likely to be affected by complicating factors (such as cardiovascular disease) associated with aging (Laumann, et al., 2007; Montorsia, et al., 2003).

Dias (1983) in contrast, did offer some discussion about the impact of age, commenting that less than half of the men who claimed to have experienced ED post vasectomy attributed it to their age group. However, he noted that 93% of his sample's wives indicated experiencing no difference in sexual behaviour. Female partners not noticing any change in the men's sexual activity, perhaps suggests it may be less than a 'problem' than it is thought. While recent research has indicated there is no relationship between vasectomy and erectile dysfunction (e.g., Bertero, et al., 2005) (even within cultures stereotypically defined by traditional forms of masculinity, such as Brazil), the ongoing development of such research highlights a 'cultural concern' with erectile dysfunction. This concern in relation to vasectomy seems to reflect anxiety about 'proper' (coital) masculine sexuality. This focus also reinforces notions of erection as crucial for masculine sexualities and locates the *legitimate* concern as the operation which may prevent this.

Primary progressive aphasia

Most recently there have been some suggestions that there is an association between having a vasectomy and Primary Progressive Aphasia (PPA - a form of degenerative language focussed dementia) (Weintraub, et al., 2006). As already mentioned, there has been some historical concern that occasionally antibodies form that target sperm antigen, and that these antibodies have the potential to cause systematic disease (McDonald, 1997). Weintraub et al. (2006) attempted to build upon this notion by suggesting that having a vasectomy cuts through the epithelial barriers along the reproductive tract. These barriers act in a similar fashion to the blood/brain barrier, isolating sperm from the immune system, and thus there may be potential to 'infect the blood' with antisperm antibodies if it is pierced (Weintraub, et al., 2006). Weintraub et al.'s (2006) study was based only on a very small sample (30 men), was correlation based, and is the only study to demonstrate such a correlation, so no conclusions can yet be drawn from it. However, this did not preclude an enthusiastic uptake in the media, suggesting that its infiltration into public discourse was more significant than its scientific contribution. Immunological responses to sperm are an expected

outcome of vasectomy (Shahani, et al., 1983), however, this effect is transitory and there continues to be no convincing evidence that it causes such autoimmune conditions as PPA (Awsare, Krishnan, Boustead, Hanbury, & McNicholas, 2005; Köhler, et al., 2009). In fact, a recent study (Changsu Hana, in press), with 86 participants showed no relationship between cognitive/language dysfunction and levels of anti-sperm antibodies.

Testicular pain

Testicular pain is the most likely of problems to occur in vasectomised men (Christiansen & Sandlow, 2003; McDonald, 1997; Tandon & Sabanegh, 2008) and long term chronic pain (more than three months) after vasectomy, or postvasectomy pain syndrome has been described as “disappointingly common”, occurring in 1 in 1000 men (Tandon & Sabanegh, 2008, p. 166). It is extremely difficult to diagnose the precise reasons for its existence and in many cases there is no clear relationship to haematoma or infection. Christensen and Sandlow (2003) have commented that: “although the definitive cause for postvasectomy pain may be unclear, it is evident that traditional treatments such as antibiotics, excisional surgery, and chronic pain medication are unlikely to result in a successful outcome” (p. 297). While there is often some relief gained from vasectomy reversal, for many men, pain may continue for a mean period of up to 2 years post surgery (Tandon & Sabanegh, 2008). Although this is the most likely side effect of vasectomy, it is also very uncommon for men to have anything more than mild discomfort, only 2.5-15% of men with post-vasectomy pain syndrome seek treatment (Awsare, et al., 2005; McDonald, 1997). There has been no work on the psychological aspects of post-vasectomy pain syndrome, despite strong correlations between depression and the ‘condition’ (Tandon & Sabanegh, 2008).

The ‘psychology of the vasectomised man’: Sex, sex and more sex?

Literature that focuses on the “psychological sequelae of vasectomy” has tended to be limited and sporadic (Sandlow, et al., 2001, p. 547), and almost inevitably focused upon sex. While it is perhaps

unsurprising that sex was a discussion point for many researchers of vasectomy, due to the contraceptive purposes of the operation, from the earliest key studies on vasectomy onwards it seemed less a minor component but a primary factor. Roberto (1974) commented that:

a sexually orientated expectation should be the most important determinant of vasectomy attitude and that this expectation is part of and related to an organisation of other expectancy beliefs about vasectomy... [which] clearly constitute some important educational and administrative considerations for family planning programs (p. 704)

Some of the earliest research on the 'psychological effects' of vasectomy portrayed the operation as having a somewhat *traumatic* effect on many men in relation to their sex lives. Ziegler, Rodgers and Prentiss (1969) suggested that "adverse psychological changes can occur in response to vasectomy. We interpret the evidence as indicating that vasectomy is reacted to by most subjects and their wives as if the operation had 'demasculinizing potential'" (p. 53). Among these 'adverse changes' were a significant increase in demands for sexual activity, and contradictorily, decreases in the sexual performance of these same men, both of which resulted in 'marital disharmony'. Ziegler et al. (1969) suggested that both increased demand for sex and 'sexual dysfunction' were due to the aforementioned demasculinising effects and the former was considered a form of overcompensation behaviour. Despite this, Ziegler and his colleagues found in two studies that, for the most part, men and their partners were extremely satisfied with their vasectomy, even when they reported physical and psychological problems (Ziegler, Rodgers, & Kriegsman, 1966; Ziegler, et al., 1969).

Williams, Swicegood, Clark and Bean (1980), while reporting similar findings to Ziegler's team, distinguished between men's different levels of 'masculinity' and its effects on the reporting of greater demands for sex. They argued that there is a positive correlation between a high masculinity rating (on the traditional masculinity/femininity scale) and an increased desire for sex post-vasectomy. They suggested that this is compensatory, men attempting to alleviate concerns they might have about the vasectomy somehow emasculating them. They also commented that men who

were higher on the femininity end of the spectrum, were more likely to have higher marital satisfaction and that the choice to have a vasectomy was not one imposed on them.

What is interesting about Williams et al.'s (1980) study is their focus on the desire for *sexual intercourse* among men post-vasectomy. This explicit focus on one particular act, rather than a desire for *sexual activity* per se, helps ratify the suggestion that vasectomy is a product of sexual (particularly coital) imperatives that are part of the package of forming a masculine identity.

The claimed 'demasculinising' effect in the 1960s/70s was often associated with the relative novelty of the vasectomy, despite it having been around for some time and the(at the time) increasing numbers of men having had it done. Wolfers (1970) suggested that in her recent past vasectomy was still considered an "obscure contraceptive practice" (p. 298). Kohli and Sobrero (1973, 1975) also commented that many men felt there was some social stigma associated with receiving the operation due to its newer place in society (also commented upon by Ziegler, et al., 1966). As many as a third of men reported negative comments from others post-vasectomy in this study (Kohli & Sobrero, 1973), but similar to Ziegler et al.'s (1963; 1966; 1969) studies, it reported improvement in marital harmony and sexual enjoyment (see also Maschhoff, Fanshier, & Hansen, 1976). While Maschhoff et al. (1976) were not clear what created this observed effect of increased marital harmony, they noted that non-sexual areas such as communication and 'understanding' showed little change from prior to the operation.

Kohli and Sobrero (1975) noted in contrast to Ziegler et al. (1969) that the 'observed effect' of post-vasectomy increases in sexual "enthusiasm" came about "by removing anxiety of impregnation" (p. 1094). This echoes an earlier suggestion that "along with release from the fear of pregnancy, the spontaneous and aesthetic nature of coitus when a contraceptive was no longer necessary was the major source of enthusiasm about the operation" (Poffenberger & Poffenberger, 1963, p. 330).

Work by Dias (1983) also had an explicit focus on sexual behaviour, and continued the pattern of earlier work in by noting post-vasectomy changes.⁶ He made the somewhat noteworthy statement that although the operation only involves the closing off of two ducts and does not interfere in any way with the “exocrine function of the testis, plasma testosterone levels... and spermatogenesis” a significant number of men (56% of his sample of 200 soldiers) still claim to have experienced some difference in their sexual behaviour (Dias, 1983, p. 334). Among the differences men claimed to have experienced were: a loss in sexual desire, changes to frequency in intercourse and erectile dysfunction. The implication of Dias’ (1983) statements regarding a lack of physical indications for such changes was that they were likely to be psychological in nature.

Although It would be relatively easy to set aside many of the conclusions of these earlier researchers as somewhat antiquated, the trend to focus upon the sex lives of men post-vasectomy seems to continue. While some writers claim an interest in ‘marital satisfaction’ post vasectomy (e.g., Hofmeyr & Greeff, 2002), their aims/purposes tended to frame this in particular ways. For instance: “the purpose of this study was to determine whether a vasectomy had any effect on important aspects of a marriage, such as, *sexual satisfaction*, martial satisfaction, communication and *frequency of sexual intercourse*” (Hofmeyr & Greeff, 2002, p. 339-40). Sex, or a potential loss of interest in it, was highlighted in this South African work as paramount to understanding marital satisfaction; it formed the focus of over two thirds of their discussion. The focus of penetrative sex was implicit in their work, as alternatives to coitus were not considered throughout their paper. They determined that none of the men showed any diminished sexual interest and, in fact, 46.8% showed increased desire. More recently, Dilbaz et al. (2007) chose to focus upon similar issues in their research in Brazil, asking participants about “premature ejaculation, sexual desire and sexual performance” (p. 22).

⁶ He also distinguishes himself by referring to negative changes as ‘sexual disabilities’!

Gutmann (2007) has pointedly argued that professionals tend to attribute certain characteristics to the men they study, and this has much impact upon the conclusions they come to. For instance, he commented that the small numbers of vasectomy clinics in Oaxaca, Mexico had more to do with *assumptions* that men will not have vasectomies due to *machismo* than the concerns of the men themselves. The same may be said of much of the psychological literature on vasectomy since the 1960s: sex and men's interest in it seems to have been as much to do with the researcher's formulation of questionnaires and interviews as a concern of the participants. Gutmann (2007) commented that across disciplines (beyond vasectomy) "relatively little has been written about heterosexual men *not* enjoying sex, not enjoying it often and not missing sex when they do not have it" (p. 31). This sort of bias may have much to do with the prevailing focus within vasectomy research of men seeming to worry about their sexual performance and vasectomy's impact on it.

Regret and the decision making process

Another concern of the 1970s and 1980s was vasectomy's rapid uptake – a culture of 'vasectomania' that appeared to be sweeping the United States and Britain. Wolfers (1970) suggested vasectomy was a "highly emotional issue to several groups in the community with (real and imaginary) conflicting interests" (p. 298). Worries about historical associations with the eugenics movement and Nazi Germany appeared to be rife, as were concerns about 'undue pressures' placed upon men (Drake, et al., 1999).

Research into men and their partners who regret having a vasectomy initially arose (unsurprisingly) as a parallel concern to 'vasectomania'. Rodgers, Ziegler and Rohr (1963) argued that the overwhelmingly positive descriptions of marital satisfaction and sexual enthusiasm that seemed to be coming from other research groups, was more an indication of dissonance management in the lives of the men studied than a 'real' effect. They theorised that men, having made such a significant,

permanent, life changing decision, had to resort to convincing themselves (and others) of the positive impact of the operation in order to maintain normal levels of self esteem. This argument was also followed by Wolfers and Wolfers (1973, 1974; Wolfers, 1970) who commented that “ the problem facing the individual after vasectomy, is to bolster the damaged self image, and to reassure himself that the feared castrating effects, loss of sexuality and emasculation have not occurred” (Wolfers & Wolfers, 1974, p. 230). Such concerns speak to an *expectation* by these researchers of widespread regret among men. However, this has not been borne out in later research. Sandlow et al (2001) claimed that with changes in the way sterilisation is perceived in the contemporary West, men are less likely to report such concerns.

Various studies have suggested that the percentage of men and/or their partners who regret having a vasectomy is approximately ten percent (Holden, et al., 2005; Philliber & Philliber, 1985). However, Holden et al. (2005) note that among those who experienced regret there was only a reversal rate of 1.4%, which was largely dependent on whether the regret was caused by, or caused change in marital status (with men who remarry tending to have higher numbers of reversals). Clarke & Gregson (1986) have noted that seventy percent of men who had reversals did so because they were now with a new partner and wanted a family with them. This has also been commented upon more recently by Dassow and Bennett (2006) , who note that “change in marital status was the most common reason for wanting a reversal” (p. 2069) (see also, Jequier, 1998; Schwingl & Guess, 2000).

Several papers on post sterilisation regret in the 1990s (Miller, Shain, & Pasta, 1990, 1991b, 1991c) offered some important understandings regarding why men would regret a vasectomy and may choose to have a reversal. Their conclusions were that typically this occurred as a result of their partner being the one who ‘made the decision’ and the men’s own processing of the decision being limited and defined by fear and lack of knowledge. Despite this commentary, very little work has been done on the reasoning behind having a vasectomy or how men make decisions to have

vasectomies. What little work on the decision making processes exists seems to focus concerning the need for greater prevasectomy counselling and information (Miller, Shain, & Pasta, 1991a; Mumford, 1983; Rogstad, 1996).

One exception to this limited focus was Mumford's (1983) US based model of the vasectomy decision making process. He described this process as a "long and deliberate one" (p. 86). He puts the process into five phases, with each phase providing a different set of implications for providers of vasectomy. Phases 1-3 were characteristically about use of, then a growing disenchantment with, temporary contraceptive methods (typically condoms and oral contraceptives). A fourth phase is begun with a firm decision to have a vasectomy, but then followed by a significant period of delay. Mumford (1983) argued that "men in Phase IV worry excessively about pain and inconvenience" and that "many men overestimate (some grossly exaggerate) the amount of pain involved" (p. 86). In many cases Mumford (1983) suggested a 'scare' occurs, typically in the form of a missed period or negative side effects of oral contraceptives, which is necessary to get past the fixation with pain and can speed up the process to Phase 5 (getting the operation). While the 'scare' was not an inevitable factor, it occurred in about half of the men's experiences of the decision making process (Mumford, 1983). The outcomes of Mumford's (1983) work also suggest that at a certain point in the decision making process, the vasectomy becomes constructed as 'inevitable', fitting into a life trajectory discourse.

Other Scottish-based research has tried to determine how couples make a choice between tubal ligation and vasectomy (Thompson, McGillivray, & Fraser, 1991). These researchers argued that fear of adverse effects was more likely to occur among men. This was considered enough reason to go through with female sterilisation in some cases. Sandlow et al (2001) found that while fear about pain and the 'unknown' still existed among men's concerns, these were relatively easily set aside. He argued that a higher self-concept than control groups (a sample of 402 people from the general

population) implied a greater capacity to challenge myths, and with adequate prevasectomy counselling would have little difficulty with the operation. There has, however, been some recent evidence which suggests such fear may lead to longer than necessary delays (Amor, et al., 2008).

The 'inevitability' of vasectomy found in Mumford's (1983) study has been echoed in recent work in the United Kingdom. Amor et al (2008) suggested that having a vasectomy became expected by family, friends and colleagues. Amor et al (2008) argued that this expectation has become a cultural norm that men feel pressure to respond to as a "task of manhood" (p. 238), which is close to being a reversal of the findings of the 1960s and 1970s, where manhood was 'at risk' due to having a vasectomy.

Cutting it short: 'Childfreedom', Pre-emptive vasectomies and 'pathology'

Also receiving limited attention is how the vasectomy plays into the 'cultural conditions of possibility' for men (and their partners) who choose not to have children at all. Some of the earliest references to men voluntarily having vasectomies without having had any children concerned cases of young men having vasectomies without adequate knowledge or making giving fully informed consent and that this behaviour was being driven by 'vasectomarketing' (Wolfers & Wolfers, 1973, 1974). Such concerns have remained in the limited discussion about men who have 'pre-emptive' vasectomies and women who have tubal ligations without having children (e.g., Benn & Lupton, 2005).

When reading about contraceptive use and reproductive control, the issue of voluntary childlessness or 'childfreedom' seems to be becoming more prevalent (see for instance, Bumpass, et al., 2000). Many demographers, concerned with the phenomenon of 'subreplacement fertility' (or numbers of children being born not 'replacing' their parents) (see for instance, Goldstein, Lutz, & Testa, 2003), have begun to notice a trend towards smaller families in many parts of Europe and Asia and more

recently in New Zealand (Boddington & Didham, 2009). Subreplacement fertility is seen as largely an economic concern, as a baseline workforce is needed to deal with a top-heavy retiring population (McDonald, 2006). The biggest area of unease for these researchers is often families consisting only of the dyadic couple, categorised somewhat haphazardly with terms such as 'childless' and 'childfree' (each term having differing emphases on the involuntary or voluntary nature of the 'state'),⁷ especially when such couples 'finalise' their decision through sterilisation.

Heterosexual couples might choose not to have children for a number of reasons (e.g., realisation of career, educational and economic aspirations, feminist theorising of reproduction as creating an unfair burden on women, environmental reasons, concerns about passing on health issues to a child etc.). The association of vasectomy with eugenics has made the choice not to have children due to concerns over the future health of the child, a stigmatised position. Even in contexts where one or both of the parents may transfer a disease (e.g. AIDS) or a genetic disorder (such as sickle cell) to their children, there is still such strong social pressure to have children, that sometimes these risks are considered secondary to the need for motherhood (Asgharian, Anie, & Berger, 2003). This is especially true if the genetic trait is one that will result in a disability (either physical or intellectual) (Lawson, 2001).

Other reasons to be childfree (such as economic or career based) are often presented as 'selfish' (Campbell, 1999; Lunneborg, 1999; Mawson, 2006; Rowlands & Lee, 2006; Somers, 1993) and for women this 'selfishness' is often attributed to a lack of femininity or nurturing capacity (Gillespie, 2003). While it is understandable that people may feel it is a major life decision not to have children (in some ways considerably *less* of an issue *to* have them), many of those who had made such a

⁷ While there is some suggestion that a couple deciding to call themselves childfree is insulting to those that have children, this group is considerably more marginalised (and in many cases stigmatised) than those that have children (Gillespie, 2003; Mawson, 2006). Recognising this, for the purpose of this study, I will refer to couples without children as childfree, a decision which also honours the identity work done in using this label, and its importance in the reduction of felt stigma that many feel (Cameron, 1997).

decision either felt they had to hide it, or that they had to prepare for questions and stigmatisation as a matter of course (Campbell, 1999; Gillespie, 2003; Mawson, 2006).

When the choice to be childfree intersects with sterilisation, it becomes a marked indicator of the seriousness of a person's choice not to have children (Baum, 1982; Cameron, 1997; Magarick & Brown, 1981; Somers, 1993). Less than 1% of men who have had vasectomies in Australasia have had them 'pre-emptively' according to relatively recent studies (Holden, et al., 2005; Sneyd, et al., 2001). While it is far from common, when it is combined with statistics for increasing numbers of women choosing sterilisation over childbearing, it appears to be a growing lifestyle choice for many individuals and couples (Benn & Lupton, 2005; Cameron, 1997; Campbell, 1999; Gillespie, 2003; Lunneborg, 1999; Mawson, 2006; Somers, 1993).

A vasectomy or tubal ligation in almost all cases is seen as a permanent end to the possibility of biological children with approximately only 1 in 10 people feeling regret after having been sterilised (Holden, et al., 2005; Sneyd, et al., 2001). Cameron (1997), following previous research, refers to two groups of people who have become voluntarily childless: 'early articulators' and 'postponers'. The former have 'always known' they would not have children, and typically make decisions such as sterilisation much earlier than the latter. The second group are those who have put other factors (typically career) ahead of children, and simply come to realise that they prefer life without them.

Studies from the 1970s demonstrated a 'parenthood myth' that claimed that to achieve true happiness and fulfilment, couples must produce and invest in children (Veevers, 1974). This myth manifests in the firm belief that it is normal and natural for people to be parents, and that parenthood is a necessary prerequisite for emotional maturity and psychological stability (Veevers, 1973a). Individuals who deviate from the parenthood norm run the risk of being labelled selfish, irresponsible, immature, abnormal, unhappy, or sexually incompetent, unnatural or in poor health.

This is almost as true for men as well as women, although for men, it is suggested, there is a balance between the status gained from 'correctly timed' impregnation of a woman and that from an early, unplanned 'mistake': "While men's enactment of a breadwinner role can accrue masculine status, as Wilton (1997) argues, premature fatherhood can work in the opposite direction, in thwarting young men's career ambitions whose fulfilment would also have earned masculine status" (Flood, 2003: 357).

Just over 20 years ago, the notion of a person voluntarily choosing childfreedom needed to be qualified by questions of whether there is personal or social pathology associated with the choice (e.g., Magarick & Brown, 1981). Magarick and Brown (1981) compared vasectomised men with no children and men who were fathers, making the somewhat startling suggestion that "childlessness is not determined by, or associated with, social or personal pathology" (p. 165).

Non-Western contexts

Much of the *recent* research concerning vasectomy has occurred within non-Western contexts such as Brazil (e.g., Kincaid, et al., 2002; Manhoso & Hoga, 2005; Marchi, de Alvarenga, Osis, & Bahamondes, 2008; Penteadó, et al., 2001), Mexico (Gutmann, 2005, 2007), and Bangladesh (e.g., Khandaker, Vereecken, & Nijs, 2001). The evidence it provides seems to suggest that men in these contexts are often willing to be involved in the reproductive and child rearing process and also in having vasectomies. As mentioned, some researchers have highlighted that often it is the health professionals' interpretations of men's motivating characteristics (such as *machismo*) that prevents vasectomy being taken up in higher numbers (Gutmann, 2007), which stands in stark contrast to Wolfers and Wolfers' (1974) earlier concerns about vasectomarketing. Research from places such as Brazil also provides a particularly useful snapshot of the sort of cultural structures the might limit the uptake of vasectomy (i.e. intersections of masculinities, religion, health policies and politics).

This newer non-Western focus arises perhaps as a response to the UN's mandate to provide a focus on men's reproductive health (See Chapter 3), however, it has also tended to draw attention away from the still low levels of uptake found in many 'developed' countries such as the United States. There may also be a sense that 'everything has been said' about vasectomy and Western contexts, as many recent medical studies, when referencing psychological works, largely end up referring to the 'heyday' of the 1960s and 1970s (see Sandlow, et al., 2001 for some critique of this).

Summary

Vasectomy is certainly an under-researched phenomenon. Contemporary research on the psychological or sociological aspects of vasectomy, particularly within the West, is extremely limited and seems to reflect a sense of having been 'completed'. This can be seen in the ongoing application of ideas of research from the 1960s and 1970s, even though, as Sandlow et al (2001) have pointed out, contemporary men have quite different framings of the operation than their predecessors thirty years ago. Some of the weakest areas in the research are in the areas of decision making and the processes of men who choose to have a vasectomy without having children. The research within this thesis goes some way to fill in the weakness and gaps in the literature, and builds upon what little work exists. As New Zealand has such a high prevalence of vasectomy (Sneyd, et al., 2001), it would be valuable to see this as a context that useful, textured information about men and vasectomy can be drawn from.

The next chapter will further develop the place of vasectomy within a wider socio-cultural framework: men, masculinities and reproduction. In contrast to this chapter, it will emphasise the social conditions of possibility that both constrain and produce high vasectomy uptake.

Chapter 3: 'Let off the hook': Men, masculinities, privilege and reproduction

In the previous chapter I examined the research on vasectomy as it currently stands. As I have discussed, research on vasectomy (considering its place as one of very few contraceptive options for men) is both scant and limited in focus. Within this chapter, in order to help both balance and theorise this dearth of knowledge, I will locate this particular project on vasectomy within a broadly social constructionist theorisation of men, masculinities, male bodies and reproduction.

Ostensibly this thesis is an examination of the place of vasectomy in the lives of a number of New Zealand men, and falls within the broad discipline of psychology. It is, however, also a critical examination of the ways in which these same men make sense of themselves, their relationships and their place as men, using the meaning-making resources of a shared culture. This thesis is then primarily about masculinities, male identities and the positions men invest in and take up, and the positions made available for them to do so within a Western developed country.

In the next section I will broadly discuss these ideas and how they provide an 'intellectual home' for the thesis: the social construction of masculine identity. In particular, I will focus upon some of the different ways masculinities have been theorised (primarily in relation to the work of Raewyn Connell), and their applicability to men's decision to have vasectomy. Following this I will discuss the social construction of men's bodies, particularly the (until recently) lack of medical focus upon men. Last, I will discuss the broad (and developing) field of men's involvement in reproduction and contraception, and again locate vasectomy within this.

Hegemonic and 'orthodox' masculinities

Raewyn Connell's (1995) important theory of *hegemonic masculinity* is crucial to any serious study of men and their identities (Worth, Paris, & Allen, 2002). Its influence upon contemporary research in the field of men and masculinities cannot be overstated nor overlooked (Messerschmidt, 2000; Wedgwood, 2009), as it offers the most developed (and highly cited) account of masculine identity formation and male privilege available (Wedgwood, 2009).

Dealing with the structural inequalities that exist within gender relations, Connell (2005) has argued that the notion of hegemonic masculinity embodies "the currently most honoured way of being a man, it require[s] all other men to position themselves in relation to it, and it ideologically legitimate[s] the global subordination of women to men" (p. 832). Built upon Gramsci's (1971) marxist notion of hegemony, maintenance of power by an exalted group (in this case, men) is managed through practices that do not necessarily have to rely on force. Rather "ascendency [is] achieved through culture, institutions and persuasion" (Connell & Messerschmidt, 2005, p. 832). Hegemonic masculinity is therefore about gender at the collective level, rather than individual manifestations of masculinity (Flood, 2002).

Connell (2005) has suggested that the number of men that actually embody this exalted form of manhood is statistically small. However, the vast majority of men (and women) within a given society will be complicit in idealising its status (bound to the historical and cultural context of that society). As an outcome of this hierarchal understanding of gender, Connell (2005) has argued that masculinities are multiple, with various kinds competing for dominance in a complex hierarchy:

We must also recognise the *relations* between different kinds of masculinity: relations of alliance, domination and subordination. These relations are constructed through practices

that exclude and include, that intimidate, exploit and so on. There is a gender politics within masculinity (Connell, 2005, p. 37).

Being 'masculine' for individual men will involve reference to whatever the dominant form of masculinity is in their culture at that historical moment. Those who do not 'stack up' are often subordinated and potentially marginalised. As forms of masculinity wax and wane in their dominance, different groups of men will gain or lose power (Anderson, 2009).

Currently in the neoliberal West, Connell (2002) has suggested that the hegemonic form of masculinity is associated with "those who control the business institutions: the business executives who operate in global markets, and the political executives who interact (and in many contexts merge) with them" (p. 39). She refers to this as "transactional business masculinity" (p. 39) and notes that it manifests itself in various ways, but that it is marked by "increasing egocentrism, very conditional loyalties (even to the corporation), and a declining sense of responsibility for others... a person with no permanent commitments, except (in effect) to the idea of accumulation itself" (p. 39).

Connell's (1995) work has not come without criticism, with many suggesting that its focus upon structural inequalities has meant it is too sweeping or 'global' in its application (e.g., Demetriou, 2001; Wetherell & Edley, 1999). Flood (2002) has suggested, however, that this sort of criticism can often be due to a theorist's lack of clear understanding of the theory behind hegemonic masculinity and a tendency to try and reduce it to character traits. He notes that "one finds simplistic claims that masculinity is premised upon being strong, unemotional, heterosexual, powerful, self-reliant, in control, aggressive, objective and rational, bold and unafraid" (Flood, 2002, p. 206). While these traits might often be associated with hegemonic masculinity in a given historical and cultural moment, they miss the relational constitution of hegemonic masculinity, in relation to both femininities and non-hegemonic masculinities. Flood (2002)

goes on to suggest, however, that this can be an easy mistake to make as ‘hegemonic masculinity’ refers to both the system that maintains patriarchal power and the dominant form of masculinity in a given context.

As a consequence, to help alleviate these concerns within this thesis I will refer to the system of gender relations that produce different masculinities and continues to subordinate women as *hegemonic masculinity*, however, following Anderson (2009) I will refer to the “masculinity that occupies the hegemonic position” (Connell, 2005, p. 76) as either “orthodox” or “inclusive”. The former might well be associated with the character traits Flood (2002) describes above and is also referred to as ‘dominant’ masculinity, ‘hegemonic’ masculinity, ‘retributive’ masculinity or ‘traditional’ masculinity. The term ‘orthodox’ seems to capture the essence of many of these other descriptors without the weakness associated with them (e.g., traditional as being associated with the past). Primarily however, it refers to masculinities based on gender difference and male privilege that are typically homophobic and sexist.

I would argue that it has become relatively accepted within recent theorising of masculinities that more traditional, conservative forms of masculinity (orthodox versions, which have been and still are hegemonic) are ‘giving way’ to (at least superficially) more egalitarian expressions (inclusive versions) (Anderson, 2009). The contestable and therefore unstable status of hegemonic masculinity has meant that hegemonic masculinity does not immediately *have to* equate with ‘negative masculinity’ (Anderson, 2009; Connell & Messerschmidt, 2005; Flood, 2002); however, more often than not, it *is* associated with orthodox masculinities, and the negative outcomes masculinities at this end of the spectrum tend to be associated with (i.e. violence, homophobia etc.). While ‘orthodox’ masculinities are still dominant (hence orthodox), they were formed within a context that Anderson (2009) refers to as of “high homophobia” (p.

8) and premised upon a rejection of the characteristics/attributes constructed as feminine (see also, Kimmel, 1996).

Anderson (2009) proposes that there is a shift toward forms of masculinities that are gaining equal share in hegemonic status for men, which do not have this same 'in-built' rejection of feminine attributes or activities. In other words, they are becoming as hegemonic as orthodox forms of masculinity. He suggests that we are entering a period of lower homophobia, where men do not have to prove themselves as heterosexual to the same degree (see also Messner, 2004). Even in the great bastion of orthodox masculinities – sport – changes in the ways men relate to each other (whether homosexual or heterosexual) and women, or at least speak of each other, seem to be changing. Similarly, research suggests within one of the more gendered social locations, that of the home, expectations of men and the masculinities they embody have begun shifting to some extent. Henwood and Proctor (2003) comment:

Considerable enthusiasm is being expressed about the benefits to individuals and families of rejecting the idea of the father as a detached, distant, largely disinterested figure and turning towards a new, attentive, caring or nurturing father who begins by being present at antenatal classes and at the birth... continues by actively participating in the raising of his children, and generally shares with his domestic partner commitment to and responsibility for maintaining family life and the home (p. 337).

While this 'shift' in fatherhood masculinities has come under critical scrutiny (see for instance, Everingham & Bowers, 2006; Johansson & Klinth, 2008; McGowan, 1998; Nentwich, 2008; Ranson, 2001; Wall & Arnold, 2007, and later chapters in this thesis), that the rhetoric of equality appears to be becoming dominant (even if practice does not match it) gives credence to Anderson's (2009) thesis that newer, more inclusive masculinities are developing and challenging the hegemonic status of orthodox masculinities.

Masculinities in the Aotearoa/New Zealand context

Orthodox masculinity within Aotearoa/New Zealand is largely defined by the 'imaginary' figure of the 'kiwi bloke'. As with many post-colonial contexts, this form of masculinity is associated with the white majority group (Connell, 2002), in this case the prototypical Pākehā⁸ settler. It was from this 'settler masculinity' (hard working, practical, isolated) that the 'kiwi bloke' arose and became embedded in cultural consciousness (Phillips, 1996). Its impact on what it is to be a New Zealand male, while waning, is still profound. As I have written elsewhere:

An example of 'hard' masculinity, the imaginative potential of this figure shapes both the identity work of the hard working, beer swilling, rugby playing, homosocial, homophobic, sexually predatory male, whose lexicon includes terms such as 'harden up' and 'get hard' but also the men to whom these terms are directed (Terry & Braun, 2009, p. 165)

But if this is the blueprint for orthodox masculinity in New Zealand, its power is not as a pure exemplar, but in its *shaping* of contemporary New Zealand masculinities (Phillips, 1996; Terry & Braun, 2009; Worth, et al., 2002). The figure itself has steadily become a caricature associated with the past (i.e. rugby players before professionalism, the settler/farmer, the ANZACs, television ads), yet still impacts upon the way many New Zealand men make sense of themselves in the present (Noone & Stephens, 2008; Phillips, 1996; Terry & Braun, 2009; Worth, et al., 2002). It is certainly not the type of man you would expect to be concerned about health issues of any kind, let alone involved in the 'feminine' domain of contraceptive and reproductive decision making.

While the notion of the kiwi bloke (and its implications for men's identities) may have some effects on men's health statistics and choices, this is not a linear or even straightforward correlation (Hodgetts & Chamberlain, 2002; Noone & Stephens, 2008). Men have more recently been theorised as not being limited to one particular expression of masculinity and all its negative (or positive) health associations (Hodgetts & Chamberlain, 2002; Noone & Stephens, 2008). Recent research on kiwi

⁸ Pākehā is the Maori term for New Zealanders of European descent and is occasionally a disputed term, particularly among those to whom it is applied.

masculinities has demonstrated, in fact, that it is more common to see orthodox forms appearing in a 'hybridised' manner, with 'softer' more 'egalitarian' expressions of masculinity (Allen, 2007; Terry & Braun, 2009).

But how does this 'new', 'hybridised', and increasingly 'inclusive' face of masculinity (if indeed it 'exists') relate to the uptake of vasectomy in New Zealand, let alone men's general involvement in contraceptive/reproductive tasks? Oudshoorn (Oudshoorn, 2004) has argued:

In the second half of the twentieth century, the idea of women as the sex responsible for contraception thus became the dominant cultural narrative materialized in contraceptive technologies, in social movements and the gender identities of women and men.

Consequently, contraceptive use came to be excluded from hegemonic masculinity (p. 353).

If indeed masculinities are changing (and potentially men's material practices are changing with them), this claim is one which needs to be addressed in light of high uptake of vasectomy and similar 'events' in the contraceptive/reproductive landscape. If masculinities are becoming more 'inclusive' or at the least 'hybridised', then evidence will be found in the commonsensical explanations men give for their choices and decision making processes. This thesis will be examining how this claim manifests itself in the talk of men when they are asked to explain, describe and justify their decision to have a vasectomy.

Masculinities-in-interaction

There have been various attempts to theorise the 'shifting' and 'greyness' in masculine identities and the ways in which men "will work with the historical and cultural resources available for making sense of the Self" (Wetherell & Edley, 2009, p. 202). For instance, I have suggested elsewhere that men are oftentimes 'answerable' to competing and contradictory expressions of manhood (Terry & Braun, 2009) and that men will draw on notions of 'immature' and 'mature' selves in order to give rhetorical 'evidence' for changes to egalitarian expressions of masculinity. Allen (2008) has also

suggested that when 'blending' contradictory accounts (for instance romantic and 'macho' discourses), a hybridisation of hegemonic and subordinated forms of masculinity can occur, creating a new form of dominant masculinity. Potts (2001, 2002) has proposed that men will often excuse their risky sexual behaviour through reference to a 'penis self' that undermines a rational, self-controlled 'interior self'. This sort of framing potentially allows men to claim an interest in egalitarian behaviour, all the while 'behaving badly'.

Finally, Wetherell and Edley (1999, 2008) have argued that in order to make sense of the difficulty of self-description that men will refer to 'imaginary positions' which are tentative and transitory, but allow them to describe the self they are invested in through temporary investment and comparison with others (see Chapter 4 for more discussion on imaginary positions). They propose that such tools allow a clearer understanding of men and the ways in which they make sense of themselves than broad application of cultural ideals of masculinity to individual psychologies (Edley & Wetherell, 1997, 1999, 2009; Wetherell & Edley, 1998, 1999, 2008, 2009). This also allows for men to lay claim to egalitarian expressions of masculinity, even as they simultaneously rely on 'orthodox' notions of manhood, which problematises the theorisation of men in a polarised fashion. The authors comment:

From a social psychological point of view and from the standpoint of those seeking to develop a more adequate feminist politics, one of the difficulties with these notions of the new man and retributive man is their global sweep and lack of grounding in the interactional and discursive practices of men in mundane life (Edley & Wetherell, 2009, p. 328).

One of the ways in which such features can be analysed is by understanding both the socio-cultural and interactional dynamics of masculinity within a given context. This thesis will rely on both in order to fully understand the place of vasectomy in New Zealand and in kiwi men's lives.

In the following sections I will discuss the context of vasectomy from a critical perspective. First, I will place the current research within a context of men, masculinities, health and embodiment, a relatively recent and still developing body of scholarship (Watson, 2000). I will use the discursive constructions regarding Viagra as an example of male, heterosexual bodies finally coming under scrutiny. Second, I will discuss the issue of men and their place in reproduction and the ways in which this has been theorised. Last, I will draw the focus back to vasectomy and why a 'high' intake such as New Zealand's is indicative of wider structural gender imbalances that still need addressing.

Men, embodiment and privilege of the male body

Men have bodies.

On the surface, this does not seem a controversial or even an interesting statement; however, bodies marked by being simultaneously white, male and heterosexual seem to have disappeared somewhere on the way to the theorising and medicalising that has occurred to other bodies (Rosenfield & Faircloth, 2006; Watson, 2000). Stephens and Lorentzen (2007) have argued:

traditionally, male bodies – especially white, heterosexual, male bodies – have been subjected to an act of double erasure: first, its norms are projected onto a generalized category of 'the body', which is assumed to be a stable construct; then this corporeality is displaced onto the bodies of cultural 'others', leaving masculinity to occupy the place of reason, rationality and the disembodied mind. As feminist theorists have extensively argued, the ability of male corporeality to render itself both general and invisible is integral to its power (p. 6).

Despite the fact that feminist, Foucauldian and other critical approaches have challenged the deviance of 'non-default' bodies, the 'default' itself has (until recently) maintained its invisibility and thus its privilege.

Proponents of the 'medicalisation thesis' suggests that this 'double erasure' has occurred over a significant period of time (see Rosenfield & Faircloth, 2006). Medicalisation is seen to have occurred where the control of medicine over social problems has increased, giving the medical community power to categorise (and surveil) that which is considered 'deviant' or 'unhealthy' (Rosenfield & Faircloth, 2006). The biomedical model that underpins medicalisation was, and still is, reductionist in focus, primarily interested in forming simple models of 'health' in order to help control what was, in contrast, perceived to be 'unhealthy' (Sabo & Gordon, 1995; Watson, 2000).

Medicalisation has seen the white, male, 'healthy' body initially used as the basis for all anatomical knowledge; in so doing it implicitly became the 'default' or 'prototype' against which all other bodies were compared (Rosenfield & Faircloth, 2006; Watson, 2000). As a consequence, "it is women's *ordinary* physical and psychological functions that have been medicalized, as opposed to men's exclusively *deviant* ones" (Rosenfield & Faircloth, 2006, p. 9 (emphasis in original)), a situation that is true of all deviations from the default white, male body. Male bodies are, in this perspective, automatically deemed healthy, whereas women's bodies are by their difference from men's associated with ill health and complexity, primarily due to the processes of menstruation, childbirth and constructions of higher levels of emotionality due to different hormonal structures to men (Oudshoorn, 1994; Seymour-Smith, Wetherell, & Phoenix, 2002).

The treatment of women's bodies as inferior (and thus in need of greater surveillance) is not restricted to medicalisation; it is simply the most recent 'regime of truth' (Foucault, 1980) to do so. The concept of medicalisation allows some insight into the way in which 'gender' has been constructed only as feminine and that "only under-represented groups are medicalized" (Rosenfield & Faircloth, 2006: 11). White men's bodies have become invested with a sense of normalcy and the unproblematic, while Other bodies are not.

This has meant that to a large degree, when men's bodies 'fail' it is considered a much more significant issue than when women's bodies do, the latter being a consequence of their ongoing deviance from the 'health' of the male body and therefore commonplace (Seymour-Smith, et al., 2002). Seymour-Smith et al (2002) contend that male health issues are thus taken more seriously than women's, because men's bodies are only supposed to fail when something is *terribly* wrong (see also Watson, 2000). It is expected that the 'unhealthy' female body will need constant care and medical focus because the most mundane of its functions are problematised. Thus, when 'male health' is discussed and the male body becomes central, it is the generally unhealthy body that is the object of study (Worth, et al., 2002). The question of trying to understand the *healthy* or *everyday* experience of the men and their bodies, and how this intersects with meanings and identity is, for the most part, left untouched: while the white, male body is healthy, it is not considered a matter of concern or even interest. Worth, Paris and Allen (2002) have commented that: "despite the centrality of the body to constructions of male health, minimal research has been conducted on men's experiences of their bodies in this area or more generally" (p. 24).

When attempting to understand a phenomenon such as vasectomy then, a procedure performed on 'healthy' male bodies to, in effect, *constrain* reproductive health, it is not surprising that the focus of much research (as seen in Chapter 2) has largely focussed on *negative* aspects of vasectomy (i.e. side effects, concerns about post-vasectomy sexual potency). If men's bodies are 'normal' and 'healthy' by default, then any remotely negative impact must be considered worthy of concern, and thus research. Positive, or even neutral accounts of men's bodies, are by and large deemed unnecessary within a climate defined by medicalisation.

Social constructionist perspectives in the field of men and masculinities have not remedied this historical (and contemporary) invisibility of men's bodies. When 'forced' to interact with questions

of male embodiment, efforts seem to have been tinged with a sense of embarrassment or at the very least have, as with medicine, only focused on that which is considered 'unhealthy'.⁹

Such critical research has focused more readily on the ways in which, non-male, non-white, non-heterosexual bodies have been forced into deviance (e.g., Ussher, 2006; Ussher, 1997), and in doing so largely neglected the ways in which 'default' bodies have been positioned to make those Other bodies 'deviant' in the first place (Rosenfield & Faircloth, 2006). This has meant that research which focuses on the intersection between masculinities theory and male bodies has been particularly limited. Where it does exist it tends to be focused only where those bodies 'deviate from the default', as in the case of chronic illness (e.g., Gibbs, 2005), impotence (Potts, 2000) or other 'sexual dysfunction'. Male privilege must remain invisible in order to keep benefiting men (McIntosh, 2003), and yet the paradoxical consequence of this is that men's health remains under-researched, and men remain un-invested in understanding their bodies and the very real health concerns which do exist for *all* bodies.

While male bodies have largely avoided the gaze of 'medicalisation', their ontological existence is, of course, not under question (except perhaps in the truly relativist sense). A real concern is how they constitute or help in the constitution of men's lived experiences, particularly in the processes associated with identity formation. The next section will discuss how different theorisations of masculinities have interacted with the notion of embodiment.

⁹ Attempts to distance themselves from sociobiological explanations for male behaviour, were, and to some degree, still are, a major factor underlying this discomfiture (Connell, 2005; Watson, 2000). Foucault's (1977) emphasis on the docility of bodies, and the internalisation of the monitoring gaze of institutions (such as the medical community, society, government and the family) being constitutive in their formation, has also been pointed to as a contributor to this 'problem' (Watson, 2000).

Masculinities and male bodies

When the male body has been discussed in connection to masculinities, it has been, in many cases, treated as secondary to the rational mind so prized in Enlightenment thought (Seidler, 2006).

Masculine subjectivities (particularly those considered to be complicit with dominant discourses of masculinity) typically privilege rationality in their construction, and thus are less interested in engaging with the body, except as a tool, a vehicle of the mind (or in the case of sportsmen, a weapon or a machine (Messner, 1992)). Seidler (2006) has suggested that this lack of engagement with the body, particularly the emotional content of the body, is what prevents men from recognising (or even caring about) the experiences of others. The power that comes to many men, simply as a consequence of having a white, male body, that performs in a particularly heterosexual way is often disregarded, particularly within the current neoliberal climate (see also Connell, 2002). The body is experienced, within this theorisation, as focussed on performance and function, rather than intimacy and process.

Connell (2005), while informed by poststructuralism, stands within a materialist Marxism, and it is from this standpoint that she suggests:

True masculinity is almost always thought to proceed from men's bodies – to be inherent in a male body or to express something about a male body. Either the body drives and directs action (e.g. men are naturally more aggressive than women; rape results from uncontrollable lust or an innate urge to violence), or the body sets limits to action (e.g. men naturally do not take care of infants, homosexuality is unnatural and therefore confined to a perverse minority (Connell, 2005: 45).

While human biology is not treated as the *source* of an individual's masculinity, for Connell, neither is it the simple 'landscape' or 'canvas' on which discourse imprints itself that many social constructionists sometimes claim it is (Connell, 1995). Bodies, she argues, are 'onto-formative', they

create difference in society and culture, but are also shaped by that same environment (Connell, 2005). They are the 'arenas' of masculine formation (Connell, 2002) where 'dialogue' between social expectations of masculinity and the 'maleness' of the body occur in a circuit of practices. The body limits certain expressions of masculinity (i.e., the steady wearing down of the bodies of the working classes (Donaldson, 1991)), and social expectations place limits on the ways bodies can act (i.e. feminine behaviour from a male body is still considered transgressive).

'*Embodiment*' then, is Connell's concern, how men live in and experience the social through their bodies, and the practices that give white, heterosexual, middle/upper class men, as a group, a far greater share of power than any other group combined. Connell (2005) argues that what drives difference in power distribution in society is bodies. Women, as a consequence of their bodies, are considered inferior, as are those outside the 'ideal' hegemonic masculine body, such as men of colour, working class men, men who sexually desire other men and those with chronic illness or disability. Connell argues for a turn away "from the ideological and cultural towards the bodily without falling into the trap of biological reductionism" (Watson, 2000: 41), and insists on highlighting the way that having a white, heterosexual, male body gives power to individuals, but more importantly to these men as a group. By exposing the unfair share of power men have (what she calls the 'patriarchal dividend') purely as a consequence of how they look, political impetus is provoked among those who do not 'match' this form of embodiment. Of course, the response of men who receive the patriarchal dividend is to try to reinvokethe invisibility of their group status, by focussing on *individual* bodies who challenge the suggestion that white hetero-masculinity has more power than any other group (i.e. women who have succeeded, white men who have failed, or the illnesses that 'afflict' individual men).

What is drawn from Connell's (and others) work is the idea that simply having a male body invisibly enables privilege for men. Tied to this is the systematic deployment of discourse about the (male)

body that continues this privilege in multiple social spheres. One of the areas that has received much challenge from critical theorists is the privilege and positions of power that men maintain in heterosexual encounters. The research of discursive analysts has shown, for example, the continued articulation of a male sexual drive discourse (see Gavey, 2005; Hollway, 1984) and coital imperative (see Gavey, McPhillips, & Braun, 1999; Jackson, 1984; McPhillips, Braun, & Gavey, 2001), which privileges male 'needs' within heterosexual encounters. Resulting from a particular construction of the male body, both discourses rely on the suggestion that testosterone, evolution and 'hard wiring' are behind men's seemingly insatiable need for regular, penetrative sex.

The deployment of such discourses shape male experiences of heterosex, and in many ways structures sex as a privilege men are *entitled* to experience in particular ways (Gavey, 2005). For instance, the mind-body split is a construct, which in many cases can enable men (and to a lesser degree, women) to diffuse any sense of male responsibility for particular (physical and potentially coercive) activities. The mind-body split can also work to place the blame for undesirable behaviour on a man's body, while the mind is constructed as separate from and subject to the body; as struggling to make sense of the demands of the body (Potts, 2001). When the body (particularly via hormones or evolution) can be blamed for sexually coercive behaviour despite the efforts of the 'interior self' (or mind) to challenge it, the man 'himself' cannot be blamed, or benefits from reduced blame.

Straight men's accounts of sexual experiences also see them distancing themselves from their bodies (Flood, 2003), especially from the privileged site of the penis, which is treated as a realm unto itself, and even, in discourse frequently equipped with its own 'mind' (Potts, 2001). This focus on the penis as the centre of men's sexually embodied experiences is discussed by Flood (2003) in his research on condom use, where he argues: "widely circulating notions of the 'shower in a raincoat' and condoms as desensitizing assist in the constitution of men's bodily experience of condom use as diminishing

penile sensation and postponing time to ejaculation” (Flood, 2003: 359). He suggests that these sorts of discourses constitute practices that privilege the penis over all other erotic sensation and are deployed in ways that create unsafe sexual encounters and enable the normalisation of coercive practices. He also argues that because the penis is treated as the one place men are ‘allowed’ to focus on their bodies, it eliminates interest in non-coital activity.

This is combined with one of the primary ‘consequences’ of intercourse (i.e. pregnancy) being made somewhat invisible through the advent of oral contraceptives, resulting in what Giddens (1992) refers to as “plastic sexuality” (p. 2). He argues that this shift has placed an emphasis on sex and sexuality as *the* defining factors in most relationships, factors which are fleeting as a relationship will only last “so far as it is thought by both parties to deliver enough satisfaction to each individual to stay within it” (Giddens, 1992, p. 58). While coitus and the penis continue to be privileged, many women (and men) may feel unable or at least unwilling to think of sex outside of a limited set of parameters.

This over-privileging of the penis has, however, resulted in one of the ways that the male body *has* been constructed as deficient, when the penis ‘fails’ the man through impotence or ‘erectile dysfunction’. The next section will discuss one way in which the normative white (straight) male body *has* appeared: the social construction of ‘erectile dysfunction’ and the development of Viagra.

Viagra and privilege of the penis

The erect penis is constructed as *essential* to contemporary notions of normative heterosex, (even though it is really only ‘essential’ – and becoming less and less so – for sex intended to result in reproduction). While a couple may not be interested in reproducing, the need for sex involving an erect penis is still considered vitally important (Potts, 2000). The importance of the erect male penis to heterosex, even when only loosely tied to procreation (through coitus), is such that ‘erectile dysfunction’ has become a major health concern (Loe, 2001, 2004). Tiefer (2000) has commented:

“Sexual virility – the ability to fulfil the conjugal duty, the ability to procreate, sexual power, potency – is everywhere a requirement of the male role and thus ‘impotence’ is everywhere a matter of concern” (p. 141).

Using a form of post-structuralism informed by psychoanalysis, Potts (2000, 2002) has suggested that as well as being a site of privileged connection between men’s minds and bodies, the erect penis can represent the phallus, the symbol of male power in the world. Within this understanding, the inability to maintain an erect penis symbolises the loss of male power, indeed, the loss of being seen as a man. Potts (2000) comments:

the absence of - or difficulty in ‘achieving’ and ‘maintaining’ - a robust ‘hard on’ in appropriate circumstances thus presents as a disastrous affliction in the male – an abnormality, a failure to stand up and be counted as a ‘real’ man. It constitutes an illness peculiar to the male body – or rather, its diminutive ‘deputy’ (p. 40).

Potts (2000, 2002) has further argued that for most men this ‘loss of manhood’ precludes this bodily experience being treated as something that could lead to alternative ways of experiencing sensuality and sexuality. As Connell (2002, 2005) has argued, the social puts limits on men’s bodily experiences, even as certain bodily experiences have impacts on the social.

Instead of framing impotence as a viable challenge to the performance of the penis’s associations with male virility and normative heterosexual practices, medical science has reaffirmed (indeed exacerbated) the dominant meanings of male bodies, sex and power. It has come to the fore with Viagra, a quick ‘technofix’ that enables men to ‘perform’ coitally again. Loe (2001) has argued that male privilege plays a key part in this rush to aid ‘afflicted’ men:

In a patriarchal world, the traditional American phallogocentric sexual script is alive and well. And it looks like the tide has changed – the West’s twenty-first century sexually frigid and sick who deserve to be healed are primarily white, middle class heterosexual males over forty (p. 104).

Any absence of (coital) sex in a man's life is constructed as so abnormal that hundreds of millions of dollars have been spent by men and their partners on rectifying the 'problem' of 'erectile dysfunction' (Gavey, 2005). This particular demonstration of the way in which an institution such as medical science has rushed to protect particular ways of having sex or experiencing sexuality reveals the distaste with which 'sexual absences' are dealt with in the West, particularly when there is crossover with a reduction in male power. So we can see "Viagra itself is a technology for the production of gender and sexuality. Viagra can be understood as a tool for the repair and/or production of hegemonic masculinity and sexuality" (Loe, 2001, p. 119). This has been particularly highlighted in contexts such as Japan, where in 1998 approval was delayed for oral contraceptives (again) and yet a year later Viagra was quickly approved and brought onto the market as a 'social necessity' (Castro-Vázquez, 2006).

However, even as the *sexual* penis is considered an area which must be focussed on and billions of dollars spent to maintain, the *reproductive* penis is still largely invisible. While the penis, through its involvement in coitus, does have biological consequences, medical science has worked quickly to obscure these consequences, working in combination with existing social structures that produce and reproduce discourses of men as sexual, but not reproductive creatures. Viagra is largely situated within a discourse of sex, pleasure and intimacy, *not* reproduction (Castro-Vázquez, 2006; Oaks, 2009) and oral contraceptives 'hide' the reproductive nature of sex (Giddens, 1992). Despite these issues, discourse concerning Viagra and its equivalents, potentially open space for understanding the ways in which men experience their bodies through the reproductive and therefore 'healthy' functions. By making the male sexual body visible through its increasing medicalisation, the male reproductive body may only be a short step behind (Oaks, 2009).

A focus on men's reproduction potentially offers, in the same way Viagra does, an insight into aspects of male sexuality that have, through their invisibility, maintained male privilege. The next

section will focus upon the historical structuring of men's privilege (via absence) within the reproductive domain and how recent attempts to involve men have begun to highlight the disparities in the 'reproductive/contraceptive burden'.

Men and Reproduction

In research on reproduction, men are all but absent, making only brief appearances in reference to their impact on women's lives (Inhorn, Tjørnhøj-Thomsen, Goldberg, & la Cour Mosegaard, 2009).

While there are some (very recent) indications of change in this regard (e.g., Gutmann, 2007; Inhorn, et al., 2009), historically there has been a strong assumption (both in research and in family planning education programmes) that men do not readily involve themselves in the reproductive/contraceptive process (Inhorn, et al., 2009).

This culturally inscribed orthodoxy portrays men as *sexually* driven and uninterested in issues of fertility/reproduction. Responsibility for reproduction, it has been argued, is not primary to the formulation of masculine identities (Connell, 2005; Mundigo, 2000; Thomson, 2008) and where it has been a consideration, it is usually so in reference to what Giddens (1992) has referred to as 'plastic' sexuality: the 'silencing' of the reproductive or risky aspects of sexual activity in order to highlight the pleasure and relationship orientated elements. Even when individual men might show some interest in being 'equally' involved in the reproductive share, many of the social structures that shape, constrain and enable greater reproductive health are focussed almost exclusively on women (Thomson, 2008).

Perhaps as an outcome of these issues, active attempts to recruit and 'involve' men in reproductive and family planning programmes have only been a relatively new phenomenon. As recently as 1994, the International Conference on Population and Development (ICPD) in Cairo stressed the need to maintain the decline in world population growth that was occurring at the time, and saw the need to

target men (for the first time) as a part of this goal. In order to have any success in creating population stability, increasing the reproductive responsibility and involvement of males was seen as important; not in terms of population control, but in decreasing the levels of inequality in the 'contraceptive burden' that exists between men and women and changing the focus to sexual health (Dudgeon & Inhorn, 2003). The report developed out of this conference contained the following statement: "Special efforts should be made to emphasise men's shared responsibility and promote their active involvement in responsible parenthood, sexual and reproductive behaviour, including family planning: maternal and child health; prevention of STIs, including HIV" (UN, 1994). This statement was only necessary in light of a set of social structures, which enabled men's past opting out of reproductive responsibility (or even the recognition there was anything to opt out of!), and in some ways actually prevented the possibility of talking about male reproductive bodies (Oudshoorn, 2004). The challenge involved in creating such 'shared responsibility', however, is that when addressing sex, sexuality and reproduction, the weight of research evidence suggests that men are typically defined by irresponsibility and untrustworthiness (Cornwall & White, 2000; Daniels, 2006).

This suggests that men's global opting out of reproductive responsibility has implications beyond individual or even certain groups of men; it is certainly a wider structural issue. Dudgeon and Inhorn (2003) comment:

because most human societies privilege men in both the public and private domains, men also structurally affect the reproductive health of others in ways that women do not, namely through the positions they occupy, the resources that they control and the sexual and reproductive norms that they support or subvert (p. 32).

Vigoya (2002, cited in Gutmann, 2005) referred to a global *cultura anticonceptiva femenina* (a female contraceptive culture), where, despite the possibility of men taking more responsibility for birth control, there is virtually nowhere in the world where true contraceptive equality exists.

The issue is more complex than simply getting men involved, and is tied into masculine power and privilege in society and, in many cases, harmful masculine practices. For example, in Ecuador some women do not want their partners involved in reproductive decision making (even concerning STI risk) “because of the man’s dominance and mistrust and /or her fear of her partner’s aggression” (Shepard, 2004, p. 163). While there is less occurrence of such cases within contexts where egalitarian discourses hold sway, men’s reproductive responsibility is still tied to structured inequality and to some extent is less *obvious* in its manifestations. In the decade following the Cairo conference, while some important steps *have* been made by many countries in promoting male reproductive responsibility, there is still a significant gender imbalance in the way reproductive responsibility is handled.

Oudshoorn (2004) has suggested that the taking up of any technology (even one like vasectomy with a long history) is not simply about its usefulness or how it can simplify people’s lives. Rather it relies on a network of interactions between social, economic, political and technical spheres, nothing like the linear path that scientific ‘progress’ is often idealised as (see also, Oaks, 2009). For instance, Ewalds-Kvist, Rantala, Nikkanen, Selander and Lertola (2003) have postulated that a Finnish history of using sterilisation eugenically has made many men suspicious of receiving a vasectomy, with only the most recent generations of men acknowledging vasectomy’s usefulness. De Bessa (2006) has suggested that due to sterilisation being illegal in Brazil until 1997, prior to which it was done in a clandestine fashion, getting a tubal ligation developed a mystique for women, with associations between wealth, privilege and control over one’s body. She notes that 70% of tubal ligations occurred at the same time as C –sections in private hospitals, compared with 20-30% in public hospitals, highlighting its privileged status.

Feminist work in Brazil has thus aimed to provide greater availability of tubal ligations, rather than pressing for male involvement. This sort of cultural climate (combined with the assumption of a more 'traditional' masculinity among men (see also Arevalo, Wollitzer, & Arana, 1987)) has meant the issue of vasectomy has not even been considered a viable form of birth control for the vast majority of the population (Gutmann, 2005, 2007). In relation to the US, Uhlman and Weiss (1988) noting a significant downturn in the late 1980s in US vasectomy uptake, suggested this was due to physicians being 'overzealous' in refusing vasectomy over potential health concerns (e.g. associations with prostate cancer – see Chapter 2). They point out that despite increasing awareness of side-effects of female contraceptives and very little evidence of serious side effects of vasectomy, male concerns dominated and resulted in less male involvement. All three of these cases (i.e. Ecuador, Brazil and the US) emphasise the importance of local context in shaping the choices and involvement of men in reproduction and contraception, suggesting that in order to 'improve' involvement, such factors need to be considered.

The Cairo Plan of Action (UN, 1994) can be seen as the culmination of a long history of feminist theorisation which has 'allowed' discourse about male reproductive bodies to become more available. Although there tends to be a split over the value of male *controlled* contraception, men participating in contraceptive/reproductive choices and processes is almost always viewed as a positive thing by family planning advocates, health researchers and demographers (Inhorn, et al., 2009). Some writers have begun to make such suggestions as: "involving men in family planning programs and encouraging them to assume greater responsibility for fertility control... will make [men] more aware of and empathetic towards women's reproductive rights" (Green & Biddlecom, 2000, p. 94). That there is a discrepancy in the contributions men and women make to the contraceptive share may not even be something many men are aware of or choose to think about. Creating programmes that involve (or at least create the option to involve) both partners at any level

may highlight the impact that contraception and reproduction have on a woman's body and facilitate (some) men's increased support.

Reproduction and (hetero)sexual intercourse involve the bodies and genetic material of two (or more) (male/female) participants. However, reproductive responsibility tends to be focussed on only *one* of those participant's bodies. All available forms of contraceptives, while not excluding the *involvement* of a partner (e.g., condom application during foreplay, help remembering use of the Pill), are explicitly focussed on the body of only one of the participants. This is true of both the more 'temporary' forms available (such as condoms, diaphragms and the pill) and also the more permanent options, which are dominated by male or female sterilisation.

As noted, the majority of this focus is weighted heavily toward women's bodies. Greene and Biddlecom (2000) have argued that the overarching focus on women is also a demographic concern, men do not have babies, so if an organisation is interested in the reduction of (or increase in) childbirth, men will not be considered a primary focus. However, as Inhorn, Tjørnhøj-Thomsen, Goldberg and la Cour Mosegaard (2009) have commented:

Men contribute not only their gametes to human procreation, but are often heavily involved and invested in most aspects of the reproductive process, from impregnation to parenting. .. That men may be major contributors to women's reproductive health and the health of their offspring is often overlooked when men are left out of the reproductive equation. Thus men need to be reconceived as reproductive in their own right, an insight well overdue (p. 3)

Being 'reproductive', as I have argued, is not typically associated with men and the construction of masculine identities. This is such a prevalent notion that the impact of unhealthy sperm is often overlooked when addressing fertility and the health of a foetus (Daniels, 2006; Thomson, 2008). Despite this, growing research evidence has suggested that many men *are* interested in their

reproductive capacities, however are often excluded (e.g., Gutmann, 2007; Malik & Coulson, 2008; Solomon, Yount, & Mbizvo, 2007).

Currently, there are four available choices for 'contraceptive responsibility' existing for men: the withdrawal method (although not really valid if talking about 'responsibility'); abstinence from coital activity; use of condoms; and vasectomy. Vasectomy is the only option that is not used *at* the time of coitus. With abstinence typically unheard of for heterosexual masculinity (McPhillips, et al., 2001; Terry, 2006) and the withdrawal method problematic in terms of 'success' (Bajos, Leridon, Goulard, Oustry, & Job-Spira, 2003), condoms tend to be the primary form of contraceptives used by men (6% worldwide, but in countries such as Japan as high as 41.3% of all contraception used (Clifton, et al., 2008)). Research in the United States has shown, however, that men and women prefer to use contraceptive options that do not 'interfere' with sexual activity, and so tend to rely on options that are 'unrelated' to the act, such as oral contraceptives or sterilisation, which means that women take much more responsibility (Grady, Klepinger, & Nelson-Wally, 1999). A coital imperative (Jackson, 1984; McPhillips, et al., 2001) means non-coital practices are typically not considered a viable *alternative* to intercourse. The vasectomy, by its nature, ratifies this coital imperative, in the same way *Viagra* does. Although some authors have noted there is some space for alternative sexual practices to coitus (McPhillips, et al., 2001), they are almost always seen as alternatives, something to be done occasionally, *not* replacements. Like the contraceptive pill, sterilisation makes the reproductive aspects of sexual activity invisible, allowing unmitigated, coitally orientated sex.

Others have demonstrated that the use of male orientated contraceptives tends to be pushed aside in favour of the pill, when sexual encounters between a heterosexual couple develop into the status of a 'relationship' (Flood, 2003; Willig, 1994, 1995, 1997). One of the markers of a 'real' relationship is the shift to unprotected sex (in the sense of STIs) as this is symbolic of trust (Flood, 2003). It might be argued that such a discourse further erases the associations of men (and their genetic material)

with pregnancy. Contraceptive responsibility in long –term relationships becomes, by default, the ‘woman’s problem’ as options that fulfil the criteria of being ‘trust-based’, invisible and *temporary* do not exist for men in the same way they do for women. Mundigo (2000) asks another valid question with regard to the potential existence of male equivalents to the pill, wondering whether: “women would trust and be happy if men suddenly had the same ability to control fertility?” (p. 231). The implication of these factors is that, even when options such as the condom are readily available, men are often let ‘off the hook’ with regards to contraceptive responsibility, allowed to fade into the background of family planning and contraceptive decision making.

With this focus on at least one of the participants’ bodies, historically almost all of the available reproductive technologies have revolved around the bodies of women, with the only exception being the disdained or ‘casual sex only’ condom, and the vasectomy, with the former being the only ‘temporary’ contraception. Surgical and chemical interventions, as well as practices such as the ‘rhythm method’ tend to impact on the fertility of women. Much of the last decade’s work that has been done with men and the reproductive arena has been focussed on increasing men’s involvement in decision making and practices that work to rebalance the gender inequality and inequity that currently exist. However, we are still a long way from Barker and Abhijit’s (2004) interpretation that the Cairo Plan of Action not only called for the engagement or involvement of men “in sexual or reproductive health, but [also] in *overturning* the inequitable gender order” (p. 147).

Economies of obligation and gratitude

While there is some degree of logic involved in this imbalance (i.e. women are the ones that get pregnant, give birth, take primarily responsibility for child care etc.), it is also a culturally inscribed task that women manage the day to day mundane issues of contraceptive activity in longer term heterosexual relationships (Oudshoorn, 2004). Along a similar line, Dixon and Wetherell (2004)

discussed discursive practices among couples describing the ways child rearing and household labour are split. They noted that despite the rise of egalitarian language, and women taking a larger portion of the full time paid employment share, “women in heterosexual relationships continue to bear more responsibility than their male partners... for tasks which have been variously described as ‘mundane’, ‘repetitive’, ‘unrelenting’ and ‘non-discretionary” (p. 168). Child rearing and domestic chores are still heavily weighted as ‘women’s work’, even where partners might have an equal career or non-domestic workload.

How this unfairness in the domestic share continues to be ‘managed’ by men, women and couples has been the subject of several studies. Dixon and Wetherell (2004), for instance, suggested that heterosexual couples co-construct ‘fairness’ and ‘responsibility’ rhetorically, and yet despite this rhetoric there is still an ongoing material inequality in the domestic practices engaged in by men and women. One factor that shapes this co-construction relates to who is being compared to whom when understandings of domestic fairness are formulated. Heterosexual women may not actually be comparing their spouse’s domestic workload to their own, but rather making comparisons between their spouse’s work and that of other women’s spouses.

The phenomenon of women taking on the burdens of mundane household tasks, has also been discussed by Hochschild (2003). She has discussed this in terms of a ‘household economy’, which she argues is highly gendered and often results in women performing chores out of a sense of obligation and even guilt. When men perform such tasks, however, they are stepping outside the bounds of their gendered place in the home and can therefore expect and receive gratitude that is well beyond their efforts.

In relation to the task of contraceptive control, women are often given the same scarcity of gratitude that they are in the domestic arena, while any involvement by men may well result in an 'economy of gratitude', whereby they receive more accolades than are their due.

Explaining men's lack of involvement (in vasectomy)

Given that vasectomy is a far simpler, less risky option than tubal ligation (see Chapter 2), there seems to be little justification from a medical or family planning perspective for the imbalance which has historically (and in many countries, currently) burdened women (as a group) with undergoing sterilisation and/or ongoing use of oral contraceptives. Given the facts, vasectomy should be a much more readily taken up operation, even more than it is in New Zealand. While a (small) number of men do not need to have vasectomies for infertility reasons, are later starting families, or simply because they do not have a female partner, it can safely be assumed that these groups would not make up the remaining 56% of men aged between 40 and 74 (or even the remaining 43% in the 40-49 age group) in New Zealand. This says nothing of other developed countries (such as the US and France) that while claiming positive shifts to rectify historical gender imbalances, still have much higher levels of female sterilisation than male.

Wilton (1997) contended that sexual reproduction forms the keystone of hegemonic narratives of gender and sexuality. For men, fathering a child might be seen as the ultimate proof of masculinity, while financial support of both wife and children is a primary index of masculine status. Although it is not always explicitly articulated in New Zealand (and other western) culture(s), the power of particular notions of male virility tied to orthodox versions of masculinity (Anderson, 2009) may affect many men's choices to have a vasectomy or not. Although non-Western cultures may have more clearly articulated 'male virility discourses', Western ideas of masculinity and manhood are not formed within a vacuum and still draw to some degree from areas such as evolutionary psychology,

especially for orthodox masculinities (e.g., within Western countries some researchers have suggested that male fertility is the driving force behind the survival of the species and an evolutionary imperative has been used to justify everything from adultery, to polygamy and even to rape (see Thornhill & Palmer, 2000 for example)). So called 'educated' men in 'non-traditional' cultures might disdain the suggestion that their ability to father children is tied to their masculinity, however, as suggested above, much of the interest of men regarding sexual activity *relies* on a premise of virility and *reproductive potential*. Although the advent of effective contraception has allowed a more distinct separation between sex and reproduction, much of the discursive power around male sexuality is still implicitly tied to possibility of reproduction. This might underlie many men's reasons for having a vasectomy reversal when entering a new relationship, even when the previous family was considered 'complete'. (Potts , Pasqualotto, Nelson , Thomas Jr., & Agarwal, 1999).

There has been slow introduction of newer male contraceptive technologies (such as the Intra Vas Device – a reversible form of vasectomy, which involves two 'blockades' of easily removable silicone gel (Tulsiani & Abou-Haila, 2008). This is despite strong evidence of safety, reversibility and effectiveness), which seems to indicate that there is no strong cultural imperative that men take up the contraceptive burden at any stage prior to the end of child bearing. If they do so, it may be reluctantly even after this stage in life. While it is determined to be an acceptable risk for women to take the pill for extended periods of time (despite ongoing side effects for many women and many studies remaining inconclusive about long term safety (e.g., Hurwitz, Henry, & Goldber, 2009; Maheshwari, Sarraj, Kramer, & El-Serag, 2007; Scholesa, et al., 2010)) to do the same with a male pill, which might affect libido, reproductive ability when it is 'needed' or any other aspects of embodied masculinity is still considered foolhardy or not worthy of the expense (Oudshoorn, 2004). And yet this sort of limitation only reinforces the notion that contraception has little (or nothing) to do with men (Oaks, 2009). It seems that, like fusion energy, the male pill is always and forever a

technology of the future (Freidberg, 2007). It was so in the 1970s, 1980s and today and may still be so in ten years from now (Anderson & Baird, 2002; Oaks, 2009; Oudshoorn, 2003). As long as such a cultural impetus for men to be involved at every level of the contraceptive/reproductive process does not exist (even in so called 'egalitarian' contexts), vasectomy will remain an option for some, even many, but not all men.

Solomon, Yount and Mbizvo (2007) suggest that binary understandings of acceptability (either acceptable or not), perhaps need to be re-addressed in order to fully appreciate men's interactions with contraceptive technologies. What is perhaps most interesting about work done on men and reproduction is the suggestion that one of the most significant reasons for a "lack of research and development on male contraceptives stems in part from *assumptions* about men's lack of desire for contraceptives and about the nature and importance of male versus female sexuality including sexual satisfaction" (Dudgeon & Inhorn, 2003, p. 32). Dudgeon and Inhorn (2003) also argue that there is no real clear definition of what male reproductive health actually entails, making work to improve men's perceptions of it worldwide a little stilted.

Vasectomy treats reproductive capacity as a problem to be fixed. It is touted as a 'simple operation' yet speaks volumes about the complex cultural emphasis on coital sex which remains unchallenged. It also ratifies the male sexual drive discourse, which again, relies on a foundation of reproductive agency and a so called "hard wired" male need to spread genetic material. The question continues to arise then as to whether the apparent increase in men's involvement in reproductive responsibility *after* childbearing is about an interest in 'being involved' or is it more about maintaining consequence (i.e. pregnancy) free sex, all the while keeping all the reproductive imperatives for more coitus intact?

Summary

In this chapter I have discussed the ways masculine identity has been theorised within the critical study of masculinities. I have also highlighted various domains of privilege that men directly benefit from, which include their bodies, their sexuality and practices associated with masculinity. This was discussed in relation to reproduction and contraception, and the ways this privilege is maintained often at the expense of women's health and interests.

In the next chapter I will discuss the methodological approaches I have used in order to address these questions further.

Chapter 4: “Only 20 men? You must be kidding?”: Method to my madness

The quote used in the title for this chapter was taken from one of the 300 emails sent to me after the press release calling for participants. It captures the confusion that I have often encountered when discussing this research and the ways I have approached it. Qualitative research, particularly when done within a social constructionist framework, is often misunderstood and occasionally derided.¹⁰ Within this chapter I will discuss the ways in which the theoretical underpinnings of this thesis have translated into methods I have used. First, I will comment on how I have theorised the use of mixed methods (in regard to mixing quantitative and qualitative methods, but also using various qualitative methods). Second, I will briefly discuss the ethics associated with this research. Third, I will discuss the different forms of recruitment, data collection and analysis used in the thesis.

Mixed methods approach

Within this thesis I have used a variety of methods in order to generate both qualitative and quantitative data with the same subject matter: men’s experiences of vasectomy. Quantitative data were generated from an online survey of 141 men, and the qualitative through semi-structured interviews from 34 men (more detail to follow). Data were also analysed and interpreted using a number of different approaches, which will be outlined in more detail in the remainder of this chapter.

In relation to the use of different types of methods within a single project, Sunderland and Litosseliti (2008) have argued that “these days it is not uncommon to use more than one approach for a piece of research, a deliberate ‘recombination of methods’” (p. 13). In the case of this thesis, this has primarily been because I feel each of the methods I have used is the most appropriate to answer my

¹⁰ Along with emails from men expressing interest, came the occasional (often angry) email questioning my call for ‘only’ 20 to 30 participants. One in particular demanded I return money I had ‘stolen’ from more ‘worthy’ recipients (such as students of medicine and engineering), as my ‘unscientific’ approach was ‘madness’ and a waste of ‘Government funding’.

research questions. The overall approach of the thesis is inductive (data driven) and is primary driven by qualitative approaches and insights.

The first main distinction in methods is between the numerical and interview data and for this I have taken a pragmatic approach to mixed methods (Yardley & Bishop, 2008). Yardley and Bishop note that “every perspective and every method reveals some things and hides others, the pragmatic question answered by mixing methods is ‘what can we learn from each perspective’ (Yardley & Bishop, 2008, p. 367). From the collection and analysis of quantitative data we can gain a broad picture of men’s experiences of vasectomy and a straightforward comparison with much of the previous research on the subject. From qualitative data we gain the benefit of rich, textured accounts of men’s decision making processes, experiences pre and post vasectomy and the cultural resources they draw upon to make sense of these. The purpose of using both qualitative and quantitative data was their capacity to complement each other in the process of revealing as much as we can about vasectomy. As I have mentioned, the project is marked by a strong bias toward qualitative research, as this is the area I am most invested in.

While there is considerable overlap between different forms of qualitative analysis, there are also a number of distinctions that can be often overlooked. Holloway and Todres (2003) have argued that mixing of qualitative methods can provide important flexibility in a research project, but it is important in using more than one method to maintain coherence and consistency. They further argue the most important filter in this maintenance is *appropriateness* in method choice (Holloway & Todres, 2003). I have chosen different forms of analysis for each chapter due to their value in providing as sophisticated an understanding of the subject matter as possible, their appropriateness for the data being analysed, and their value in maintaining a critical approach to masculinities. I am not convinced there is a particular ‘gold standard’ (Wetherell, 1998) which must be met and subscribed to in every context, and furthermore I would suggest there is great value in the use of

various methods to create a “richer and more complete description” of vasectomy than would be given “by a single approach” (Yardley & Bishop, 2008, p. 359).

General Ethical Concerns

This project was approved by The University of Auckland Human Participants Ethics Committee (UAHPECH - Reference 2006/451) and followed all guidelines laid down in their Guiding Principles for the length of the study. These are: informed and voluntary consent; respect for the privacy of individuals; social and cultural sensitivity; soundness of research methods; transparency and avoidance of conflict of interest; minimisation of harm.

With respect to the last principle, I was aware from the outset of this project of the potential for ‘unanticipated effects’ (Brinkmann & Kvale, 2008) when discussing such sensitive issues as reproduction and sexuality. The benefits of such research to the participants (and potentially their partners), however, far outweighed any possible risks. Previous experience in similar situations (and borne out in this particular study) has demonstrated participants often feel they have processed/developed their thoughts on sex, reproduction and sexuality to a greater degree. Often the men in this study would comment on the value of speaking (in many cases for the first time) about their vasectomies in such detail.

In order to help limit the potential for unanticipated effects, a policy of informed consent was important to this project. At the start of either the interview or the survey, topics to be covered and issues concerning anonymity and confidentiality were raised with all participants, followed by the completion of a consent form for the interviews (see Appendix C for sample consent forms), or in the case of the survey, an indication they had been informed of its scope and wished to continue. Information about support services specific to men was offered at the end of interviews.

In order to protect the privacy of the interview participants (particularly due to the sensitivity of the topic) names and other significant identifying features were replaced. All of the pseudonyms were chosen by myself. In the case of the survey, while anonymity could not be completely guaranteed, every effort was made to maintain confidentiality.

Quantitative Methodology (Chapter 4)

Recruitment

Approximately 300 invitation emails were sent out to men who had expressed interest in being involved in the study, whether they had been included in the interview portion or not. They were also encouraged to pass the email on to any other men they knew of that fit the parameters of the study, namely, that they had had a vasectomy and at least one post-vasectomy semen analysis (PVSA). This last criterion had the potential to eliminate a large number of potential responders. While it was developed to give at least a six month since operation perspective, “it has been long established that a significant proportion of men is noncompliant with the instructions to provide PVSA” (Sheynkin, et al., in press, p. 1). Despite this criterion, some men who had not fulfilled it, still participated in the study.

Participants

Of the 300+ invitation emails sent out, 167 men in total initiated involvement in the survey, and 157 provided mostly completed surveys that could be used for analysis (a response rate of approximately 50%). As not all men answered all questions, however, the N for each question varies. One hundred and thirty three men were included in the scale analysis, as the remaining 24 men did not respond to all of these available questions. Respondents ranged in age from 24 to 72 ($M = 47.83$, $SD = 10.03$). Most (74%), were between the ages of 35 and 55, and 42.7% were between the ages of 40 and 55.¹¹ This bears some relationship to the national data collected by Sneyd et al (2001) in which 57% of

¹¹ This overlap is deliberate and reflects the cohort structures used in many such studies.

men had their vasectomy aged 40-49 and 47.8% of men aged 50-55. All of the respondents indicated at the outset whether they had had a vasectomy and at least one post-vasectomy semen test (or equivalent). This question was supposed to provide some 'distance' from the operation (between 3-6 months) in order to be able to more fully respond to questions about impact of the operation. While this questions was supposed to eliminate those potential respondents who had not had the test, many of the men interpreted the question as including the '20 ejaculation' test (see Chapter 2), which has become an alternative to PVSA (Bartz & Greenberg, 2008). Of those that did, only men who had had a vasectomy for longer than six months were included in the sample.

Procedures

The scales used in the survey ("Reasons for vasectomy", "Concerns about vasectomy", "Experiences after vasectomy" and "Regrets after vasectomy") were developed by myself (in consultation with Barbara Schaffer), heavily modified from scales initially created by Evangeline Heiliger (2001) in her smaller study for the Family Planning Association (NZ). All items were developed prior to the analysis of the qualitative data, and were informed by my own engagement with the accounts of men I interviewed.

The survey was uploaded to an online Survey Monkey template that emphasised both functionality and user-friendliness. The home page consisted of a welcome message and information about the study (See Appendix D). This introductory page linked to a consent page (See Appendix E), with only those men who consented to the parameters of the study (by checking a series of boxes) being able to proceed to the survey proper (See Appendix F for a sample of the survey questions).

Analysis

Descriptive statistics and two examples of exploratory factor analysis (EFA) were the primary form of analysis used in this chapter. Exploratory Factor Analysis in particular was used to help develop

latent 'themes' (or 'factors') from the 'reasons for vasectomy' and 'concerns about vasectomy' scales. This fits with the goals of factor analysis, which according to Tabachinick and Fidell (2007) are: "to summarize patterns of correlations among observed variables, to reduce a large number of observed variables to a smaller number of factors, to provide an operational definition (a regression equation) for an underlying process by using observed variables, or to test a theory about the nature of underlying processes" (p. 168). Important to the form of EFA used (maximum likelihood with direct oblimin rotation) is the concept of *covariance*, or the shared variation in the way variables were responded to. What this means in practice is that factors are generated based on similarities in the way men answered items in the survey, Tabachinick and Fidell's (2007)'underlying processes'.

'Underlying processes' in personality psychology are more likely to be associated with traits or types of intelligence (Tabachinick & Fidell, 2007). Within this thesis, this would not be appropriate nor would it be particularly useful, due to the overarching social constructionist orientation of the project. Instead I argue that the 'underlying processes' were the types of cultural resources the men relied on and drew from in order to answer questions.

While factor analysis alone cannot make sense of the direction of certain relationships (a process instead associated with confirmatory factor analysis and structural equation modelling (Tabachinick & Fidell, 2007)), it can draw attention to the ways men in the study have clustered their answers to certain questions and thus show the relationships between them.

Qualitative Data (Chapters 6, 7, 8 & 9)

The majority of data in this study was collected through qualitative methodologies. The design was of a multi-phased interview study. Semi-structured interviews were used to collect talk data. These interviews were designed to offer access to in-depth accounts and personal meanings associated with having a vasectomy or choosing not to have one.

Recruitment

Almost all of the participants were recruited as a result of a press release that led to news pieces in several key newspapers and their online counterparts (e.g., NZ Herald and stuff.co.nz), several interviews on national radio stations Radio Live, National Radio and the Rock, and a television interview for One News. Approximately three hundred emails in reply to this press release and the media response were received in the first three days after the initial release and were then filtered and sorted according to location and interview viability.

Participants:

Data were gathered from 34 male participants who had had, or were going to have, a vasectomy. Participants were split into three groups: 1) 'typical' - 16 men who had decided they had a 'complete family' (see Table 4.1 for demographic information), 2) 'pre-emptive' - 12 men who had a vasectomy without having fathered children (see Table 4.2), and 3) 'repeat' - six men who were in the process of making a decision about having a vasectomy, and whom I intended to follow up once they had completed operation (See Table 4.3).¹²All identity categories (e.g., sexuality, ethnicity etc.) were chosen by the men in an open ended demographic questionnaire, which resulted in different labels for the same categories (i.e. straight versus heterosexual). Four interviews with professionals who perform vasectomies were also used at the beginning of the project to collect expert discourse on the operation. These four were selected due to their public profiles and expertise in the area.

*Table 4.1
Demographic information about the men interviewed ('Typical' group)*

Code	Pseudonym	Age	Sexuality	Ethnicity	Occupation
V1	Antony	38	Heterosexual	European	Management
V2	Evan	52	Heterosexual	European	Civil Servant

¹² Only two of these men (Brent and Jason) had a follow up interview subsequent to having had a vasectomy, none of the other men had gone through the procedure after one year from the initial 'pre-vasectomy' interview.

Table 4.1 (Cont).

Code	Pseudonym	Age	Sexuality	Ethnicity	Occupation
V3	Steven	43	Heterosexual	Pākehā	Academic
V4	Bob	54	Heterosexual	New Zealander	Management
V5	Chad	44	Heterosexual	NZ European	Consultant
V6	Mike	47	Heterosexual	Pākehā	Civil Servant
V7	Sam	47	Straight	NZ Maori/European	Academic
V8	Vic	56	Heterosexual	NZ European	Management
V9	Graeme	64	Heterosexual	NZ European	Retired
V10	Paul	40	Heterosexual	NZ European	Media
V11	Patrick	38	Heterosexual	NZ European	Engineer
V12	John	35	Hetero	European	Academic
V13	Andy	48	Gay	Pākehā	Procurement
V14	Dan	38	Heterosexual	NZ European	Computer/IT
V15	Vince	48	Heterosexual	NZ European	Management
V16	Tom	43	Heterosexual	Pākehā	Management

Table 4.2

Demographic information about the men interviewed ('Pre-emptive' group)

Code	Pseudonym	Age	Sexuality	Ethnicity	Occupation
NK1	Jeremy	38	Hetero	Euro	Computer/IT
NK2	Johann	38	Hetero	Caucasian	Design
NK3	Geoff	35	Hetero	European	Teacher
NK4	Steven	29	Heterosexual	Pākehā	Computer/IT
NK4	Neill	33	Heterosexual	European/Japanese	Consultant
NK5	Andrew	55	Heterosexual	Caucasian	Marine Farmer
NK6	Tony	62	Straight	Basically European	Retired
NK7	Stan	57	Heterosexual	NZ Chinese	Bank Officer
NK8	Dominic	33	Straight	European	Technician

Table 4.2 (Cont.)

Code	Pseudonym	Age	Sexuality	Ethnicity	Occupation
NK9	Don	43	Hetero	European	Research
NK10	Gerald	44	Heterosexual	European NZer	Consultant
NK11	Ben	35	Heterosexual	Pākehā	Management
NK12	Brian	42	Heterosexual	NZ European	Consultant

Table 4.3

Demographic information about the men interviewed ('Repeat' group)

Code	Pseudonym	Age	Sexuality	Ethnicity	Occupation
REP1	Brent	40	Heterosexual	Pākehā	Civil Servant
REP2	Jason	41	Heterosexual	Pākehā	Editor
REP3	Darryl	39	Hetero	Maori/Euro	Sales
REP4	Drew	34	Heterosexual	White European	Management
REP5	Simon	39	Hetero	NZ Kiwi	Finance
REP6	Schalk	33	Heterosexual	South African	Procurement

Procedures

Potential participants were given a Participant Information Sheet (PIS – Vasectomy, Pre-emptive, Repeat, Professional see Appendix G), as a part of email correspondence or via post. These potential participants were then given the opportunity to ask questions before choosing to be a part of the research, no-one declined to be a part of the research at this point. The consent forms included agreement to be a part of the research, and additionally agreement for the interview to be audio taped and for the possibility of a third party to transcribe the interviews (see Appendix C).

Approximately half of the interviews were performed over the phone, as many of the respondents lived outside of the Auckland area. One research trip was made to Wellington at which six face to face interviews were completed.

Interviews were semi structured, were all conducted by myself (GT), and lasted between forty five minutes and an hour and a half.¹³ The interviews were conducted in locations that suited the participants, with all but two of the face to face interviews being done in rooms at the University of Auckland or Victoria University (those two were done in the participants' home).

With almost half of the individual interviews were done by phone, a different dynamic than face-to-face interviews may have occurred, as there was no way to 'read' body language and other cues that exist in face-to-face examples. This, however, did not present any problems or produce any obvious differences in the data. The benefits of telephone include its cost effectiveness and people often being less guarded than face to face due to a greater sense of anonymity (Shuy, 2003).

The interviews covered a range of topics, which included: motivations for operation, associations with virility, how the decision to have a vasectomy was made, how contraception was managed in the relationship prior to vasectomy, personal reasons to choose a vasectomy over tubal ligation or another female controlled method, associations of vasectomy with sex and sexuality (see Appendix I for a brief summary of interview questions).

Men and interviews

Schwalbe and Wolkomir (2003) have argued that the interview process can be perceived by men as a 'threat' to their masculine selves as they may feel vulnerable due to a lack of control over the subject matter being discussed. To help counter this issue, I gave the men the opportunity to 'tell their story' at the very beginning of the interview, without interruption, before introducing the 'formal' questions. At the end of the interview opportunity was given for the men to ask their own questions, add any further information they felt I had missed or contribute further in any other way.

¹³ There was no obvious difference between the length of time for phone and face-to-face interviews.

These techniques have the potential to reduce the ‘threat’ of the interview for many men and help build rapport in an unforced manner (Schwalbe & Wolkomir, 2003).

Schwalbe and Wolkomir (2003) also argue that concerns specific to interviewing men include minimising (especially with regard to emotion), exaggeration of rationality, autonomy and control, and bonding ploys (e.g., “you know what I mean” in relation to discussion about sex). They suggest a process of ‘circling back’ to issues raised (among other options) rather than challenging them as that might add to the sense of ‘threat’ (Schwalbe & Wolkomir, 2003). This technique was used often throughout all of the interviews and provided particularly useful outcomes. Chapter 6 provides an example of ‘revisitation’ of a previously formulated account.

Transcription and data presentation conventions

The interviews were audio-taped and transcribed verbatim (15 by myself, and the rest by three transcribers),¹⁴ to include hesitations, speech repetitions and overlapping talk but not the finer-grained features of speech and interactional style. Transcripts are physical representations of audio data, and can follow many different conventions, dependent on the research being performed (Poland, 2003). All transcripts for this project were originally presented in an orthographic style: Underlining was used when a word was stressed. Brackets were used to designate laughter, overlapping talk, changes in voice (such as deliberate accent change), or to provide an explanation that is not part of the audio. A pause was designated by (.).

The data extracts presented in the analysis chapters have been edited from the original transcripts, depending on the form of analysis used. For instance, for *thematic analysis*, text was occasionally re-structured slightly (i.e. through deletion of text) in order to create ease of reading without altering the meaning or suggestions of extracts. Punctuation was also added at times in consultation with

¹⁴ These three were given clear instructions on the style and accuracy expected, with follow up and corrections made (if necessary) after one hour of transcribing.

interview recordings. When the annotation [...] appears it is an indication that part of the transcript has been removed/omitted, typically large chunks of text that were not relevant to the analytic point being made. When shorter quotes, particularly phrases or single words, are used out of the context of an extract I have used quote marks (“”). This should be differentiated from my use of single quotation marks, which is an indication that I feel the term or word I am using can/should be disputed.

For the data being analysed using a Discursive Psychology (DP) approach, punctuation and other DP conventions were attended to by re-transcription of the interview extracts using a slightly modified version of Jefferson’s (2004) transcription approach. There has been some critique of these forms of transcription modification (see Potter & Hepburn, 2005), however, Poland (2003) has argued that despite changes, such revised versions remain “true to the original objectives” (p. 278) (see also, Smith, Hollway, & Mishler, 2005). For full description of the conventions used, see Appendix H.

Qualitative Analysis

As already mentioned, the primary epistemological assumption made in this thesis is that it fits within a social constructionist framework. While some psychologists, whose research has been informed by social constructionism, have argued that there is not one method that particularly suits this epistemology (Burr, 2003; Parker, 2002; Potter, 1996a), discourse analysis seems to best reflect the values and importance of language associated with it (Burr, 2003). ‘Discourse analysis’ is not so easily boxed, however, as the methods used to collate, describe and analyse discourse are multiple (Burr, 2003; Parker, 2002). Burr (2003), amongst others, has helpfully distinguished between two broad trajectories of discourse within psychology and the types of analysis that they produce. First, she refers to one as discursive psychology, or ‘micro’ analysis, which uses concepts related to conversation analysis (CA). Second, is ‘macro’ social constructionism, which includes Foucauldian or poststructuralist forms of discourse analysis. These two understandings of discourse analysis are less

distinct categories and more ends of a spectrum (Wetherell, 1998) or pool, with varying levels of blending, ignoring and challenging that have resulted in many different expressions of analysis and theoretical complexities (Sunderland & Litosseliti, 2008). I will now discuss each of the forms of analysis used by chapter.

Chapter 6: Thematic analysis

Thematic analysis was used initially for all the qualitative data, but its outcomes are most explicitly demonstrated in Chapter 6. Thematic analysis attempts to locate recurring patterns or themes that appear to reflect some form of collective sense making. As an analytic technique, identifying preliminary groupings of meanings (or themes) in a wider data set is common to all qualitative work (Holloway & Todres, 2003). It “is arguably the most common approach to analysis of data in the social sciences” (Roulston, 2001, p. 280), but not often branded as a form of analysis in itself (although this may be changing), but rather used as a part of the process of a wider analytical technique. Braun and Clarke (2006) have suggested, however, that locating themes within a data set “might be particularly useful when you are investigating an under-researched area” (p.83), which, without much doubt, is a category into which the study of vasectomy falls, especially in recent times. The analysis done within Chapter 5 aimed to identify the latent aspects of the data, which refers to going “beyond the semantic content of the data” and starting “to identify the underlying ideas, assumptions and conceptualisations – and ideologies – that are theorised as shaping or informing the semantic content of the data” (Braun & Clarke, 2006, p. 84). As such, it is explicitly social constructionist in its approach, seeking to describe patterns of talk that seem to be socially produced. Analysis was data driven and also informed by insights from critical qualitative psychology (which will be discussed in a later section).

The analysis itself was performed following Braun and Clarke’s (2006) six stage approach to thematic analysis: familiarising, coding, searching, reviewing, defining/naming, and producing the report.

Orthographic transcripts were read multiple times and codes developed from these readings until a number of themes were extracted from the data. These themes were then further reduced to primary themes and interpreted. Themes developed from the 'typical group' became the basis for the analysis in Chapter 6.

Chapter 7: Discursive psychology (with a touch of the critical)

The analysis within Chapter 7 falls broadly within the field of discursive psychology (hereafter DP). DP highlights the centrality of language to psychological processes, and according to Potter and Hepburn (2007):

treats discourse as having three characteristics. First it is *action orientated*. Discourse is recognised to be primarily a practical medium and the primary medium for action. Second it is *situated*. It is organised sequentially, such that the primary environment for what is said is, typically, what was just said previously... Third, it is both constructed and constructive (p. 161).

Discursive psychology focuses on the way that language is used in interactions between people and how it is orientated towards performance and achieving certain forms of action (Potter, Wetherell, Gill, & Edwards, 2002). This *action orientation* suggests that participants in a conversation understand the rules that should be followed in such interactions, and that these rules are both context shaped and context renewing (Heritage, 1984). Discursive psychology, following its links with CA, works with conversational accounts and how those accounts work to achieve certain ends rather than being transparent reflections of a participant's mental processes (McIlvenny, 2002). Discursive psychologists have:

investigated the way that accounts are built in interactions to suit particular purposes – fashioning identities, justifying our actions, blaming others and so on – and argue that people draw upon a shared cultural resource of tools, such as interpretative repertoires for these purposes (Burr, 2003, p. 62).

The notion of discourse at the micro level then, focuses on particular, situated moments of talk in interaction and how participants in a conversation use shared cultural resources that enable a particular conversation to make sense (Potter, 1996a).

One way of pinpointing these references has been through the development of the concept of *interpretative repertoires* which have been described as:

systematically related sets of terms that are often used with stylistic and grammatical coherence and often organised around one or more central metaphors. They develop historically and make up an important part of the common sense of a culture, although some are specific to institutional domains (Potter, 1996a, p. 131).

Interpretative repertoires are to discursive psychology what discourses are to Foucauldian discourse analysis. They are the cultural resources people use to make sense of, and account for, their experiences and 'realities'. However, as mentioned discourse at this level is action orientated and involves the analysis of rhetorical devices that are used and the way they are deployed in conversation. In analysing texts within this paradigm, there is also a reliance on such concepts as ideological dilemmas, identity work and what individuals are achieving by 'doing' conversation. The concept of ideological dilemmas (Billig, et al., 1988) suggests that the sense-making involved in identity formation never deals with singular entities, but is always interacting with multiple (and competing) claims and positions. Identity work assumes that "through mutual negotiations participants work up to certain identities during the talk-in-interaction by aligning or resisting certain features of categories connected to specific identities" (Tianio, 2002, p. 181).

Analysis of the three data extracts used in Chapter 7 followed the recommendations set out by Wiggins and Potter (2008). After determining one particular interview (Chad's) was potentially amenable to discursive psychology, data were re-transcribed using Jeffersonian techniques (see Jefferson, 2004 and Appendix G). These new transcripts were then reanalysed, alongside repeated

listening to the audio recordings. Three extracts of data were then drawn from the wider data source, followed by further re-reading and re-listening with a focus on “how the discourse [was] constructed and constructive of different versions of events, how it is situated in interaction, and how it is bound up in action” (Wiggins & Potter, 2008, p. 84). Analytic insights were then confirmed through reference to a discursive psychology ‘corpus’ of ‘essential’ readings (Potter, 2007).

While Chapter 7 is largely driven by insights from discursive psychology, the analysis of data has also been influenced by *critical discursive psychology*, and thus is not ‘limited’ to the CA-informed aspects of ‘typical’ discursive psychology. While the analysis in this chapter *does* tend towards a more fine grained approach than other chapters, it is still interested in the cultural resources drawn upon in the participant’s account.

Chapter 8: Critical discursive psychology

Proponents of the critical discursive psychology used in Chapter 8 (but also informing Chapters 6 and 7), such as Nigel Edley (2001a) have suggested that critical discursive psychology aims “to examine not only how identities are produced on and for particular occasions, but also how history and culture both impinge upon and are transformed by those performances” (p. 190-191). Relative to this, Wetherell and Edley (Edley & Wetherell, 2009; Wetherell & Edley, 1999, 2008, 2009) have argued that in the study of identities (in their case, masculine identities), people are both the products and producers of language (Billig, 1991), and that “when people speak, their talk not only reflects the local pragmatics of that particular conversational context, but also the much broader or more global patterns in collective sense-making and understanding” (Wetherell & Edley, 1999, p. 338). In their study of masculinities they have synthesised micro and macro approaches in order to understand the way men refer to themselves within talk and the cultural resources they draw on in order to do so. They later argued: “what we are arguing for is an approach that holds together a sense of how people both *do* and are *done by* gender talk; an approach that can illuminate how

speakers construct (and use) gender categories and how they are constructed – as gendered beings – by those very categories” (Wetherell & Edley, 2008, p. 166). This blending of approaches attempts to investigate the local/interactional context, as well as the cultural resources which inform this context (see Wetherell, 1998; Wetherell & Edley, 1999, 2008; 2009 for a fuller justification).

One of the useful developments in Wetherell and Edley’s (1999) work is their deployment of the concept of *imaginary positioning*. These positions are taken up by people (in an occasioned fashion) and used to describe themselves and others and usually involve some degree of investment (i.e. *I am like this*). They suggest that within people’s talk there is the “constant creation of illusory subjects. As the subject speaks s/he produces herself or himself as full, complete, describable, as coincident with an image, as a fictional unity” (Wetherell & Edley, 1999, p. 342). Imaginary positions function as a discursive resource used in conversation to describe the self, a resource that, among men, is “one way in which identification with the masculine is achieved” (Wetherell & Edley, 1999, p. 343). More succinctly, they are rhetorical avatars deployed into conversation, and invested with an imagined sense of the self-applicable for that particular conversational context. Wetherell and Edley (1999) identified the masculine imaginary position of ‘ordinary guy’ (e.g., “I’m just an ordinary guy, trying to do my best”) as the most invested in among their participants.

Although there has been some critique of Wetherell and Edley’s (1999) work, for either relying too much on the ideological backdrop (see Speer, 2001a; Speer, 2001b for instance), or not paying enough attention to it (Connell, 2005), I would suggest that it allows for a valuable insight into the ways individual men make use of the resources that are available to them and shape them to the context they are within. As Edley and Wetherell (1997) state in an earlier article, they: “Wish to examine the ways in which men become constituted *as men* within ordinary talk and how men (as competent members of cultural communities) use debates within those communities as central resources in their self-construction.

Data were subject to multiple readings and codings to identify themes and within these themes the identification of broad patterns of self-positioning. Following Wetherell and Edley (1999), my approach in Chapter 8 was simultaneously interested in the fine grain details of participants' talk and "the much broader or more global patterns in collective sense-making and understanding" (Wetherell & Edley, 1999, p. 338).

Chapter 9: Poststructuralist Analysis

'Macro' social constructionists, particularly those influenced by Foucault, view discourse as shared "organised systems of statements that provide socially understood ways, or rules almost, for talking about something and acting in relationship to it" (Gavey, 2005, p. 84). They deal not only with language but practices and the way in which we understand those practices. Foucault (1978) referred to the knowledge-power couplet, which assumes that we are only able to do something as we can make sense of it. Discourse is what enables this to take place, framing and regulating capacity to experience. Discourse then is constitutive and productive, so rather than limiting or constraining certain notions about the world, it is what makes those forms of knowledge accessible to us.

It defines and produces the objects of our knowledge. It governs the way that the topic can meaningfully be talked about and reasoned about. It also influences how ideas are put into practice and used to regulate the conduct of others (Hall, 2001, p. 72).

Particular discourses have more authority than others and therefore appear more 'natural', especially those that come with a degree of institutional power behind them (such as scientific or medical discourses) and so are more accepted as 'Truth'. With regard to this thesis for instance, pronatalist discourse (or the assumption that long term heterosexual couples should have children) has significant power and shapes people's ability to 'choose' whether to have children or not. Poststructuralist analysis is also interested in 'technologies of the self' or the "contemporary

apparatus for 'being human'... the technologies and techniques that hold personhood – identity, selfhood, autonomy and individuality – in place” (Rose, 1996, p. 2). Butler has argued “there is no self . . . who maintains integrity prior to its entrance into this conflicted cultural field. There is only the taking up of tools where they lie, where the ‘very taking up’ is enabled by the tool lying there” (1990: 145).

Analysis from this perspective on discourse assumes that “discursive networks form the basis for the ways in which people both talk about their experiences and actually live those experiences” (Gavey, 2005, p. 97). The task of analysis then is identifying the discourses drawn upon within people’s talk and understanding how they produce certain ways of being (called subject positions (Henriques, Hollway, Urwin, Venn, & Walkerdine, 1984)), thinking and acting, and the choices that are and can be made (Gavey, 2005).

Chapter 9 follows a poststructuralist approach to analysis to discuss the choice to have a pre-emptive vasectomy. Initially themes were developed using the process outlined for thematic analysis. Broad patterns of self-description were identified as having the most value for analysis, particularly the ways the men spoke of the vasectomy as a lens through which they made sense of their identities and worldviews. Issues of power and socio-cultural meaning attached to these descriptions of the self were then analysed.

A caveat about discourse, interpretative repertoires and cultural resources

As a consequence of the use of multiple forms of discourse analysis within this thesis, certain terms and technical language may create complication as they are used variably. Within this thesis I will often interchangeably refer to the ‘cultural resources’, ‘discourses’ and ‘interpretative repertoires’, men use to describe themselves and others. I will tend to use the term ‘cultural resources’ more readily, rather than using ‘interpretative repertoires’ (Edley, 2001a) or ‘discourses’ (Gavey, 1989), as

the latter two are embedded within very particular orientation of discourse analysis. When referring to these concepts in the writings of others, I will use the term they have applied, which usually reflects a particular discourse analytic orientation. For instance when referring to 'discourses', it can be assumed that I am speaking of poststructuralist research; when referring to 'interpretative repertoires' the research is more embedded within discursive and critical discursive psychology.

Summary

Data in this thesis were collected and analysed using various methods. The overall approach used in this thesis was inductive, and methods used were defined by their appropriateness and pragmatic value. Both quantitative survey data and qualitative data from interviews were collected.

Quantitative analysis was primarily descriptive, with two factor analyses. All interviews were thematically analysed, followed by further analysis considered appropriate to the data at hand.

Chapter 5: Connections and comparisons: Survey data about vasectomy in New Zealand

This chapter aims to give a broad statistical snapshot of the types of men who have vasectomies in New Zealand and factors they implicated in their decision for having a vasectomy. It also provides a connection to, and comparison with, previous research on vasectomy, which for the most part has been quantitative (and positivist) in orientation (see Chapter 2). It will first offer some descriptive demographic data about the men who responded to a call to answer an online survey. This will be followed by descriptive statistics related to contraceptive decision making, and two factor analyses that focus explicitly upon the reasons men chose to have a vasectomy and expressed concerns about the operation. As there were no hypotheses for this survey, all of these data can be treated as exploratory in orientation.

Demographic information of participants

Ethnicity and Region:

Almost all of the men identified as Pākehā/NZ European (87.8%), 0.7% were Maori, 2% Pacifica, 0.7% Asian and 8.8% Other. In relation to national statistics this survey was biased toward Pākehā/NZ European men. The national percentage of Pākehā in the overall population is 67.6% (StatisticsNZ, 2006). However, as Sneyd et al's (2001) study showed, vasectomy prevalence is 9.1% among Maori and 13.6% "among men of men of other non-European ethnicity" (p. 156), so vasectomy rates must be considerably higher than average for Pākehā New Zealand men. The majority of the men lived in the main regions of Auckland (32.7%) or Wellington (23.8%), which mirrors the population estimates for Auckland (33.2%), but over-represents Wellingtonians (11.1% of national population) (StatisticsNZ, 2006). The other main regions of Canterbury, Otago and Waikato had proportions of 8.8%, 4.1% and 8.2% respectively, which can be compared with population estimates of 12.9%, 4.8%

and 9.4% (StatisticsNZ, 2006). Smaller population areas were relatively well represented, with the Bay of Plenty/Hawkes Bay at 6.8% (compared to 9.8%), Taranaki/Manuwatu at 6.8% (7.8%), Nelson/Marlborough 4.8%, and Northland 2%.

Religion and Politics

Nearly half of the men identified as not formally religious: Atheist/having no religion (32.8%) or agnostic (16.4%). The two largest groups of those with religious affiliation were those men that identified as Protestant (28.4%) or Catholic (4.5%). Although men who selected Other (14.9%) were a greater proportion than for those who selected Catholic, Other included a range of religious identification, from the generic "Christian", to more specific Protestant identifiers (i.e. Baptist or Presbyterian) to Jehovah's Witness. Buddhist (1.5%) and Muslim (1.5%) identified men made up the remainder. These can be compared with national statistics, which show a similar picture for 'no religion' (34.7%) or general Christian affiliation (55.6%) (StatisticsNZ, 2006). However, Catholics were under represented in this sample (13.6% nationally), which is perhaps reflective of Catholic doctrine about birth control. Politically the two 'main' parties were favoured, with equal numbers (34.4%) supporting National or Labour. The next two largest groups were Greens supporters (11.4%) and Other (14.3%), with NZ First (1.4%) and Act (4.3%) having small numbers of supporters. Based upon the 2008 elections, this is comparable with national statistics, with National support at 45%, Labour at 34%, Green at 7%, NZ First at 4.07% and ACT at 3.95% (MOJ, 2008).

Income and Highest Level of Education:

The majority of the men earned over \$60,000 gross per annum (66.7%), with 38% of the members of this higher earning group earning over \$100,000. This can be compared with the national median income of \$24,400, the national median income for men of \$31,500 and national median for people aged between 45 and 49 of \$35,200 (StatisticsNZ, 2006). Of the remainder 18.4% earned between \$40-60,000, 10.9% between \$20-40,000, and 4.1% under \$20,000. The median annual income for

people over 15 was \$24,400 in 2006, with less than 20% of the overall population earning over \$50,000 (StatisticsNZ, 2006). When broken down to age and sex, the national median income for men in 2006 was \$31,500 and national median for people aged between 45 and 49 was \$35,200 (StatisticsNZ, 2006), the sample for this study is thus very biased toward wealthier men.

The majority of men (78.3%) were tertiary educated, with 33% having a tertiary certificate or diploma, and 29.3% having a bachelor's degree. This compares with national levels of tertiary education being approximately 40% of the population, with 11% of these having a bachelor's degree and 5% any form of postgraduate qualification (StatisticsNZ, 2006). Men with at least some form of high school qualification, but no higher, made up 19% of the sample. Those with no high school qualifications were the smallest group at 2.7%, which can be compared with national population data of 25% having no qualifications and 35% with only high school qualifications (StatisticsNZ, 2006). These figures suggest a bias, not only toward higher income brackets, but being also a highly educated sample.

Children

The number of biological children ranged from 0 to 6 children with a median of 2 which compares to the national mean of 1.9 children per family (StatisticsNZ, 2006). Fourteen (9%) of the men had step children or foster children (with a median of 2) and all of these men also had biological children. None of the men had adopted children. Fifteen (10.2%) of the men in the study had no biological children nor did they care for any other category of children, these were categorised as having had a 'preemptive' vasectomy. Eighty one percent were present at the births of all of their biological children, 8.8% present at some of the births and 5.1% at none of the births of their children. The mean age of their youngest child when the men underwent a vasectomy was 3.3 years with a range of 0 (child not born) to 21 years.

Vasectomy based demographics

There was a high level of variation amongst the men in terms of time since their vasectomy, as seen in Table 1. This spread offered a good balance of experience post-vasectomy, making the data set drawn from the survey a valuable contribution to knowledge about men and vasectomy choices.

Table 5.1
Time since vasectomy operation (N=144)

Time period (years)	N	(%)
< 1	15	(10.4)
1-3	23	(16)
4-6	32	(22)
7-9	10	(6.9)
10-12	12	(8.3)
13-15	8	(5.6)
16-18	10	(6.9)
19-21	5	(3.5)
22+	29	(20.1)

Also noteworthy was the question regarding post-vasectomy semen analysis (PVSA). Although one of the key requisites for confirmation of the operation's success is that at least one negative sperm semen sample had been taken, 22 men (15%) admitted they had not had a post-vasectomy semen analysis (PVSA). Within the open ended option associated with negative answers for this question, answers ranged from "embarrassment" to "was told I needed 20 'clearances'" to "trust in procedure". This fits with comments in recent research which suggests that "it has been long established that a significant proportion of men is noncompliant with the instructions to provide PSVA" (Sheynkin, et al., in press, p. 1).

Results: Contraceptive use, responsibility and the decision making process

The following results were drawn from men's responses to questions about contraceptive use within their relationships, and specifically the introduction of vasectomy as the primary form of contraception for the couple.

Contraceptive use

As can be seen in Table 5.2, condoms and the pill were the predominant forms of contraception that the men identified as having used.

Table 5.2
*Percentage values of the various forms of birth control used by men and their partners*¹
(N=144)

Contraceptive Type	N	(%)
The pill	128	(88.9)
Condoms	117	(81.3)
Withdrawal method	28	(19.4)
Abstinence from penetrative sex	24	(16.7)
IUD	23	(16.0)
Diaphragm	18	(12.5)
Depo Provera	17	(11.8)
Emergency contraceptive	13	(9.0)
Natural family planning	11	(7.6)
None	6	(4.2)
Other	6	(4.2)
Cervical cap	3	(2.1)
Norplant (Contraceptive Implant)	1	(0.7)

¹More than one option could be chosen

Table 5.2 shows the dominance of the pill as a contraceptive measure, possibly enhanced by occasional use of condoms. The men could answer as many options as were applicable to their

experience, however, in retrospect, there are some issues with regard to the question's lack of specificity. Another question, added to the existing one that may have offered some more utility, could have been regarding the 'primary' form of contraception used and only allowed one option. The 'other' options that men identified in the open ended portion of this question included spermicides, creams, sponges and tubal ligation.

Alongside the high level of pill use, men identified their partner as taking primary responsibility for contraception only 53.5% of the time, both partners 33.1% of the time and themselves only at 13.3%. How this question was understood by many of the men and what 'both' actually means are not able to be answered.

Decision making processes

Several of the questions in the survey aimed to identify how men made the decision to have a vasectomy. One aspect of decision making related to who first raised vasectomy as an option for the men. The majority of men presented themselves as initiating the process (Table 5.3 shows over half of the men did so).

Table 5.3

Percentage of men identifying the person who FIRST raised vasectomy as an option to them (N=141)

Person	N	%
Wife/Partner	46	(32.6)
Male Friend	9	(6.4)
Relative	5	(3.5)
Physician	3	(2.1)
Colleague	2	(1.4)
Female Friend	0	(0)

Also included in this question was the option of “Other”, to which an extremely high percentage (53.9% in total) offered the answer “no-one” or “myself” and qualified these answers by suggesting it was their own processing of the issue that had first raised vasectomy as an option. A number of two tail two sample t-tests were performed to determine if there was a significant difference between the different percentages of the original groupings and this ‘new group’. Significantly more men reported it was themselves or “no-one” who first raised the vasectomy than the next highest group (wife/partner) ($t(140) = 2.794, p = .0118$). All other groups were also significantly different, including the third most common influence – a male friend.

Factor Analyses

Two exploratory factor analysis (EFA) were conducted, one for the results of the ‘Reasons for Having a Vasectomy’ (Reasons) scale, the other for the ‘Concerns about having a vasectomy’ (Concerns) scale. EFA was chosen rather than principal components analysis to explain common variance, and to increase the interpretability of the factors (Tabachnick & Fidell, 2007). This offers a similar function to thematic analysis in qualitative research. Maximum likelihood extraction was used followed by direct oblimin rotation with Kaiser Normalisation in both analyses, allowing factors to correlate with one another. Direct Oblimin rotation was used as it allows some correlation to exist between factors and identifies “independent factors if they exist” (Kashy, Donnellan, Ackerman, & Russell, 2009, p. 5). This is important as it is likely that different reasons for having a vasectomy will correlate to some extent with each other, and the same can be assumed for men’s concerns about having a vasectomy.

Reasons scale

EFA analysis resulted in six factors in the Reasons scale based on the Kaiser criteria (Kaiser, 1960) with eigenvalues greater than one. These six factors were then labelled according to the items the EFA included in each factor. The labels were: 1) Children negative, 2) Partner motivated, 3) Heroism,

4) Responsibility, 5) Time and 6) Economic. These factors encapsulated the underlying processes that informed men's responses regarding their reasons for having had a vasectomy. The survey items the factors captured can be seen in Table 5.4 and were interpreted using the survey item with the strongest relationship to the factor, and its relationship to the other survey items (e.g., Children negative: men responded in a similar fashion to the items "Children are not part of my life goals" as they did to "I have other priorities in life"). Further interpretation of the factors as 'underlying processes' and the relationships between the items are found below Table 5.4.

There was some overlap between some of the factors (which considering factors are defined by their relative independence from other factors, reduces their value to the overall model), with some items cross loading weakly across all factors. Three items, which did not load strongly on any factor, were removed: "I chose to have a vasectomy due to suggestions from a male friend", "I chose to have a vasectomy due to the possibility of genetic problems that may be passed onto a child" and "I chose to have a vasectomy because of the health risks to my partner if she got pregnant". The last two were felt to be problematic questions as the meaning for each could be interpreted in different ways and therefore be answered with wide variation. The first question loading so weakly is particularly relevant, considering Mumford's (1983) assertion that male friends played such a key part in the decision making process of the men in his study, it was clearly not a consistent experience for the men in this sample. "Family was complete" (which loaded evenly across a number of factors) was kept despite its even and low loadings, as it is considered one of the primary determinants for an 'acceptable vasectomy' (Moses & Oloto, 2008) and thus potentially highlights its lack of meaning as a measure for men in the decision making process.

The EFA analysis was generated in SPSS and used several statistical tests to determine its validity, which I will now discuss. The final model converged in 6 iterations and had a non-significant Kaiser-Meyer-Olkin value of .73 (it needs to be greater than 0.5 for success) indicating that partial

correlation between variables was small and therefore amenable to factor analysis (Kaiser, 1974). The goodness of fit test, $\chi^2 (72, N = 133) = 73.607, p < .01$, yielded statistically non-significant results indicating the value of the model. The communalities indicate that between 21% and 70% of the variance in was accounted for by the model seen in Table 5.4. In order to interpret the data, the *pattern matrix* produced by the analysis was used for interpretation. The pattern matrix identifies an item's level of importance to the overall factor, with the influence of the other items removed. Use of the pattern matrix is appropriate for this form of exploratory factor analysis (Tabachnick & Fidell, 2007) and is reproduced in Table 5.4.

Table 5.4: Factor Loadings for the 'Reasons for having a vasectomy' Scale

Item	Children	Partner	Heroism	Time	Responsibility	Economic
Children not part of life goals.	1.03					
Other priorities in life.	.80					
Doubted abilities as a potential father.	.60					
Earth is overpopulated.	.42					
Emotional Pressure from partner.		1.03				
Partner asked me to.		.65				
Invasiveness of tubal ligation.			.94			
Recovery time of tubal ligation			.86			
Health risks of pill or other contraception.			.47			
Better invest time with friends and family.				.89		
Better invest time with partner.				.76		
Better invest time in current children.				.74		
More time for interests/pursuits.				.65		

Table 5.4 (Cont).

Item	Children	Partner	Heroism	Time	Responsibility	Economic
Family was complete.	-.35			.37	.36	
Right thing to do.					.74	
Didn't want to worry about contraceptives.					.60	
My turn to take responsibility.					.37	
Could not afford another child.						.68
Cheaper than tubal ligation						.37
Variance Explained	21.62	18.03	10.07	8.07	6.40	5.6

Summary of 'Reasons' Factor Analysis

Factor 1: Child negative

This factor was distinguished by its loading of items related to the validity of having children. It contained the items "children not part of life goals", "other priorities in life", "doubted ability as a potential father", "Earth is overpopulated as it is" and perhaps oddly at face value "family is complete" and accounted for 21.62% of the variance. While a man might be invested in limiting family size due to overpopulation or having other priorities in life, the correlations with the first item: that children were not part of life goals, would likely tend to polarise answers between those who have chosen not to have children and those that have them. This means that men with children would likely have clustered their answers at the 'slightly disagree', 'disagree' or 'strongly disagree' (or 'negative') end of the spectrum for items in this factor (e.g., 79.7% of the men chose one of these answers for the life goals question). The 15.1% of men who answered anywhere on the agree (the 'positive') end of the spectrum for the same question, were likely to be men who answered similarly

for the other questions in this factor and are likely to be men who had pre-emptive vasectomies (or if they had children, had not wanted to).

Factor 2: Partner Motivated

This factor loaded with items “emotional pressure from partner” and “partner asked me to” and while only containing two variables, accounted for 18% of the variance. As with the previous factor, the primary item (emotional pressure from partner) was answered negatively by 78.3% of respondents. Men were likely answering according to their investment in wider Western discourses of individualisation and choice (Budgeon, 2003; Rose, 1996) and more orthodox masculine ‘traits’ of autonomy and independence (Anderson, 2009; Connell, 2005; Wetherell & Edley, 1999) (also seen in the data in Table 5.3). Childfree men would likely be even more motivated to present themselves as self-defined/guided (see Chapter 8). For those men who answered positively in this question (12%), ‘partner motivated’ could reflect the place of reproduction and reproductive decision making as a woman’s ‘domain’ for these men.

Factor 3: Heroism

While not the strongest of the factors (only accounting for 10.1% of the variance), this factor was built around items which used language described in Chapter 5 as ‘minor heroism’ and provided one of the major themes from the ‘typical trajectory’ interviews. The items included “invasiveness of tubal ligation”, “recovery time from tubal ligation”, “health risks from pill or other contraception”. These items relied on notions of protection and the difficulties of tubal ligation in comparison to vasectomy (see Chapter 2). Men answering strongly in agreement with these items would be invested in presenting the operation as ‘doing a favour’ for their partner, while those who answered rejecting them would more likely be interested in presenting the vasectomy as ‘no big deal’ and therefore not worth comparing with a tubal ligation.

Factor 4: Time

The time factor captured the largest number of items from this scale, and explained 6.7% of the variance. The items included: “better invest time with friends and family”, “better invest time with partner”, “better invest time in current children”, “more time for interests and pursuits” and again the “family is complete” item. Time decisions are ones which highlight the vasectomy as a permanent family size limiting intervention (as opposed to choices regarding health and wellbeing). These are potentially issues which are more common to the West where children are seen as an investment rather than a resource to draw from.

Factor 5: Responsibility

The items loaded onto this factor showed some similarity to what was also a key theme within the qualitative data (see Chapter 5). Men linking their choice to a particular type of morality and the language of ‘doing right’ or ‘responsibility’ indicates that however men answered this question, having a vasectomy was more than a simple birth control method for men. Items in this factor included: “family was complete”, “right thing to do”, “didn’t want to worry about contraceptives” and “my turn to take responsibility”.

Factor 6: Economic

Given the nature of the items loaded into this factor (“could not afford another child” and “vasectomy cheaper than tubal ligation”) and the low levels of pattern coefficient loading (especially for the item “vasectomy cheaper than tubal ligation”) it is unlikely that this factor played a significant part in the decision making processes of all of the men (either positively or negatively) and in fact, the items relationship to this factor could well be explained by the strength of another factor. This would also suggest that the men answered this question in different ways attributing different meanings to the items.

Family size is complete

While certainly not a factor in its own right, this item loaded across several factors in the pattern matrix and relatively weakly when it did. This is an issue which needs raising, as the 'complete family' was considered a key question in assessing a man's suitability for vasectomy by several of the Professional interviews and within the literature. That it was answered so diffusely (as with economic reasons) indicated its variable meaning for the men who answered this survey and highlights its weakness as a parameter for assessment. This is especially true for those men who choose not to have children as it becomes nonsensical to answer either affirmatively or negatively.

Concerns scale

EFA analysis resulted in three factors in the Concerns scale based on the same criteria as the Reasons scale. The three factors the analysis produced for the items were (1) health-related (2) individualism, and (3) loss of future fertility. Of note, was the labelling of the second factor that I have labelled 'individualism' as its label runs in contrast to the items within it. This labelling was due to the negative loadings between the items and the factor. As the items captured by this factor were related to 'collectivist' concerns (i.e. religion, culture), it makes sense that the underlying process, as negatively correlated to the men's responses, is collectivism's 'opposite': individualism.

The final model drawn from a maximum likelihood with direct oblimin rotation converged into three factors in eight iterations. The factors had moderate correlations between -.64 to .57, which showed the factors' independence from one another. The non-significant Kaiser-Meyer-Olkin value of .906 also indicates that this partial correlation between variables was small enough and therefore they were amenable to factor analysis (Kaiser, 1974). The goodness of fit test, $\chi^2 (63, N = 133) = 215.993$, $p < .01$, yielded statistically non-significant results indicating the value of the model and its associated three factors as encompassing the majority of the variance. The three factors for the scale were (1) embodiment (body related concerns), (2) Individualism's effects on concerns, and (3)

Loss of future fertility driven concerns. The communalities indicate that between 47% and 87% of the variance in each item was accounted for by the resulting factors. As with the 'reasons' scale, the pattern matrix produced by the analysis was used to interpret the factors and is reproduced in Table 5.5.

Table 5.5
Factor Loadings for the 'Concerns about having a vasectomy' Scale (N=137)

Item	Health related	Individualism	Future Fertility
I was concerned I would feel depressed after having a vasectomy	.48		
I was concerned that it is not an appropriate means of birth control in my religion		-.45	
I was concerned it is not culturally appropriate		-.56	
I was concerned about what my friends would think		-.94	
I was concerned about what my family would think		-.95	
I have felt the need to hide that I have had a vasectomy		-.78	
I was concerned about the pain associated with having a vasectomy	.67		
I was concerned about a loss of feeling/sensation during sex	.89		
I was concerned about possible future health risks	.57		
I was concerned that we might want to have more children			-.74
I was concerned that if I were to have a new wife/partner we might want to have children together			-.81
I was concerned that if one of our children died then we might want to have another child			-.87
I was concerned that I would feel less of a man	.47		
I was concerned that I was being pressured to have a vasectomy		-.40	
I was concerned that I would have less interest in sex after a vasectomy	.77		

Table 5.5. (Cont.)

Variance explained (%)	52.16	8.03	4.94
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Summary of 'Concerns' Factor Analysis

Factor 1: Health-related

The health-related factor contained items related to concerns about the physical implications of the operation: "I was concerned I would feel depressed after having a vasectomy", "I was concerned about the pain associated with having a vasectomy", "I was concerned about a loss of feeling/sensation during sex", "I was concerned about possible future health risks", "I was concerned that I would feel less of a man" and "I was concerned that I would have less interest in sex after a vasectomy". This factor accounted for over half (52.16%) of the shared variance and over a third (39%) of the items in this scale. Questions related to sex (loss of sensation, less interest) produced higher correlations with the factors than the other items, and in both cases a small majority of the men disagreed with the statements (loss of sensation: 51.5%, less interest: 67.9%), there was, however a reasonably balanced spread across all possible answers for each of these questions, suggesting that men who indicated concern about loss of sensation, also likely indicated concern about lower libido.

Other items in the health-related section (health, pain and depression) shared the even spread of answers across the 7 point scale with the two sex-related questions, but much less strongly at one end or the other. Answering any of these statements (sex related or not) with agreement would perhaps suggest a lack of understanding about the operation, or a tendency to be anxious about such things.

At first glance the item "I was concerned that I would feel less of a man" seems out of place, however it was answered in a similar fashion to the items about sex, with the majority of men

disagreeing with the statement in some way (76.9%). There was likely an association between 'feeling like a man' and sexual health, as for many men masculinity *is* sexuality (Holland, Ramazanoglu, & Sharpe, 1998).

Factor 2: Individualism

This factor explained the responses to six items from the scale: "I was concerned that I was being pressured to have a vasectomy", "I was concerned that it is not an appropriate means of birth control in my religion", "I was concerned it is not culturally appropriate", "I was concerned about what my friends would think", "I have felt the need to hide that I have had a vasectomy", and "I have felt the need to hide that I have had a vasectomy". It accounted for 8% of the variance and the items were all negatively correlated with the underlying process of Others being a important to men's retrospective processing of their concerns. This was also evidenced in the strong (almost entirely) negative responses to questions explained by this factor (e.g., 89.6% of men saying they disagreed in some way with the statement "I was concerned about what my friends would think"). As discussed previously, this would suggest that the *underlying process* was associated with discourses of individualism rather than collectivist concerns (such as influence of religious or cultural group), shaping the answers men gave to items explained by this factor.

Factor 3: Loss of Future fertility

This factor explained three items: "I was concerned that if one of our children died then we might want to have another child", "I was concerned that we might want to have more children" and "I was concerned that if I were to have a new wife/partner we might want to have children together", and it accounted for almost 5% of the variance. Also defined by strong negative loadings, the items grouped together by this factor all indicate the impact of a *loss* of future fertility shaped the men's answers. The strongest loading was in the item "I was concerned that if one of our children died then we might want to have another child", which 24.2% of men answered with some degree of

affirmation and 65.9% answered negatively. It is probable that the concept of lost fertility made such concerns salient for men and shaped their answers in a different fashion from the other items in this scale.

Vasectomy experiences

The two 'post-vasectomy' scales, 'experiences' and 'regret' were collapsed from a seven point scale to a five point scale and not applicable answers were removed to increase simplicity of interpretation (see Tables 5.6 and 5.7).

Table 5.6
Experiences post-vasectomy (N=136)

Item	Disagree/ Str. Disagree (%)	Slightly Disagree (%)	Neutral (%)	Slightly Agree (%)	Agree/ Str. Agree (%)
My post-op recovery was exactly as described by the surgeon/ physician	11.8	5.9	2.2	5.9	83.0
I had no more pain than I expected	13.3	5.9	4.4	10.4	65.9
The post-op pain lasted no more than a week	14.8	8.1	0.7	7.4	68.9
My wife/ partner was <i>verbally</i> appreciative	7.4	2.2	14.1	8.1	61.8
My wife/partner was <i>physically</i> appreciative (hugs etc)	11.2	3.7	19.4	19.4	46.3
I found that I have enjoyed sex more	5.9	3.7	33.1	12.5	44.9
My wife seems to enjoy sex more	10.6	1.5	42.4	10.6	37.5
We have sex more often	23	6.7	36.3	11.9	22.3

The majority of men who answered the ‘experience’ questions indicated that their experiences of the operation fell within the normative range (i.e. limited pain and impact on life in general). Between 11.8 and 14.8% of the men indicated they had a reasonable degree of ‘negative’ or ‘abnormal’ experience, which combined with the ‘slightly disagree’ column raises many of the percentages as high as 20%. The majority of men also indicated physical and emotional appreciation from their partner and some increased enjoyment of sex. What is interesting to note is the high percentage of men who answered neutral/no opinion to sex related questions, which was likely associated with ‘no change’.

*Table 5.7
Regrets post-vasectomy (N=136)*

Item	Disagree/ Str. Disagree (%)	Slightly Disagree (%)	Neutral (%)	Slightly Agree (%)	Agree/ Str. Agree (%)
I have regretted having the vasectomy	90.4	0.7	3.7	4.4	0.7
My wife has regretted me having the vasectomy	83.6	2.2	3.7	5.2	3.7
I have regretted my choice to have children	86.6	0.7	6.7	0.7	1.4
I have regretted my choice to not have children	83.5	2.2	23	0.8	0.8
I have regretted having as many children as we have	83.5	2.2	6.7	3	0.7
I have regretted not having more children	74.4	3.8	7.5	7.5	2.3

Slightly over 5% of men who participated in this survey indicated some degree of personal regret after the vasectomy. The vast majority of men, however, did not disagree with any statements of

regret (almost all answers over 80%). A higher percentage of the men indicated that their wife/partner had experienced some degree of regret (8.9%). When the question was framed in terms of regretting not having more children, almost 10% of men indicated feeling some regret.

Discussion

The primary objective of this part of the project was to offer a broad analysis of the reasons men might have for choosing to have a vasectomy and their experiences of the operation. Much of the earlier research on the subject has focused upon negative aspects of vasectomy, such as the historical social stigma of the operation (e.g., Kohli & Sobrero, 1973, 1975), fear of pain (e.g., Groat, et al., 1990), “adverse psychological changes” (Ziegler, et al., 1969, p. 53), sexual ‘dysfunction’ (e.g., Hofmeyr & Greeff, 2002; Ziegler, et al., 1969) or regret (e.g., Miller, et al., 1990, 1991a, 1991b).

In contrast to much of this early work, and showing a strong connection with the outcomes of Sandlow et al.’s (2001) US based study and Heiliger’s (2001) New Zealand based study, the results in this chapter tell a more positive story. The majority of the men indicated they were invested in pro-contraceptive behaviour and that the operation itself had little impact upon them. Like Heiliger’s (2001) work the overall theme of the survey’s results seemed to demonstrate men’s interest in involvement, with claims to cultural, religious, or more general concerns about others having little impact on the vast majority of men.

Contraceptive use

While the high levels of reliance on the pill are not unexpected (Colli, Tong, Penhallegon, & Parazzani, 1999), a large number of men also indicated they had used condoms. The use of condoms, as already mentioned, was probably not a reference to them being a primary method. A survey participant could justifiably tick the box if they had only used condoms once in their current relationship, and so answers to this question do not accurately measure the regular use of condoms.

Periods of time where the contraceptive pill was unable to be used for various reasons or its effectiveness was limited (due to antibiotic use, missed pill etc.) may well have resulted in condoms as a secondary form of contraception. A more useful way to ask about contraceptive use would be in terms of 'primary' or 'predominant' forms of contraception over the time of the relationship. In saying this, men indicating condom-use was a part of the sexual practices in their long-term relationships is interesting, because it is in contrast to some qualitative research on long term relationships (e.g., Flood, 2003; Willig, 1994, 1997) and quantitative research on adolescents (e.g., Abel & Brunton, 2005; Bauman, Karasz, & Hamilton, 2007). Further research with a more focussed line of questioning about contraceptive use in long-term heterosexual relationships would be useful.

The proportion of men who identified non-penetrative sex as a form of contraceptive practice (16.7%) may be further evidence of McPhillips et al.'s (2001) suggestion of 'slippage' in the coital imperative. Like condom use, however, it is unlikely that this was consistently used as a *primary* contraceptive practice.

Decision making

Some of the men indicated that they were not influenced by others in the decision to have a vasectomy (53.9% of men saying they were the first person to raise vasectomy for themselves). While partners were given value in the process by some of the men (32% of men), all other sources were significantly less represented than these two. This provides a different picture to Mumford's (1983) claim that other men who have had vasectomies are identified as the biggest motivating force for a man deciding to have one (in the results in this chapter, the t-test indicated a p-value of less than .0001 ($t(140) = 8.155, p < .0001$)). Either there is a noteworthy difference in cultural context between New Zealand in the 2000s and the US in the 1980s, and/or the men in this study were invested in presenting a 'different face' due to other concerns. It is also likely that the significant difference in the percentage of men identifying themselves as the primary instigator of

the operation, may be indicative of an expectation of personal responsibility that constructions of the autonomous, rational, choosing social actor presuppose in a Western neoliberal context (Budgeon, 2003). It is also feasible that the *first* person to raise the issue is not the person who provides the main impetus for getting the operation, however the other scales related to decision making seemed to point away from this possibility.

The results in general, and in particular the factors extracted from the reasons and concerns scale, indicated the appeal and power of neoliberal notions of personal responsibility (Budgeon, 2003; Rose, 1996). They also highlighted some investment in more orthodox constructions of masculinity, which tend to emphasise investment in the protection of family and heroic acts (Anderson, 2009; Connell, 2005; Wetherell & Edley, 1999, 2009). This probably reflects the bias of the sample. Neoliberal discourses of individuals as self-contained, rational social actors, needing to be responsible for their decisions and actions, tend to benefit and be taken up more often by Pākehā in higher income brackets (Connell, 2002; Hodgetts, Masters, & Robertson, 2004). These and other discourses indicating education and access to egalitarian language were also reflected in the ways questions were answered.

The discourses drawn upon by a dominant group may be useful for offering some insight into men who are not complicit with, and may even be marginalised by hegemonic forms of masculinity (Connell, 2005). Lower vasectomy uptake among these men may be indicative of cultural rather than individual issues. Rather than a 'silver bullet' of greater education and more funding, perhaps what could be suggested from this research is that for those men who do not identify with neoliberal discourses and hegemonic forms of masculinity, perhaps a different approach could be taken. A focus on contextualised, couple based or even (wider) family based decisions, rather than vasectomy as a 'personal choice' demonstrating 'personal responsibility' could be of value. Of note, is Gutmann's (2007) research, which has suggested that often the greatest impediment to uptake of

vasectomy is not the men themselves, but the health professionals who market and provide the operation.

Regret

Some research evidence suggests approximately 10% of men who have vasectomies will indicate some kind of regret after the operation (Holden, et al., 2005; Miller, et al., 1991a). A number of men (5%) in this study also indicated some degree of general regret over having had the operation. What was interesting were the responses to more specific questions about regret. Indications of regret almost doubled when children became the focus (9.8% of men saying the regret not having more children). This would perhaps suggest that the concept of regret perhaps needs to be contextualised in further studies in order to more fully understand *what* it is which is being regretted.

Experiences

The majority of men indicated that they experienced vasectomy exactly as they expected and the large majority indicated that their partners were both physically and verbally appreciative of the men having the operation. This latter feature perhaps reflects the perpetuation of an 'economy of gratitude' (Hochschild, 2003) concerning the operation (which I will discuss in later chapters), but also reflects the positive experience of having a vasectomy for many of the men. Sex for men was either positively changed or not noticeably different for the most part. This is in sharp contrast to earlier research on vasectomy (Ziegler, et al., 1969) and more contemporary research from other contexts where research questions have largely been defined by *concerns* about sexual impacts of vasectomy (Hofmeyr & Greeff, 2002). The results related to post-vasectomy sexual experiences in this chapter show similar (positive or neutral) effects to recent US based (Sandlow, et al., 2001) and Brazil based (Dilbaz, et al., 2007) research.

There were, however, a number of men who gave negative responses to the items on experience. These numbers were much higher than many other recent studies of similar nature (e.g., Dilbaz, et al., 2007; Sandlow, et al., 2001). While I would be loathe to discount the experiences of men who participated in the study, I strongly suspect this is indicative of the self-selection process for this sample and an investment among men who may have had a more negative experience to participate. Some research has shown that men who feel 'pressured' into having a vasectomy, will be more likely to suffer from adverse effects and regret than those who 'willingly' participate or consider the idea to participate their own (Miller, et al., 1990, 1991a, 1991b). This likely has much to do with the expectations orthodox expressions of masculinity place upon some men (e.g., autonomy) and reinforces the positive implications of introducing access to more inclusive expressions of masculinity (Anderson, 2009) and the discourses that uphold them.

Limitations of the study

As with almost all previous studies on vasectomy (both internationally and in New Zealand), the cohort represented here was largely comprised of white men (more specifically Pākehā/NZ European) with much higher levels of education and income when compared to national statistics (e.g., Heiliger, 2001; Sandlow, et al., 2001; Sneyd, et al., 2001). This might represent the types of men who have vasectomy; it is also likely an effect of the self-selection process. Unfortunately, this sample does little to contribute to knowledge about Maori (or other ethnic groups) and vasectomy and so the results are reflective of the cultural resources drawn upon by a select group of men in New Zealand.

This survey as a small part of the overall research project was exploratory in nature; it did not have hypotheses and was not intended to produce generalisable results. While this is not a limitation for the overall project in light of the theoretical drive of this thesis (social constructionist), it may potentially reduce the usefulness of these results for work more influenced by positivist approaches.

While the factor analyses gave insight into the underlying processes (or cultural resources) that informed men's answers, use of confirmatory factor analysis (likely through structural equation modelling) would have increased the interpretability of factors.

Summary

Research on vasectomy continues to be under-researched and this chapter offers a connection point between what little research exists and the chapters and analysis to follow. The results from these survey data demonstrate that the men who participated were invested in notions of personal responsibility and involvement in the 'contraceptive task'. For the most part, men indicated that their experiences were both positive and that they suffered no regrets. The social constructionist orientation of this study adds to and enhances previous research on vasectomy by highlighting the cultural discourses men appeared to be drawing from in order to respond to items. These insights will be added to and reinforced in the chapters to follow.

Chapter 6: “It’s kind of me taking responsibility for these things, instead of pushing it off, pushing off and declining to be involved”: Themes of responsibility and heroism

The process of developing themes (from the accounts of men who had ‘typical’ vasectomies) produced a recurring account of ‘reproductive responsibility’, which was by far the most prominent theme in the interviews.¹⁵ Almost all of the men spoke of ‘taking on’ responsibility for contraception by having a vasectomy. While this may be constructed as a positive reshaping of masculinities to more egalitarian ends, many of the accounts were produced through a particularly ‘heroic’ portrayal of this responsibility: the vasectomy was framed as a reasonably significant act of masculine valour, done to protect their female partner (and in some cases their family) from harm or a loss of wellbeing. This sort of portrayal demonstrates either a blending of different models of masculinity within the participants’ discourse, or perhaps, as Wetherell and Edley (1999) have suggested, a hegemonic form of masculine sense making that shapes even the most egalitarian of masculine identities.

“She’s taken responsibility for contraception and having kids and all that, so maybe it’s my turn to do something”: Responsibility

For the majority of the men, an investment in being ‘responsible’ was evident, particularly in relation to questions about the type of man who has a vasectomy. Those questions were deliberately constructed so as to allow the participants to offer accounts of the types of

¹⁵ When a theme is discussed within this chapter, some quantifying language will be used to discuss its prevalence across the data corpus. It is important to note that these terms are not in any way attempting to ‘count’ the instances of a theme’s occurrence (as per content analysis), but rather to provide some indication of the strength or consistency of a theme. Where the term ‘many’ is used, it refers to occurrences of the theme within at least 10 of the 17 ‘typical’ participant’s accounts. When I use ‘most’ or ‘almost all’, this will mean at least 12 to 14 occurrences are being referred to, and ‘some’ as six to eight. Terms such as ‘commonly’ and ‘typically’ or ‘often’ will more broadly refer to occurrences of the theme in anywhere between 10 and 17 interviews and ‘occasionally’ or ‘uncommon’ will refer to less than half of the participants.

masculinities they identify with and invest their sense of self into. The following account was a typical response to this question:

GT: There's a lot of questions about what type of men are having vasectomies [...] how would you describe yourself in terms of the type of man who goes out and has a vasectomy?

Dan: I think (.) I guess it's someone who takes responsibility I guess [GT: mmn] and (.) who (.) I mean particularly, I mean I think that most people I think would have vasectomies are men who are and, of course, I'm only guessing because I don't know this for a fact, but are in relationships and within their relationships they've decided they don't want to have any more children so I guess they're taking, they've decided that it's you know their turn to take on the responsibility. Up until that point (.) you know, it's been the woman's responsibility in regards to if they've taken the pill [GT: mmn] and it's their turn to do something [GT: mmn] you know take that responsibility.

Here Dan made the connection between a couple's interest in not having any more children and the 'new' opportunity for men to be 'responsible' for contraception. The accounts of the men interviewed, typically framed the pill being 'traded' for a one-off operation.

Responsibility at this new point in the relationship was described as an attribute that could then be 'taken', rather than given or offered by the female partner. This was a common formula amongst the participants' accounts, with many of the men emphasising their own decision making processes as primary to the choice to have the operation, for instance Mike commented:

Mike: I just decided that a vasectomy was, I just decided that I wanted to have some control [GT: yeah] for [...] I like the fact that sexually [...] if a time and a place or whatever happened that you could just act on that [GT: mmn] and basically and she is still um having periods so she's still possible could possibly have a childbirth [GT: mmn] and it was just one of those (.) I feel for me it was one of those things where I decided I'd take

some responsibility [GT: mmn, mmn] and that's really what [...] I decided that that's what I wanted to do.

This trade in responsibility was treated as a straightforward transaction, with virtually no construction of it as inequitable. When specifically referring to 'responsibility' for contraceptive tasks, whether speaking of 'female controlled' contraceptives or vasectomy, men did not often comment on the 'costs' and 'benefits' of each to the person involved. Twenty or thirty years of hormonal and chemical changes, typical side effects of the use of the contraceptive pill by women, or the use of invasive implant technologies, were simply, and as if they were equivalents, 'replaced' by a vasectomy.

'Responsibility' in these types of portrayals was reduced to the body in question (i.e. whose body is rendered infertile), not to the acts of constant self-surveillance many women undergo as part of their contraceptive regimes. A vasectomy is a form of 'forgettable contraception' (Grimes, 2009), requiring action to reverse it rather than (often) daily monitoring of the process (and the potential side effects) expected in use of oral contraceptives. Having a vasectomy requires little monitoring (especially after the final semen sample) and marginal scope for side effects. Despite this, there was a strong tone of finality in this transfer of responsibility in the majority of participants' accounts, constructing a straightforward move from one individual's body to the other, for the benefit of the couple.

Mike's account is also marked by a theme of controlling the uncertainty associated with unprotected sexual activity ("could possibly have a childbirth"), and also by the notion of 'spontaneous sex' as an ideal, fitting it within anti-condom discourse (Flood, 2003; Willig, 1995, 1997) and the coital imperative (Jackson, 1984). The way he described his primary motivations for having a vasectomy emphasised a desire for this spontaneous sex, without the concerns of pregnancy. The implicit argument in this accounting was that someone must take responsibility to reduce or eliminate the

uncertainty and thus allow this ideal form of sex to occur. Although his partner had used the pill before their relationship, she was not at the time; this provided Mike with the 'space' to be responsible for contraception ("I decided that's what I wanted to do").

This idea of needing space to be responsible was evident in many of the interviews, with the vasectomy being suggested when there was some question as to the validity of using the pill or other forms of contraception. Key to this concept is the notion that men simply need this space to 'become' responsible, and until that point it is almost as if they are being 'deprived' of the opportunity to do so. The pill is constructed as acting as a 'barrier' to men's (desired) responsibility, leaving them with little ground in which to share the burden of contraception. Once this barrier becomes problematised and then removed, the men in this portrayal are freely able to step into the gap created.

Following this logic, many of the men described the decision as natural and inevitable, something men should not feel any interest in avoiding:

Andy: you know there's no reason on earth why you'd not have it done and it is unfair on your partner to expect her to take responsibility for contraception [GT: mmn] and especially oral contraception so yeah do it's the most reasonable and decent thing you can do.

Andy described the vasectomy as something which should be inevitable for men. The unreasonableness of indifference is framed in light of their partner's responsibility for contraception, especially when it is oral contraceptives that are being used. In an earlier comment Andy referred to the 'toll' the pill had taken on his former partner's body and, in light of this, his account constructed the man who chooses *not* to have a vasectomy as *unreasonable* and *not* decent. He situated vasectomy (unlike some others) as *always* a viable option for men, so to *not* choose this option therefore makes the man involved unreasonable.

Many of the accounts contained reference to such unreasonable 'other' men who had made a point of not having a vasectomy. They were usually contrasted with a masculinity the participant was invested in as his 'own'. For instance, when asked to describe what type of man has a vasectomy, Chad commented:

Chad: maybe there's more awareness of the fact that there are alternatives to just taking the pill [GT: yeah] I mean the IUD just seems such a brutal thing to do, I can't, just, just, I mean I just can't understand it but I, you know, we have friends, for example, and he will not get a vasectomy, he absolutely refuses and she reacts badly to the pill, so she's, she's on IUD, um (clicks tongue), I mean he is pretty, well I wouldn't say he's typical, but he's, he is you know, rural bloke "not bloody getting a vasectomy" you know, "blah, blah, blah", so, yeah I dunno, I don't know. Maybe it's a bit of an awareness thing, maybe it's just a new age guy thing, I don't know.

Chad, much more explicitly than Andy, referred to the 'unreasonableness' of men who are unwilling to have a vasectomy. The negative points Chad listed against his friend worked to construct Chad's own involvement as reasonable, responsible and decent and presented getting a vasectomy as a choice, but one which is easy to make if you are 'aware' or a "new age guy". This sort of argument was ratified in Sam's account, where he suggested that the ease of 'taking responsibility' was because it was a life-course decision, a normative part of being in a loving long-term heterosexual relationship:

Sam: it was a really easy, a really easy decision and I see that as part of, um, the, the relationship that we have again it's kind of me taking responsibility for these things instead of pushing it off, pushing off and declining to be involved, um, so as part of a kind of a trajectory for want of a better word of a relationship, it's, it's definitely part of that.

These sorts of accounts are important for the shaping of egalitarian masculinities as they suggest a positive shift in the discourses straight men draw upon in the formation of their identities. For many

of the men, even if there was difficulty in articulating *how* having a vasectomy was ‘being responsible’, their accounts implied investment in the ideas of responsibility and care for their partners at the very least. As discussed above, within certain contexts, some men’s accounts have suggested an investment in being an egalitarian and loving partner (Terry & Braun, 2009) or certainly articulating it as such to social science researchers. The choice to have a vasectomy, for many of the men in this study seems to be tied to this sort of identity: mature, egalitarian, responsible and caring.

In contrast, however, among a few of the participant’s accounts were descriptions of female partners having to present a case for the vasectomy, by comparing it with other forms of contraception, labour or the invasiveness of a caesarean section to try to convince their (reluctant) partner. This was evident in Patrick’s story:

GT: mmn, cool, OK (laughs) um (.) you’ve had two kids, um, there’s a process of starting to talk about and all that sort of stuff who initiated the, the, the discussion there

Patrick: oh, ah, um (.) I think, um, I think that my wife might have said something to me like, you know, she wasn’t, she didn’t want to go back on the pill ‘cause she’d been on the pill for quite a while and was concerned that, you know, that, I guess if you’re on it for too long there could be side effects and things like that, ah, and sort of like, she’s taken responsibility for contraception and having kids and all that, so maybe it’s my turn to do something and she had a, um, caesarean section for the first kid so she figured you know me going and getting a little bit of day surgery.

Here, Patrick tentatively located responsibility with his wife, reporting her justifications for him having a vasectomy, her concerns about the pill, having had their children and having had a caesarean. At one level this sort of account worked to present Patrick as a reasonable guy, not avoiding the issue of getting a vasectomy considering what his wife had done. It only works in this way, however, in light of the normative status of women as primarily responsible for reproduction,

with any 'effort' made by a man being praiseworthy (Dixon & Wetherell, 2004; Hochschild, 2003; Pyke & Coltrane, 1996). The way Patrick presented the story it seemed as if his wife had to pressure him with the accumulated weight of all her contributions to the family in order to convince him his involvement in contraception was necessary.

This sort of construction positioned the vasectomy as 'almost, but not quite' on the same level as the long term use of contraceptive medication, or even caesarean. It did this by using these examples of the contraceptive/reproductive burden as comparative referents with the vasectomy, and presented Patrick's 'turn' as within the same category of 'involvement' as his partner's. While there was a degree of 'doing' self-deprecation in the account (i.e. "getting a little bit of day surgery") the overall picture still made the vasectomy into a reasonably serious effort on Patrick's part as he took his "turn to do something".

The importance placed upon the vasectomy and the impact upon the man having it done, was often couched in language that could almost be described as 'heroic'. The majority of the men framed their vasectomies as an act which was outside of the norm (and certainly nothing like the mundane, repetitive 'habit' of contraceptive pill taking), and in many ways an act of masculine protection of their more 'fragile' female partners. While the language of responsible partnership could be constructed as helping to shape less traditional, more egalitarian masculinities, the inscription of heroism into the accounts disrupts this. It ratifies the suggestion (Wetherell & Edley, 2009) that masculinities do not rely on a single 'style' of masculinity, and in many cases will draw from styles which are opposing. Wetherell and Edley (1999) have claimed that "we need to consider the multiple and inconsistent discursive resources available for constructing hegemonic gender identities, and... we need to allow for the possibility that complicity and resistance can be mixed together" (pg. 352). The following section, while continuing to discuss the theme of vasectomy as reproductive responsibility, does so within the framework of vasectomy as act of heroism.

“I was prepared to get a vasectomy rather than her continuing to sort of pump herself full of chemicals”: Heroism and ‘drugged up’, ‘irresponsible’ partners

The next key theme in the men’s talk about vasectomy was related to the risks to and vulnerabilities of their partners. When talking about why they had a vasectomy, many of the men spoke about the dangers of the contraceptive pill and the risks they hoped to protect their partners from. The choice to have a vasectomy was then constructed as them creating a barrier between the risks and side effects of long term use of medication and their partner, opting to undergo ‘physical harm’ so their partners would not have to. Chad’s account was an exemplar of this sort of formulation:

GT: and so um what sort of lead you to make the decision to have a vasectomy in the first place. What did how did you get to that point?

Chad: um probably two reasons one was um (smacks lips) I didn’t want my wife to be on the pill in the longer to be honest I sort of made up my mind that I was prepared to get a vasectomy rather than her continuing to sort of pump herself full of chemicals [GT: mmn] she wasn’t having any real issues with being on the pill but I’d sort of read stuff that suggested it might be cancer causing and all that sort of carry on so [GT: yep] that was that was so I’d made up my mind that I would be prepared to.

Chad’s description of his reasons for having a vasectomy seem to be shaped by a heroic undercurrent where he portrayed himself as ‘being prepared’ to stand between his wife and the ‘evils’ of the contraceptive pill (i.e. the ‘risk’ of cancer). This account was also marked by a description of his wife as a somewhat passive ‘victim’ of the pill, and of Chad’s desire to ‘save’ her from it. The language he used carried an implication of addiction, or illicit drug-use (“pump *herself* full of chemicals”) and she was framed as being almost irresponsible (considering the risks and side effects) in not having any real objection to it (“she wasn’t having any real issues”). In Chad’s construction of her, she needed an intervention of sorts and he was going to be the one to provide it for her. He was the heroic agent in this account, taking responsibility for his wife’s wellbeing, as she

was positioned as being unable, or even unwilling to – Chad’s accounts were more complex, Chapter 7 provides a more detailed analysis of Chad’s account about vasectomy.

Chad’s account here was representative of many of the men’s accounts. These sorts of accounts worked up being ‘prepared’ or ‘willing’ to have undergone the ‘costs’ of vasectomy, which might include pain and loss of fertility. While it would be unsurprising to see the *occasional* account of men claiming some sort of heroic status to an action as straightforward as turning up for a simple operation (see, for instance, Seymour-Smith, et al., 2002), it was a consistent theme across the interviews. Men seemed inclined to ‘play up’ the importance or difficulty of the operation and the seriousness of it as a choice. Some men, particularly those who commented they had found the operation problematic (i.e. pain), would go as far as to counsel other men to take it more seriously than they seemed to. Paul, for instance, who needed to have two vasectomies due to his vas reconnecting and causing post-op infection, argued the potential for problems needed to be made clearer to men. While this is an understandable position, his account also worked to emphasise the ‘significance’ of the vasectomy:

Paul: and again I remember when they were talking about it, I put in my little two cents worth and said hey you know, it’s a simple operation, but it’s still operation, you know don’t guarantee that it’s snip snip and everything’s hunky dory, you may always have that thing that things can go wrong thing to do with them [...] I guess um but I think it I think it should be something that should be taken very seriously I think a lot of guys might be forced sometimes to do it and I think they really need to know that you can’t you can’t be pressured by your partner or whatever to have it or if you don’t want to have kids you know I remember they were a couple of cases but of young men in their twenties and I would not recommend that I really I mean yeah (.) that’s yeah it’s a drastic move and I think that that (outbreath) it should it’s not and I think it’s treated as contraception I mean the doctor told me it’s not like that [GT: mmn] maybe some men

think it's like that [GT: yeah] you know and it yeah [GT: mmn] I think but again it just depends on really how men value being fathers and children and you know society it's still a good thing a good thing to have children but yeah it's a lot of work into it and yeah.

The chances of post-op infection and other side effects are minimal in today's climate of antibiotics and a high emphasis on hygiene (Adams & Walde, 2009; Sparrow & Bond, 1999) with minor side effects occurring in between 1% and 6% of operations (Schwingl & Guess, 2000). However, such risks tended to be worked up in many of the interviews as common factors (see also Chapter 8). Many of the men spoke of 'someone they knew' or recounted stories about their *own* experience which made problems with vasectomies almost seem normative rather than issues for a particularly small minority.¹⁶ Any sense of potential troubling of the operation through concerns about mild or even more serious side effects (see Chapter 2) tends to be overzealously reported in media representations¹⁷ and thus becomes more a part of cultural consciousness than is appropriate to their effects. This construction of vasectomy as a 'serious operation' is associated with the (invisible) privileging of male bodies in wider discourse (see Chapter 3). As male bodies are often constructed as not to be 'tampered with' this provides a basis from which men can construct their vasectomies as heroic acts.

In many of cases, the choice to have a vasectomy was framed in light of a number of possible options, which were assessed on a cost/benefit basis. While the vasectomy was constructed as the 'obvious' choice of these when family 'completeness' occurred, enabling the male partner to 'step up' and take on the responsibility of having the operation, it was almost always done in a way which

¹⁶ It is also probable that men who had problems with their vasectomy would be more likely to take part in the research than those who had not.

¹⁷ This was particularly the case after the Weintrub et al (2006) study. Despite serious weaknesses in the study, its results were reported as concerning for men in major newspapers around the world and major news broadcasters such as CNN.

made it seemed *significant* for him to do so . Patrick¹⁸ spoke about the choice to have a vasectomy as natural, yet framed it as a dialogue that involved tabling all of the options.

Patrick: I knew there was other options out there available for women but it really for me it was it was a natural sort of conclusion [...] my partner and I did talk about say look you know um what do you want to do for this do you want to get a tubal ligation do you want to go on the pill and you know we sort of talked about said you know if you go on the pill there's other complications later in life and it stuffs around your period that sort of jazz and you know it has been associated with cancer and things like that um you know plus it's just the stress of her having to manage that as well as managing the kids during the day and I thought well it's just far easier and simpler procedure for me just to go in and get the snip we don't want any more kids um let her body restore itself back to whatever um and um take a break from all these chemicals and um you know just go in for twenty minutes and wham bam it's all over so yeah um it was done with consensus but really at the end of the day you know the obvious choice stuck out which was to have the vasectomy.

Patrick's use of his own reported speech presented him as the one directing comments about risk and stresses at his partner ("do you", "if you"), constructing the pill (or depo provera which had also been used by Patrick's partner in the past) as a 'major' physical stress that needed to be managed and needed 'recovery from'. The construction of this account portrayed him as embodying concern for his partner and the difficulties associated with the options available to her. She is silent (or at least has no reported speech), except as the occasional "we" or reference to "consensus". The vasectomy, while constructed as simple by Patrick through its description as the 'snip', was offered as a way of freeing his partner from reliance on stressful chemicals and their side effects, and thus as significant (and 'heroic').

¹⁸ Patrick's partner was present for much of the interview and he regularly asked for qualifying comments and she readily interrupted to 'repair' his accounts. The extract associated with this note was an account Patrick produced while she was out of the room.

Although the vasectomy is portrayed as minor in comparison to the 'chemicals' of female contraception earlier in the interview, Patrick discussed delaying the operation some time after the birth of their 'last' child ("it didn't end up being a high priority... it sort of melted into the background"), so long, in fact that his partner got pregnant again. While both Patrick and his partner commented on this being an 'acceptable' consequence (as they didn't mind having a second child), it potentially emphasised the rhetorical rather than 'material' value of concerns about 'chemicals' and 'cancer'. This appeared to be the case in almost all of the accounts that made reference to such problems associated with the pill: a simultaneous construction of it as 'risky', yet the default option they continued to use while vasectomy was (often) delayed (see Chapter 8).

In Patrick's account, as in Chad's, the issue of 'cancer' comes up as a potential consequence of long term use of oral contraceptives. This claim was common, in spite of strong research evidence that this is a particularly low level risk of oral contraceptives, and in fact they can have a protective effect (see for instance, Beral, Doll, Hermon, Peto, & Reeves, 2008; Marchbanks, et al., 2002). This sort of regularity in accounts reflected a lay discourse of oral contraceptive technologies as inevitably cancer causing over the long term. Cancer has also become synonymous with a general cultural acceptance that long term use of medication is risky. This positioning of medication is also not helped by media hyperbole concerning this issue (Barnett & Breakwell, 2003; Stacey, 1997). It was important to many of the men's accounts to portray the immediate risks of contraceptive medication to their partner's health and wellbeing and certainly the connection to cancer worked to create the issue as one needing intervention. Patrick lists several options that he felt were available to his partner, but then emphasised the risks or possible side effects associated with each. His choice to have a vasectomy was then constructed as a choice to make his partner's life easier ("it's just the stress of her having to manage that... as well as managing the kids during the day"), an opportunity

to take up one option amongst many, but one which allowed his wife to be free of 'chemicals' and 'stress', thus enabling his 'sacrifice' for her.

The use of contraceptive 'chemicals' by female partners, and the side effects associated with them was a common theme among the participants. Many of the men, however, only claimed a need to start addressing the issue of the 'dangerous chemicals' after a clear stage of life had been passed (i.e. the decision not to have any more children). Constructions of the pill within what Billig et al. (1988) refer to as an ideological dilemma were common. In other words, different constructions of the pill were deployed in ways that at times seemed to completely contradict each other, but made sense in the local context of the interview when used for different ends. For example, in contexts where the early decision making regarding contraceptive choices was being discussed, especially in justifying why condoms were not used more regularly, the important decision making and day to day, mundane responsibility of using the pill was downplayed, a necessary function of a sexually active woman's life. The alternative form was almost always deployed in the context of discussing the reasons for the vasectomy, positioning the operation as enabling the man to take over the burden of contraception and 'save' his partner from the harmful pill. It constructed oral contraceptive use as a highly dangerous, carcinogenic, risky enterprise that needed to be stopped as soon as possible. In fact, it not only needed to be stopped, but, as in Patrick's account above, a woman's body needed time to "restore itself" afterwards. It also positioned the pill as having such a negative impact on a woman's body that in order to appear 'reasonable', let alone 'heroic' a man simply *must* have a vasectomy.

The framing of the pill was largely based on the ways in which the participants were currently managing the task of discussing their own contraceptive 'passivity' or 'responsibility'. However, both were sometimes used simultaneously, as in Bob's case. Bob described his wife as having suffered significant difficulties with pregnancy and childbirth and also a more long term problem with heavy

menstrual bleeding since being on the pill. As Bob explicated his choice to have a vasectomy in the following extract, he managed to portray the pill as relatively mundane and the pill as risky simultaneously:

Bob: Nearly three years after my daughter's birth and we decided we'd didn't want any more children. My wife had taken the responsibility, if that's the word, for contraceptives for most of our married life up to that time taking the pill, and we certainly didn't want her to continue on the pill she didn't ever have an easy time with periods at any stage of (.) her life and it was certainly something that I thought I could do (laughs) as part of a partnership and I didn't have any qualms about a vasectomy anyway everything that I have read or heard about vasectomies was that it was a safe (inbreath) effective um (.) relatively painless form of contraception that would serve us for the rest of our married life[...] it was just a mutual discussion and one of those things that we decided well (.) really that (.) partly we didn't my wife to stay on the pill I'm not sure that it is good for woman to be on long time [...] and as I say the vasectomy certainly seemed to be a very good option, and something that I could do um whereas I'd never had to take the pill or remember to as it was in those days or still is probably um so you know it was something that I could contribute and I really didn't mind that at all.

Bob seemed to downplay the partner's contraceptive burden for "most of" their "married life" by undermining its connection to responsibility ("if that's the word"). While he later commented that he never had to take the pill, or even to remember it, he made an indirect comparison between his own vasectomy and the struggles with his partner's long term use of the pill and with childbirth. Bob noted that "he didn't really mind" having a vasectomy so he could 'do his part', which potentially positioned vasectomy acceptance as something he could, should or might mind. Bob's account of his researching vasectomies emphasised the safety of the operation, its effectiveness and the lack of pain associated with it, which he compared to the pain his wife had with periods and also with potential side effects of the pill. While he suggested he was able to assess the cost benefits of a

vasectomy, *and* wait for a three year period after the (difficult) birth of their last child, he described his wife as simply 'carrying on' her contribution to contraception.

Side effects and difficulties of the pill were often constructed in the interviews as something to 'put up with', with the vasectomy a considered and often *delayed* intervention. This 'carrying on' was often presented in the interviews as the inevitable consequence of there not being many options available for men to take their share of the burden. While this is potentially a material factor associated with the 'permanence' of the vasectomy, the time it took for many men to have their vasectomy after 'family completeness' (usually a *minimum* of one year – but on average 3.3 years in the qualitative data in Chapter 5) would suggest this was not the only factor involved in the delay of the operation. Contraceptive permanence would only be problematic when a couple have not yet decided to stop having children (although, see Jequier, 1998), and yet it seemed that this decision was only the first step in a long process (see also, Mumford, 1983).

Within the interviews, when the vasectomy was finally done, usually in the final ten years of the female partner's reproductive span, it was constructed as a pseudo-heroic act that accomplished an equal share of the reproductive burden. Sometimes this sort of heroism was even manifested (as in Bob's case) where the decision to have children *at all* was something that a partner needed to be 'convinced of':

Bob: and I think I'd always known that I would want to be a father but I'm not sure that it was in my wife's thoughts (laughs) and we had quite a discussion about it and I can still remember the discussion (laughs) when we were in England it was ah yeah something we both can remember and it was wide ranging and why you would and why you wouldn't and a good frank discussion ah I thought we agreed that we would yes have children (.) my wife wasn't quite so sure that we'd made the agreement.

While there was a strong rhetoric of caring for his partner throughout his interview, Bob's account still made reference to his wife "not being so sure" about an agreement to have children. Bob downplaying his wife's ambivalence to children offers a troubling counter to his repeated positioning of himself as caring, egalitarian and responsible. However, in his accounting of the way his relationship worked, it positioned Bob's partner as needing his guidance and direction in major life choices and, when he did, it was successful, the "best thing I've ever done... and my wife would say the same thing, she's a fantastic mother". When tied to the earlier extract, Bob's construction of his actions became a part of an overall positioning of 'saving' his partner from herself. He was depicted as stepping in when the impact of the pill was affecting his wife's wellbeing, and also when her indecisiveness (or even indifference) concerning the choice to have children was in question. In both cases it was constructed as benefiting her more than her own path of decision making would.

Despite the rhetoric of oral contraceptive risk, it was unusual to hear participants advocate non-coital options for sex, or even the use of condoms. While non-penetrative sex was considered a viable alternative 'once in a while' by some of the men, it was not a part of normative sexual activity (which fits with previous New Zealand research, see Gavey, et al., 1999; McPhillips, et al., 2001).

When condoms were discussed they were generally done so in a concessionary sort of manner, for example:

Mike: um [having a vasectomy] meant that she didn't have to take drugs um yeah condoms were fine but it actually just (.) I could I could see probably (laughs) there would be times when they wouldn't u- be used or something would happen and it was just at my age it was the most... it wasn't going to affect her as far as... like drugs were concerned. There was no risk it was um quick it was easy it was definite [GT: mmn] um yeah it was just a it was just that it seemed to be the easiest option.

Condoms as a mainstay of contraceptive use were given quite limited value by Mike. They were "fine" but not 'fine enough', as much as Mike and his partner could be relied upon to use them

consistently. As in many accounts of condom usage (or lack thereof), Mike framed the condom almost as a subject, where limited responsibility is taken by the sexual actors for their use, but rather use is almost determined by the condoms themselves (i.e. “they wouldn’t be used”).

Mike’s use of the term ‘drugs’ in his account, like Chad’s, bore some similarity to the language of illicit chemicals, invoking a particular construction of oral contraceptives and their dangers. While the notion of ‘drugs’ is to some degree synonymous with particular forms of medication, it can be used as a colloquial reference to pain relief or mood change, certainly not typically associated with oral contraceptives. This reference to ‘drugs’ seemed to be indicative of a negative influence on the wellbeing of his partner (“wasn’t going to affect her... like drugs”), which would imply a pejorative use of the term. In combination with the unreliability of condoms, the account works to suggest that the vasectomy is something done to overcome the inevitable risks produced by other forms of contraception, framing them as unnecessarily unsafe and producing uncertainty. By having a vasectomy, Mike was constructing his own actions as highly invested in an identity position of responsibility and care and in finding an option that benefited both he and his partner. While it is not specifically his partner who was constructed as irresponsible in this account, there is a studied deflection of any question of Mike’s own irresponsibility (i.e. his not taking ownership of the lack of condom use), a fairly common practice across the data corpus.

While the majority of the men used language that might be defined as mildly hyperbolic, some, as with Patrick’s extract above, used language which made the vasectomy a much more momentous effort. Antony, whose partner had refused him sex until he had a vasectomy, spoke about his vasectomy in terms of sacrifice. Although he didn’t explicitly identify what the sacrifice was, it can be presumed (seeing as we were discussing his vasectomy) that he was talking about his fertility, or potentially his sense of manhood. In the context of speaking of his wife’s positive attitude to his vasectomy, he equates it with her bearing their children:

Antony: and I think the vasectomy came at just that right time and obviously like I say, the fact that I have maybe taken that responsibility as well, it's probably played a big part [GT: mmn] psychologically for her [GT: yep] (laughing) um probably more so than me [GT: yep] ah and I made that point so coming back to your original question she's made the sacrifice of giving birth I've made the sacrifice of making sure that that's as far as it goes [GT: yes] so from her point of view I think that's shown that I'm committed [GT: yes] to her and the family I suppose [GT: yeah]... I haven't thought of it that way it's showing that a I'm making a commitment to you for life [GT: yes] that we are going to work [GT: yeah] and that is my family and I'm going to make sure that I've made that commitment.

The language of personal sacrifice in Antony's account was connected also to a description of a sense of commitment to his family. The vasectomy in this description acted almost as a ratification of earlier commitments made to his partner and the newer commitment to restrict themselves to the two children they had at the time. The language of sacrifice also positioned Antony as having made a life altering decision by having a vasectomy, which brings to mind potential questions of a relationship breakdown or partner death and the chances of Antony wanting to have a 'new family' if this happened.

The suggestion that the vasectomy means more than just 'no children with you' but also 'no children with anyone' (an issue which was often constructed as needing some thought), was not an uncommon formulation in the interviews. There is some research evidence to suggest that many men who remarry/repartner will have more biological children with their new partner (Manning & Smock, 1999; Manning, Stewart, & Smock, 2003) and so a need for 'future proofing' was occasionally described by the men as important to their decision making. By having a vasectomy this possibility of any future biological children, in another marriage or relationship, is eliminated. Why having more children to 'seal' any new relationship is necessary was left unsaid in the interviews and appears to

be a blind spot in research. This is likely tied to pronatalist norms and constructions of the family within society. The possible implications of a language of 'sacrifice' or a concern about a loss in fertility seemed to draw from this remarriage/repartner trajectory discourse.

Discussion/Conclusions

Important to positive material outcomes for women, is the availability of positive, egalitarian-focused discursive resources for men to draw upon (Allen, 2007; Terry & Braun, 2009; Wetherell & Edley, 1999). Positive accounts, suggesting an interest in responsibility and care, are a useful rhetorical/discursive base from which to strategically reinforce men's behaviour and actions in their long term relationships and to a lesser extent in other areas of gender relations. While New Zealand has one of the highest rates of vasectomy in the world (Sneyd, et al., 2001), there are still large numbers of men with 'complete' families who have not opted to have the operation (approximately 45% of men over the age of 50 have not chosen the operation). Although a reasonable percentage of these men may be single, already infertile (or have infertile partners), or in non-heterosexual relationships, it will not account for this entirely. There is likely a large group of men who are potentially *not* invested in masculinities of responsibility and care, or who manage these 'traits' in other ways. Attributing vasectomy to responsibility and care (and therefore implicitly, vasectomy's absence as irresponsibility and a lack of care) has the potential to enable a greater uptake of vasectomy and, through changes to the socio-technical field of contraception (as discussed in Chapter 2), increase pressure to introduce new 'male-orientated' contraceptive technologies and practices (Oudshoorn, 2003). Helping define this context as one in which it is normative for male partners, who invest themselves in identities of responsibility and care, to have a vasectomy, or to be interested in new forms of technology is an important step in improving the reproductive health of both women and men.

There is, however, some danger in wholesale acceptance of men's accounts of responsibility when they are tied to the hegemonic sense making of heroism and control. This sort of formulation, at an individual level, can diminish or neglect the importance of years of mundane commitment to the contraceptive/reproductive burden that the vast majority of heterosexual women have had to deal with. At a more systemic level, the importance of women's movements that have pushed the contraceptive agenda forward and allowed greater sexual freedom for women (Oudshoorn, 2003) also has the potential to be swallowed by this construction of the neoliberal responsible, caring male partner. The implication of a context free 'choice' to be responsible and caring at best downplays the efforts of these groups as having little bearing on changes that seem have occurred in 'orthodox' masculinities. At worst, much like the subject position of the 'new father', a rhetoric of involvement, care and equal share disguises the ongoing material gap in actual work that exists between many couples (see for instance, Johansson & Klinth, 2008; Ranson, 2001; Wall & Arnold, 2007). As will be discussed throughout this thesis, the notion of an 'economy of gratitude' (Hochschild, 2003) may well exist in this case: any involvement by men at all in the reproductive arena is considered a major step and is thus encouraged more than is due.

The analysis in this chapter, however, suggests that in some relationships there is still a vast gap in the power share of men and women, in terms of the ways in which men can easily co-opt aspects of domestic power without having to fulfil the obligation and mundane-ness of 'normal' domestic life (see for instance Bob's stories). While participants suggested that 'equal share' of responsibility is a natural life-course process, research tends to show that there is an ongoing 'reproductive burden' for women, in that they still maintain the larger proportion of the (largely silent and unnoticed) domestic share, through child care etc (Dixon & Wetherell, 2004). A further question also arises with regard to whether female partners ever really stop being responsible for contraception, for although it is men's bodies that are 'reproductively managed', it is perhaps still the domain of women to facilitate the occurrence of vasectomy and its ongoing associations (i.e. sperm tests etc.). Some of

the men, for instance, spoke of having their morning schedules and responsibilities lightened by their partners in order to provide a semen sample for testing, hardly a trying 'procedure', but facilitated nonetheless. Others described their partners making the booking for the operation itself, or otherwise organising the time and space for it to occur.

Perhaps more useful in interpreting this position of the responsible, caring partner from a theoretical/academic point of view is its place within wider changes to 'orthodox' masculinities in the West. Following Correa's (2000) point in relation to a shift in language from the Cairo goals of male 'involvement' or 'responsibility' to that of male 'transformation' would offer more long term value. Transformation is a term which implies ongoing change rather than one of replacement or a wholesale shift in the reproductive burden from one partner to another. The language of participants in this study reflected notions of a degree of completeness in 'taking responsibility' or at the least a notion of having taken on some sort of *equal* share in reproductive/contraceptive burden. While there have been quite clear changes to the contraceptive 'make up' in New Zealand (Sneyd, et al., 2001), there is still a long process of change needed before equity will occur. The problem with the notion of 'taking responsibility' is that it does not allow a sense of beginning a process, or working toward true equity in the home and the wider public sphere. Like the position of the 'new father', it assumes that the work of 'male involvement' in reproductive decision making ends when men assume certain tasks or roles otherwise avoided, just when greater efforts could be made to close continuing gaps. This privileging of any male involvement over and above the (typically) much longer, quieter and more mundane 'involvement' of women is an example of the ongoing imbalances of gender being perpetuated, while there are continued claims to be breaking them down.

The participants in this study *do* seem to be less invested in the suggestion that their involvement in the reproductive/contraceptive arena somehow impinges upon their masculinities (although see

Chapter 8 for some discussion concerning this concept). However, the notion of the heroic to some degree 'reinscribes' an element of masculine endeavour onto the process of this involvement. This may well be a normative outcome of this 'transformative shift' in relational masculinities, but perhaps a sign of more complete transformation would be a greater degree of the 'mundane' in men's accounts of their vasectomies. Only one or two of the men in this study were able to present this sort of understanding of their vasectomy, which potentially suggests they were drawing on non-hegemonic resources to make sense of the operation in their lives.

Summary

This chapter has relied on thematic analysis (with some insights from critical discursive psychology) to analyse interviews from participants who had 'typical' vasectomies. Primary themes of 'taking responsibility' and 'vasectomy as an act of minor heroism' were extracted from the data. I have further demonstrated the ways in which men referred to their new found responsibility and the heroic slant they added to it in ways that are reflective of an 'economy of gratitude' (Hochschild, 2003). This is the suggestion that men's involvement in the reproductive/contraceptive sphere is worthy of more praise (and value) than women's. While there may be some strategic value in the generation of these ideas, they draw upon existing discourses of orthodox masculinities and in this way may perpetuate (rather than challenge) the notion that men are doing something 'special' by having a vasectomy.

Chapter 7: Talking about responsibility

“Every encounter... is fraught with risk. The selves we try to create, the selves to which are attached some of our strongest feelings, can be sabotaged by our own gaffes or by the antagonistic acts of others. All selves are provisional; none is safe from the threat of discrepant information or disbelieving audiences” (Schwalbe & Wolkomir, 2003, p. 57)

In many of the interviews, men worked to position themselves simultaneously as a responsible and caring individual, yet ‘deeply masculine’ (in many cases manifested as investment in an heroic imaginary position), which at times created quite contradictory accounts. This chapter is focused around a pair of extracts from an interview with one participant ‘Chad’, to offer an insight into what happens when such a dilemma occurs in talk. It demonstrates how particular imaginary positions might be deployed in identity work with differing degrees of investment according to the context of the conversation. This chapter offers a much more fine-grained analysis of men making sense of the cultural resources that Chapter 6 shows are readily available to them and frequently ‘taken up’.

It is likely that in relation to my project, the first turn of the interview really began – to some extent – in the discourse produced by a *New Zealand Herald* article from which many of the men (including Chad) were recruited. The author commented: “it had also been suggested New Zealand men, after having children, were keen to take a turn at responsibility for contraception, and also to care for their partner” (Marshall, 2007). Many participants may have started the process of positioning themselves in relation to the interview along these lines or were drawn to take part because that account resonated with certain ideas or a position they identified with. The other likelihood is the growing influence of neoliberal discourse of personal responsibility on individuals (particularly among educated, Pākehā) (Hodgetts, et al., 2004), combined with the integration of (some) feminist

ideals of equal partnership in heterosexual relationships, especially with regard to having some responsibility for child rearing.

The first extract and the analysis following it will focus upon the way Chad uses sequencing and pronouns to generate a particular (positive) portrayal of himself; while the second section's analysis will be used to highlight the way memory and 'humour'/laughter are used to continue this occasioned positive self-production.

Chad: Today's Responsible and Caring Superhero?

Chad's interview was primarily about him making sense of his experience and reasons for vasectomy; it was also about Chad accounting for how the decision was made in the context of his relationship with his partner. Within the one to one interview context, and therefore removed from the potential 'repair' or challenge of his partners' version of the stories (c.f., Seymour-Smith & Wetherell, 2006), Chad's account could be, and was, orientated towards a positive self-presentation. His narrative was based upon a description of events in which it may be relatively easy to blame him for a pregnancy. At first non-discursive glance these could be taken as an example of autobiographical 'recall'. However, this account is here interpreted as an occasioned production, which from the outset was orientated toward managing the potential for blame for the decisions and actions that led to the fourth (apparently initially unwanted) pregnancy.

At the beginning of the interview (as shown below in Extract 1), Chad identified the key reasons for choosing to have a vasectomy, and what he referred to as the "drivers" that moved him from decision to action. The interview context was defined by answers to questions about the choice to have a vasectomy, and as such, was demarcated by a claim to memory. As Edwards and Potter (1992) have noted on the subject of memory, however: "everyday conversational remembering often has this as its primary concern – the attempt to construct an acceptable, agreed or

communicatively successful version of what happened” (p. 75). In this case the focus of this analysis is not so much upon the ‘truth’ of the account, as “there can be no neutral, interpretation free record against which to check claims” (Edwards & Potter, 1995, p. 32) but rather the way in which the participant orientates the account.

Chad articulated at the outset his stake in being a responsible, caring partner, interested in his wife’s welfare. This was despite his delaying of the procedure and insisting on condom free sex, even after his wife had stopped other forms of contraception. This series of factors resulted in an (initially by her) unwanted pregnancy. In this particular case the account seemed to be attending to the question of his selfishness and working to restrict any criticism of his actions (or perhaps, more accurately, his lack of action):

Extract 1 (V5, 24 May 2007, Tp.1-2)

- 1 GT: and so um (.) what sort of led you to make the decision to have a vasectomy in the
2 first place (.) where did, how did you get to that point?
- 3 Chad: ↑um probably two reasons, one was um (smacks lips) (.) hhh I didn’t want my wife to
4 be on the pill any longer to be honest (.) I sort of made up my mind that I was
5 prepared to get a vasectomy rather than her continuing to sort of pump herself full of
6 chemicals
- 7 GT: mmn
- 8 Chad: she wasn’t having any real issues with being on the pill but I’d sort of read stuff that
9 suggested it might be cancer causing and all that sort of carry on so
- 10 GT: yep
- 11 Chad: that was that was so I’d made up my mind that I would be prepared to (laughing) the
12 the challenge was actually (.) um when to do it and ah I well the other driver was my
13 wife was quite keen if I was going to go ahead and do that would I get on and do it
14 because we’d had our third child and
- 15 GT: mmn
- 16 Chad: she was pretty keen to hhh to leave it at that
- 17 GT: mmnhmn
- 18 Chad: um and then I guess the ultimate reason I actually finally bloody plucked up the
19 courage to do it was because um because we had a fourth child which was unplanned
- 20 GT: right (laughs) OK oops (laughs)
- 21 Chad: so so pretty much it was um no more sex unless you bloody well get this sorted out so
22 I went ahead and had it done
- 23 GT: yeah so was she she was a:ah not on the pill when (.) when you guys a:ah when the
24 fourth child was conceived
- 25 Chad: no no
- 26 GT: OK
- 27 Chad: we we um (0.8) we took a bit of a risk

28 GT: mmn
 29 Chad: yeah we were we were basically um u:uh (0.3) yeah generally we would be using a
 30 condom, but occasionally we'd just, because I just hate the bloody things
 31 GT: mmn mmn
 32 Chad: so occasionally we'd just take the risk when you know when it was when the timing
 33 was right in terms of her cycle
 34 GT: yep
 35 Chad: um but we just yeah
 36 GT: mmn
 37 Chad: missed that one
 38 GT: yep (laughs)
 39 Chad: so u:uh yeah not it's actually been a it I personally think it's the best thing that
 40 could've happened 'cause our fourth child's just fantastic so
 41 GT: yeah yep
 42 Chad: yeah but yeah but up until been you know (1.0) a:ah you know just generally speaking
 43 we used a condom
 44 GT: yeah
 45 Chad: worked the cycle and um (0.5) yeah and when we found out she was pregnant u:um
 46 (0.3) uh basically it was a you know I I mean right through the pregnancy I'd put it off
 47 and put it off and put it off obviously there was no real issues
 48 GT: mmn
 49 Chad: at that point but pretty shortly after she was born I had it done

Shifting pronouns and condom hatred: responsibility and risk

One of the most interesting features of Chad's talk in this extract is the shifting use of personal pronouns. The pronoun "I" is largely used to indicate agency within talk, or as Harré (1995) has suggested:

One of the main ways in which we take and assign responsibility is by the use of pronouns and other personal inflexions of verbs, particularly in the first and second person. The taking and assigning of responsibility is achieved by exploiting the indexical properties of these pronouns (p. 124).

The use of "I" is also associated with investment in particular imaginary positions. When the first person pronoun is used in conjunction with descriptions of the self it makes that particular account of the self seem authentic and complete, although it may be discarded for the next interaction the individual has, or in some cases within the same interaction (Wetherell & Edley, 1999).

Whenever Chad spoke about his concern for his partner and the choices involved in having a vasectomy, he used “I” to position himself in relation to these choices (e.g., L3-4: “I didn’t want my wife to be on the pill”). Right from his first turn in the conversation, Chad worked to present the decision about the vasectomy as primarily his, and his use of the “I” when talking about responsibility and his wife coming off the pill locates the decision for the operation with him. There was the clear implication in this sort of framing that Chad was actively involved in contraceptive practices and the ‘driving force’ in the decision making processes regarding vasectomy. Chad’s use of the first person in this manner can be interpreted as working to bolster his rhetorical investment in the imaginary position of responsible, caring man. This imaginary position drew on multiple interpretative resources to present a man who is lovingly interested in the welfare of his partner and is willing to make the ‘ultimate sacrifice’ of having a vasectomy to prove that interest.

However, an heroic imaginary position (Wetherell & Edley, 1999) was simultaneously funding his account (L4-5: “I was *prepared* to get a vasectomy rather than her continuing to sort of pump herself full of chemicals” and L16: “I actually finally bloody plucked up the courage to do it”), inflecting the position of responsibility and care. This worked to construct his ‘caring’ as not simple or ordinary, but as ‘caring’ which needed preparation and the working up of significant levels of courage. This ‘heroism’ was indexed with the first person pronoun and can be contrasted with his use of the third person “she”, which seemed to be associated with passivity in relation to changing contraceptive practices (L7: “*she* wasn’t having any real issues with being on the pill”). Another striking contrast was between Chad’s use of “I” and “we”. Whenever Chad more generally described his own contraceptive/reproductive ‘involvement’ (particularly when discussing risky sexual practices), the footing shifted through pronoun management to “we” (e.g. L25: “we took a bit of a risk”) and then to the third person “she” (L43: “she was pregnant”) when pregnancy results from unprotected sexual intercourse. The shift from ‘I’ to ‘we’ in this context, while perhaps undermining the extent of

the 'caring' account, effectively worked to reduce sole blame for contraceptive 'failures' directed at him, invoking them as couple or 'female' problems.

This use of different pronouns, as it attended to and deflected any potential accusations of selfishness or irresponsibility for the (unwanted) pregnancy, emphasised that any 'risky' unprotected sexual activity that took place was a consequence of *equally* blameworthy behaviour by both partners. Chad's efforts and 'good intentions' in planning to get a vasectomy and 'get his wife off the pill' were prefaced by an 'I', providing him with the full credit for these positive contraceptive 'choices'. This shifting was clearly demonstrated in lines 27-28 where Chad commented that "generally we would be using a condom", noted briefly that "I hate the bloody things" which then resulted in "so occasionally we'd just take the risk". Flood (2003) has noted that men in his research treated condoms as a necessary evil, and if they could be avoided they should be, especially within the context of long term relationships where a discourse of 'trust' exists. This is not solely a gendered account (see for instance Willig (1995)), however it is more often invoked by men.

This sort of accounting relied on dominant phallogentric takes on heterosexuality and prevailing discourse of the 'unnaturalness' of condoms and the 'naturalness' of unprotected sex (Flood, 2003; Gavey & McPhillips, 1999; Gavey, McPhillips, & Doherty, 2001; Willig, 1994). It also derived much power from the *coital imperative* (Jackson, 1984; McPhillips, et al., 2001), which leaves little room for alternative, less risky, and potentially just as (and for many men and women more) pleasurable non-penetrative sexual activities. Chad seemed to be appealing to this common knowledge/experience regarding condoms. His statement "I hate the bloody things" (L29) was enough, he did not articulate *what* about them he hates, simply that he did. This lack of explanation/rationale suggested he was articulating a common sense and/or widely held view, as it was treated as not in need of explanation and unlikely to be disputed. It also potentially invoked experiential 'authority' (i.e. I hate condoms and you cannot tell me differently). But despite condoms

clearly being framed as something *he* objected to, and other forms of birth control, such as non-penetrative sex, as ‘unthinkable’ (expressed later in the interview: Tp. 21, L903: “no, I mean, um, no, never, I don’t think actually”), risk was always articulated in terms of the couple (“we”) in this extract, and across the interview. The pronoun shifting in Chad’s account suggested that, for the purposes of this interview at least, Chad was managing several possible interpretations of this story, and working toward a version of the story that reduced blame directed at him.

“I’d sort of read stuff that suggested it might be cancer causing and all that sort of carry on”:

Masculinity, Concern and Honest Heroism

As well as the pronoun shifting, the narrative followed a clear sequential path, which worked to further delineate the different areas of responsibility and the weight which can be placed upon them, privileging those that portray him positively and downplaying those that do not. Chad used a three part list formulation to develop this sequence: first, he decided to get a vasectomy in light of new knowledge about side effects of the pill; second, he described his wife as “keen” as she did not want a third child; and lastly (or the “ultimate reason” (L16)) his wife *did* get pregnant for the fourth time. Three part lists are rhetorically robust and give a sense of completeness to whatever is being described (Edwards & Potter, 1992). Discursively there is little need to offer more than three parts to a list to enable it to sound like the ‘full story’ – they are hearably ‘complete’.

Chad explained that it was he who initiated the decision for his wife to come off the pill, an event which was supposed to be followed by a vasectomy he was ‘prepared’ to have. While the decision making and intention of vasectomy was firmly embedded in the realm of ‘idea’ rather than action, Chad’s placement of this as “firstly” and its association with “I” weighted the positive aspects of the process of decision-making upon his part in it. It appeared that he was working to ensure his role as the positive change-maker was made clear and that the following problems were a consequence of external factors rather than his own procrastination. The claim that “she” had “no real issues” (L7)

regarding the use of the pill, further constructed Chad as the active participant in making decisions about reproduction. It was he who has read about the “cancer causing” (L8) effects of the contraceptive pill, and this worked to suggest that he was being heroic in ‘allowing’ her to go off the pill in spite of her lack of concern and the potential for an unwanted pregnancy. He used a softened extreme case formulation (ECF) (Edwards, 2000; Pomerantz, 1986) (e.g. L7-8: “I’d sort of read stuff that suggested it might be cancer causing and all that sort of carry on”), implying that that the pill creates risk of cancer for *all* women who use it. He thus created a mandate to stand between her and harm, as the only ethical course of action. ECFs according to Edwards (1997), often occur to help bolster a particular claim in the face of criticism or challenge by *maximising* in rhetoric its chances of occurring. In this case, his language depicts the likelihood of cancer as *certain* rather than subject to statistical chance.¹⁹

Softening an extreme case formulation (in this case through the use of the hedges “sort of” and “might”) works rhetorically to distance a speaker from the information they are presenting, balancing the rhetorical power needed from an ECF without being accountable for the extremity of the statement (Edwards, 2000). While highlighting the need for particular concern (as discussed later in this section), the softening of the extreme case formulation allowed for the appearance of a much more factualised account: this was not simply hysterical, nameless anxiety but the presentation of (someone else’s) relatively scientific data which makes any concern expressed seem rational and justified. He was, according to Potter (1996b), *glossing* on his account, by drawing upon representations of science as true and reliable. The very implication of ‘using’ scientific data adds veracity to his explanation. To add to this, the generalised list completer “all that sort of carry on” (L8) continues to work up the implications of risk by adding an unknowable number of health

¹⁹ Even if Chad had presented figures to ‘back’ his claim, his representation of them would still likely have benefited his overall argument. Potter (1996b) has noted that when hearing or viewing statistics the temptation is to “see them as merely descriptive rather than rhetorically constructive” (p. 190), but that different positioning of the same data set can produce entirely different arguments.

problems to use of the pill. While “all this carry on” is hardly scientific discourse, it fulfils rhetorically the need to take a three part list to completion (Jefferson, 1990; Potter, 1996b).

Chad appeared to be dealing with an ideological dilemma (Billig, et al., 1988) based around two imaginary positions of masculinity he was attempting to balance: the responsible and caring partner, and the heroically masculine, self-determining individual. It seemed there was a strong investment in both positions which was to some degree managed through heroic rhetoric (i.e. by constructing his acts of responsibility and care as acts of heroism), but also through the heavy use of hedging and softening and expressions of concern.

Chad at times used what Potter and Hepburn (2007) have referred to as a c-construct. A c-construct is “an expression of concern” (p. 169), that is premised upon the construction of the situation being talked about as damaging or upsetting, needing some sort of intervention, and not something Chad took pleasure from. In this case it rhetorically reduced the need to provide any further evidence for the risks associated with oral contraceptives (e.g., L7-8: “I’d sort of read stuff that it might be cancer causing”). Chad’s expression of concern manifested in an apparent interest in caring for and protecting his wife from harm, all that was necessary to deploy it was the notion that Chad is concerned about health risks. This formulation acted as a *prefacing move* (Potter & Hepburn, 2007), emphasising a ‘heartfelt’ concern that is difficult to interrogate, and set the boundaries of the rest of the explanation (i.e. that his concern/care is paramount).

By emphasising one of the more serious (potentially imaginary) risks at this point in the interview, rather than weight gain, or “skin issues”, for instance, the c-construct worked to make Chad’s part in the decision making process involved in getting his wife to stop the pill more key than any concerns she may have had. It also worked to position him as authoritative about the risks of using oral contraceptives and her as almost negligent or uninformed. As the following parts of the three part

list are given, both Chad and myself (unwittingly through not questioning the c-construct) collude in allowing some aspects of the story to be understood in light of his concern and desire to be responsible.

Many of the potential criticisms for the delays in getting a vasectomy were to some degree 'managed' by the introduction of this c-construct. Chad, however, continued to invest in appearing responsible and caring, yet also heroic, while simultaneously downplayed the latter using other linguistic devices. The use of the hedge "sort of" (L4) would suggest that the 'making up of his mind' was not a straightforward decision. The pauses, rising intonation at the start of L3, and lip smacking served to reinforce this hedge, as Chad 'searched' for a particular framing of the story he was telling. This made sense given the problematic/delicate nature of what followed.

Chad's "I didn't want my wife to be on the pill any longer to be honest", was an example of Chad 'doing modesty', that is, demonstrating an unwillingness to draw attention to himself or his 'heroism'. Chad's use of the phrase "to be honest"(L4) is what Edwards and Fasulo (2006) refer to as an honesty phrase (HP). Edwards and Fasulo (2006) argue that this prefacing move indicates that whatever the phrase is referring to (known as 'the complementary') is a 'dispreferred response', an answer to a query that may trouble the conversation or account (Pomerantz, 1986). The HP signalled that taking full credit for his partner coming off oral contraceptives was a dispreferred statement. It is framed as though it was only in the context of answering an interview question that he would be willing to talk about himself in this way. When linked with the earlier hedging, this HP gave the impression that Chad would prefer not to be telling me how 'responsible' and 'caring' a man he is (and certainly not in such a heroic self-production), but the interview context required his honesty. It could also possibly reflect Chad attending to the statement being *too* masculine, after all why should he be the one who decides what is right and wrong for his partner?

The HP also worked to suggest he was giving the interviewer unrestricted access to his actual thoughts, which operated in a way that he could 'explain' some parts of the story that did not reflect as well on him. This sort of 'internalistic' framing attended to the possible interpretation of his selfishness in delaying the vasectomy. It suggested that despite the lack of action on his part, his *internal* interests were motivated by responsibility and care for his partner (she is virtually *excluded* from 'concern'). In contrast (as discussed earlier), Chad's 'negative' actions were modified by Chad to *include* his partner (through use of "we"), and thus made blame for the pregnancy something which was shared with his partner equally (e.g., L31-36 "we'd just take the risk when you know when it was when the timing was right in terms of her cycle [GT: yep] um but *we* just yeah [GT: mmn] missed that one"). He thereby raised his own profile by emphasising his heroic *intentions*, all the while framing his wife's concerns as somewhat 'petty' in comparison.

This was explicitly highlighted later in the extract when he contrasted his own position with the assessment of his wife's lack of interest in a fourth child: "I personally think it's the best thing that could've happened 'cause our fourth child's just fantastic" (L37-38). The use of the phrase "I personally" (L37) also worked as an HP (much like "to be honest"), giving value to the complementary as reflective of Chad's deepest inner thoughts. Again, this may work as a prefacing strategy to challenge an argument that may exist (i.e. that he was irresponsible), but it relied heavily on the suggestion of the complementary that the joy of the fourth child outweighed the pain and stress of an unwanted (by his wife) fourth pregnancy. The "just fantastic" nature of the fourth child worked as an extreme case formulation to suggest that not only is he *not* irresponsible, but in fact, his delayed vasectomy and failure to use a condom was the best thing he could have done in light of the outcome. The only thing missing from this account is a reference to fate, something that was clearly "meant to be".

Managing questions of his selfishness through a presentation as responsible and caring, yet masculine and self-determining was an ongoing thread in Chad's interview. At times one position would appear to be dominant, at other times the other. Throughout, Chad was managing a dilemma of stake or interest in the narrative he was presenting. As Edwards and Potter (1992) have commented:

Anyone who produces a version of something that happened in the past, or who develops a stretch of talk that places blame on someone or some category of persons, does so at the risk of having their claims discounted as the consequences of stake or interest... participants should be thought of as caught in a dilemma of stake or interest: how to produce accounts which attend to interests without being undermined as interested... people can perform attributional actions such as blamings indirectly or implicitly through providing an ostensibly factual report which allows others to follow through the upshot or implications of the report (p. 158).

To try and deflect blame completely from himself would potentially risk a complete rejection of Chad's account by the interviewer. Chad had a stake in this particular presentation of himself as responsible and caring, even heroic, and yet in order to tell his particular story he had to rely on resources which may not have painted him in a positive light. There was a constant balancing act in shifting blame from himself without taking it too far, making statements which called into question the validity of some of his wife's concerns, without invalidating them completely. The twin dilemmas of stake and positioning continued to frame the whole interview context, causing a series of inconsistencies that needed 'tidying' near the end of the narrative. In Extract 1, Chad was dealing simultaneously with acknowledging a period of delay in getting a vasectomy and yet working to portray himself as both responsible and heroic. He did this through recourse to blame distribution (through pronoun shifting), risk discourse, a c-construct, honesty phrases and 'doing modesty'. In the next section I will analyse an extract in which, having attended to questions of selfishness, Chad turned his attention to managing earlier inconsistencies in his narrative. The balancing act (as

described in this section) had created some potential “troubles talk” (Edwards, 1997), which needed revision.

“I think I can even remember words along the lines of you know look I don’t want to get pregnant”:

Memory work, reported speech and light-heartedness

The account presented in Extract 3 was a highly developed example of revision: Chad retold almost the whole narrative of the previous extract, and as such it needs to be read in view of that previous context. In the retelling that occurred, Chad highlighted along the way elements which had either produced inconsistency or which could be interpreted as reflecting badly upon him. As already discussed, variability between these two accounts should not necessarily be associated with truth or untruth (Edwards & Potter, 1992). Accounts of autobiographical narrative are always incomplete in their formulation, as they are always built within interactional situations, in an attempt to achieve a certain end (Wortham, 2000). Differences in accounts, formulated by the same person, about the same situation can give us some insight into the participant’s self-positioning. In other words, what was Chad trying to achieve in the previous extract and despite both extracts being a part of a wider narrative? What was he trying to accomplish in this different conversational occurrence?

In the previous extract, at stake was the question of his selfishness, which, in order to present himself as a responsible caring man, had been attended to by subtly shifting blame from himself and making accountability for the fourth pregnancy shared between his partner and himself. At a much later stage in the interview, Chad was working to accomplish a different task or set of tasks than he had been in the first part of the interview. One difficulty for him was that there had been a context of him discussing his wife’s *refusal* to have sex with him to pressure him into getting a vasectomy (Extract 1), and yet later, when commenting upon their sex life, he had argued that not having sex was ‘impossible’ for him:

Extract 2 (V5, 24 May 2007, Tp. 28)

- 1 GT: sometimes sex is about, having kids
2 Chad: (overlaps) having kids, yep
3 GT: and sometimes sex is about pleasure
4 Chad: yep
5 GT: and all that sort of stuff, did um
6 Chad: did that change? [...] I mean we talked about it, well, before we got married and I, I said
7 to my wife, I need to be very clear, that, that I, I don't want to have a great sex life, get
8 married, sex drops off, have kids, no more sex sort of thing [...] I'm not interested in
9 that, I'm, you know, I, I need and enjoy sex and I need to know that you do as well...
10 and, you know, she said, no, no problems there at all, so [...] and it never has been

Extract 2 connects Extract 1 and Extract 3 by highlighting Chad's rhetoric concerning 'how his sexual relationship was', but will be analysed in conjunction with Extract 3, as it is only of analytic interest in relation to Extract 3. Extract 3 occurred much later in the interview, nearer to the end, and came about in response to a question about Chad and his partner's use of the so-called 'rhythm method' of contraception (or conception in their case!) and how that related to the final action of having a vasectomy. The vast majority of Extract 3 is based on a revision of many earlier statements that had been made, primarily about his wife's fourth pregnancy and how that came about. As such, it is a much more 'cognitively located' account than Extract 1, making multiple claims to memory and forgetting to continue managing a certain self-presentation.

Extract 3 (V5, 24 May 2007, Tp 31-33)

- 1 GT: you said that, sort of, in between the third and fourth kid you were using the rhythm
2 method
3 Chad: mmn
4 GT: type of thing, so using the cycle and all
5 Chad: mmn
6 GT: that sort of thing, um, how did that decision get made
7 Chad: um, we, we talked about it actually
8 GT: yeah
9 Chad: u:um (5.0) aw actually no when I think about it let me think about it (3.0) a:ah (.) I
10 actually think what happened (2.0) was that Karen said to me "come on you said
11 you're going to get a vasectomy"
12 GT: mmn
13 Chad: ah I want you know and I you know and "you've told me that one of the reasons is
14 because you know you want me off the pill I I'm quite keen to get off the pill"
15 GT: mmn
16 Chad: you know "it makes me skin go funny" and all this sort of stuff
17 GT: mmn
18 Chad: that's right (.) so she said "I'm going off the pill and if you don't have it then you're just
19 going to have to work my cycle" s- so

20 GT: right
 21 Chad: that's it
 22 GT: right |yeah|
 23 Chad: |so that's| pretty much why we did it |yeah|
 24 GT: |yeah OK| yep and so so that was it was
 25 like a pragmatic sort of (.) um this is the option?
 26 Chad: yeah
 27 GT: you don't like using condoms
 28 Chad: yeah she said "you can carry on using condoms" >she doesn't like them either<
 29 GT: yep
 30 Chad: um so "if you don't want to use a condom it'll have you know basically it'll have to be"
 31 GT: mmn
 32 Chad: "on my cycle"
 33 GT: mmn
 34 Chad: so (inbreath) so she kind of forced the issue really
 35 GT: yep
 36 Chad: but didn't sort of withdraw sex
 37 GT: yes
 38 Chad: um:m which I guess she could've but she just um (0.5) yeah (.) forced the issue
 39 GT: mmn
 40 Chad: u:um knowing that I said I would do it
 41 GT: mmn
 42 Chad: so she was saying "come on" (1.0) and um and you know I think I can even re-
 43 remember words along the lines of you know "look I don't want to get pregnant"
 44 GT: mmn mmn
 45 Chad: u:um so yeah consequently (.) she did (laughs)
 46 GT: mmn yes yeah
 47 Chad: yeah
 48 GT: which is potentially is (laughing) why there were a few tears at the start and stuff
 49 Chad: oh yeah
 50 GT: (laughs)
 51 Chad: yeah yeah yeah it was a funny story actually 'cause <I I'd um it was a quickie before I
 52 went to Australia and then I was in in Australia for two weeks and when I came back
 53 she found out she was pregnant>
 54 GT: ah right
 55 Chad: (inbreath) and so she'd been living with this probably for about a week (.) while I was
 56 away but hadn't said anything and then it all sort of came out when I got back (.) yeah
 57 (inbreath) so um
 58 GT: (laughs)
 59 Chad: and I I don't know why I was chuffed but I was chuffed
 60 GT: (laughs)
 61 Chad: I just remember thinking that I was chuffed
 62 GT: (laughs)
 63 Chad: Karen puts it down to you know just proving that you can still father another child
 64 GT: ri::ght
 65 Chad: or something I don't know |but yeah|
 66 GT: |yeah yeah|

Chad began this extract with a repeated series of metacognitive formulations (Middleton & Edwards, 1990) – reference to an inner cognitive state against which he was checking his account (L9 and 10: “actually no when I think about it, let me think about it (3.0) a:ah (.) I actually think what happened”). These sorts of formulations occurred frequently toward the end of the interview (see L18, 21, 42-43) and operated in the context of a repertoire of ‘recall’. This sort of account worked to produce the impression that ‘forgetting’ or ‘misremembering’ had occurred prior to this moment and the articulations at the time were a more accurate recollection of events as they had ‘really’ happened. These sorts of more ‘correct’ retellings operated directly in opposition to the honesty phrases of the previous extract by discounting his earlier statements, but were necessary in drawing together a more consistent narrative.

Each of the occasions where Chad answered a new question, a new context was entered into, with a new set of expectations, strategies and resources. In the longer context of the interview, it was necessary to maintain a connection between each of these disparate ‘context-threads’ and the metacognitive formulations of ‘forgetting’ and ‘misremembering’ worked to realign any inconsistencies. This ‘re-remembering’ framed the previous version (Extract 1) as if it had been the *gist* of the story, whereas the new account is given the impression of much closer to *verbatim recall* (Edwards & Potter, 1995).

In Extract 1, when Chad used his wife’s reported speech it was in situations which could seem to be undermining his own agency through threats or pressure (an example of this can be seen in Extract 1, L19: “so pretty much it was um ‘no more sex unless you bloody well get this sorted out’”).

Reported speech is normally used in a similar fashion to scientific discourse, to lend veracity to an account, but it does so by evoking the context of the original discussion (Holt, 1996). In direct reported speech the person speaks using the method of active voicing to quote a person directly (e.g. “Karen said to me ‘come on, you said you’re going to get a vasectomy’”). This gives a factual

reading (or hearing) to the account and also worked to give a sense of objectivity to the current story, accentuating its status as verbatim recall (Abell & Stokoe, 1999). In indirect reported speech they speak for the person, but without this claim to verbatim accuracy.

Chad's 'new' context demanded that he repair inconsistency with previous talk, by hinting he had not recalled the situation correctly. He did this repair by 'overwhelming' the narrative with examples of direct reported speech (hereafter DRS (Holt, 1996))(e.g., L13-14, 16, 18-19, 28-30) to contrast with the hedged indirect report from Extract 1. Li (1986) has argued that "a direct quote communicates a more authentic piece of information than an indirect quote in the sense that a direct quote implies a greater fidelity to the source of information than an indirect quote" (p. 41) and Chad seemed to rely on this in order to retell the story. He used DRS indicators (Holt, 1996) such as a pronoun or name followed by "said" (e.g., L10-11: "*Karen said to me* come on you said you're going to get a vasectomy", L28: "*she said* you can carry on using condoms"). Holt (1996) has claimed that there is a limited chance that DRS provides an accurate portrayal of the interaction being reported on, however, it is important in rhetoric as an economical way of giving evidence to support an argument in a new interaction. The story is told from a 'god's-eye' view or narrator status: Chad told the story as though he has clear insight into his partner's motivations and interests.

Extract 3 was also characterised by the use of a number of adverbial truth clauses ("actually", "really"), which, much like the honesty phrases in Extract 1, worked to give status or value to a truth statement to the prior clause (Edwards & Fasulo, 2006). When used in combination with metacognitive formulations, or in the context of such formulations (e.g. "I actually think what happened" (L9-10), "so she kind of forced the issue really" (L25)), they add to the worked up version of 'new truth' being more accurate than the original telling. The strong emphasis on "really" (L25) added to producing a sense of accurate truth telling or verbatim recall.

Difference between the original 'gist' version (Extract 1) and the later verbatim orientation (Extract 3) was evident in several other ways. For instance, there was a key difference in the way Chad's wife was present in this second extract. Instead of the descriptor "my wife" in Extract 1, her name was offered as "Karen" in Extract 2 and she was always referred to using DRS, as if Chad was operating with perfect recall of the situation (see L1-9). She is given much more agency in this telling (e.g. line 25: "so she kind of forced the issue really", L27-29: "but didn't sort of withdraw sex... um:m which I guess she could've but she just um (0.5) yeah (.) forced the issue").

Using the techniques just described, Chad managed any blame or accusations, by reporting the 'past' as if he was making factual statements rather than stating opinion. It also presented Chad as slightly more rational, slightly more responsible than he would have 'appeared' by 'hiding' this second version of the story. His diplomacy and reasonableness were made evident by the account in Extract 3 and the way in which it was structured, in that he does not apply negative attributions to his partner. The co-opting of his partner's words and 'experience' in the telling worked to validate the story as factual and made it rhetorically robust in the face of challenge. If he only told 'his' side of the story and did not voice 'hers', accusations of bias would have been unavoidable – by including her in the narrative, he gave it dialogical status (e.g., Seymour-Smith & Wetherell, 2006), a co-construction, even though she has not contributed except through him.

As discussed above, the performances of remembering and using metacognitive formulations helped create a buffer between the earlier accounts and this one. In this extract, Chad troubled the earlier statement that his wife had threatened to withdraw sex from him unless he got a vasectomy (L25-29: "she kind of forced the issue really but didn't sort of withdraw sex [GT: yes] um:m which I guess she could've"). This statement operated to produce the inference that comments about sex withdrawal were hyperbole, threats that were needed to get him to have a vasectomy, but without real intent. The threats within this context were unnecessary, as they were premised upon Chad's

agentic decision to have a vasectomy already having been made (“um:m which I guess she could’ve but she just um (0.5) yeah (.) forced the issue... u:um knowing that I said I would do it” (L29-31)). The description of sexual gatekeeping being used against Chad in order to accomplish a certain act (the vasectomy) is read in light of Chad’s efforts to manage his own self-presentation. The phrase “She could’ve” (L29) contrasted strongly with his earlier suggestion that such a possibility has been limited by their premarital conversation (Extract 2), but implied that although she “forced the issue” (L29) it was *still* his decision. In the context of Extract 2, this statement positioned his wife as a ‘contract breaker’ if she did refuse him sex, as that was their deal (presented almost in pre-nuptial terms). He did not present vasectomy as a part of this agreed-on deal, and this positioned his actions as going beyond the expectations they agreed to when they got married and had children.

The minor discrepancies between the different versions of this account give some indications as to how Chad was orienting his talk in this extract. The timeline Chad presented in Extract 1 suggested she did not “force the issue” until she became pregnant, and even then he argued it was not until “pretty shortly after [our daughter] was born I had it done” (Extract 1, L47). The rhetoric of being ‘forced’ (while putting him at risk of losing his sense of self-determination) worked to position him as the victim in the situation. He had been responsible and caring (at least in intention), yet had been ‘bullied’ somewhat by his wife and the circumstances. His earlier gist recall (Extract 1) was presented as not quite dealing with the intricacies of the decision making process, but this ‘clearer’ recall (Extract 3) was framed as him ‘picking up’ the threads of earlier conversation. In order to ‘save’ the situation of any lost sense of heroism or self-determination (i.e., questions of his masculinity), Chad became invested in a ‘victim of circumstances’ position: he was doing the best he could to be a responsible and caring partner, but had been undermined by situational forces.

In the second version of the story, it was Karen that makes the actual decision to go off the pill and get them to ‘work her cycle’ (L4-9). Her reasons, however, were much less critical to her health than

the pill's "cancer-causing" aspects Chad referred to in Extract 1. Chad voiced her concerns as "makes me skin go funny and all this sort of stuff" (L7), which trivialised the concerns to (superficial) appearance matters, rather than inner health and wellbeing. He also aligned her with his dislike of condoms (L19: "<she doesn't like them either>"), which functioned as a reframing of the earlier description (that it was just *him* that hated condoms). It was spoken quickly, interjecting before a turn initiation might occur. This articulation of his wife's dislike for condoms did important work, emphasising that not only were the risks of pregnancy shared, but also the pregnancy itself; as lack of condom use could not be attributed to his own (selfish) preferences, the pregnancy becomes a shared problem. His description of his wife was framed much less heroically than descriptions of himself. In fact, as he continued to talk of her "forcing the issue" later in the extract, there may have been some risk in making his partner appear *unlikeable* or at least unwilling to share full responsibility for the pregnancy. To some degree, he reduced this slightly through the "she could've" withdrawn sex, but didn't formulation, In other words, she had the option at her disposal, but chose not to use it. While this did not portray her in a positive light, it worked to at least give an almost neutral account of her involvement. It appeared that the necessity of portraying his (absent) partner in a particular light was necessary to his production of himself as somewhat victimised or at risk of being unfairly vilified.

In this sort of accounting, there may have been room to question Chad's stake or interest in presenting himself and his partner in this way. The tone of the extract, as with Extract 1 could be treated as an attempt to diffuse questions of blame regarding Chad's irresponsibility in the situation being described. When blame or accountability are oriented away from the participant in conversation, it is usually done so, by placing blame elsewhere (Edwards & Potter, 1992). The risk in this account was that the blame had potential to fall squarely on Chad's partner, which may have drawn attention to questions or raised incredulity on my part as the interviewer. To help manage this, at L42 Chad entered into an effort at lightening the situation through 'humour', or an attempt

to portray pregnancy as the consequence of a somewhat laughable situation. He began by painting his partner in the somewhat sympathetic light of saying “I don’t want to get pregnant” (L43) and then addressing the irony of the situation by contrasting that in his next turn with “so yeah consequently (.) she did (laughs)” (L45). His pause acts as a build up for the punchline of the ‘joke’ and his own laughter acted as an invitation for my own (Glenn, 2003). At this point, my own refusal of his invitation (L37: “mmn, yes, yeah”) has the potential for discomfort, and it appeared I chose to respond to that by reframing the issue and then adding my own laughter. I did this by working to ‘remind’ him that the story is not as funny as he thinks it is “which is potentially... why there were a few tears at the start and stuff” (L48), a reference to an earlier statement he had made in the interview, which made him somewhat accountable for it. As I had refused his laughter and invited my own, the potential for discomfort still existed (Glenn, 2003), so to help resolve this, Chad responded with an emphasised metacognitive formulation of “oh yeah” (L49), as if he had been reminded of this part of his story.

Further diffusion tactics then included a reference to a “funny story” (L51), which acted as a prefacing move (Potter & Hepburn, 2007), framing the story as funny, even though his earlier efforts at doing humour had failed. His description of the sex that resulted in the pregnancy as a “quickie” (L51) acted to present the sex as ‘not noteworthy’; it was ironic in this formulation that such almost meaningless, quick sex could result in such a major lifestyle change as a fourth child. The term “quickie” also borrowed from the lexicon of John Gray (1995), as representative of an interventionist sex therapy that serves only to reinforce the male sex drive and its importance in heterosexual relationships (Potts, 1998, 2002). The quickie in this framework is sex that is primarily focused on male pleasure (i.e. penetrative, about his orgasm rather than hers) and is framed as a ‘right’ of male partners within Gray’s (1995) analysis of its importance in heterosex (Potts, 1998, 2002), and also potentially within Chad’s ‘agreement’ with his partner.

The 'humour' of this situation was enhanced by Chad adding invitations to laughter, through inbreaths and micro pauses (L55-56) during the more 'troubling' part of the story ("she'd been living with all this [the pregnancy] for about a week (.) while I was away, but hadn't said anything" (L55-56), and I did respond with laughter. I would hope that this laughter was more embarrassed than affiliative, it condoned the value and humour of his story, in order to maintain rapport and ongoing 'openness' (Schwalbe & Wolkomir, 2001). It was important to manage this situation by momentarily accepting the politically (for me) uncomfortable position provided by his 'humorous take' on a particularly unfunny situation. Flood (2008) has made reference to similar types of situations:

"In the interviews, I adopted a similar demeanour to that of the informants and concealed my own critical analysis and rejection of patriarchal masculine and heterosexual practices. By acting in this way, effectively, I condoned their sexist practices and accounts. My ethical discomfort at doing so was mitigated only by a pragmatic concern with interview rapport and trust, and an awareness of the progressive political uses to which this research can be put" (p. 341)

This momentary acceptance of his laughter invitation allowed Chad to drop some of the risk management in his talk and gave room for some limited (but important) self deprecation. Seemingly buoyed along by my laughter he commented that "I don't know why I was chuffed but I was chuffed (GT: laughs) I just remember being chuffed" (L59-61). Metacognitive work again framed the discussion, the "I don't know why" of L59 worked as to present this 'emotion' of pleasure as not something that can easily be interrogated. Despite presenting himself as a victim of bullying and circumstance, he can still father a child and *that* appeared to be key to his sense of masculinity. His wife was framed as finding the situation somewhat humorous and he used an indirect speech quote (63: "Karen puts it down to you know just proving that you can still father another child) to describe his wife using a 'you're such a man' script formulation (see Stokoe & Edwards, 2006) and the association of virility with that script. To some extent, like Chad's use of honest phrases previously,

this use of indirect speech (where previously he had used DRS), combined with the downplaying of Karen's 'suggestion' "I don't know" (L65) acted again as a way of framing Chad as 'doing modesty'.

The phrase "I don't know" (L65) had nothing to do with memory or knowledge, but rather functioned as a way of factualising the 'recall' of his wife's analysis of the situation (Edwards, 1997). She is probably right, this formulation tells us, and Chad has not really thought about it, despite his use of it to help manage questions of blame and stake. The "I don't know" also worked to diffuse my negative reaction to him referring to himself as chuffed (64:" ri::ght"). The extension of the vowel implied incredulity in relation to this as a reasonable suggestion, and may have added further trouble to his story. By making the statement Karen's rather than his and not affiliating his own opinion with it, he reduced my implied questioning of associations between his masculinity and the ability to father a child.

The account produced by this last bit of rhetorical work acted to validate the place of an ongoing heroic imaginary position (Wetherell & Edley, 1999) in Chad's account. Here, however, heroism was less about his actions as a protector of his wife and more about his function as 'able to get his wife pregnant'. When connected to the "just fantastic" nature of their fourth child (see Extract 1), it is a positive thing that he is able to do so, even when limited by the terms of a 'quickie'. His virility is such that he can feel "chuffed" with (presumably) himself and his ability to create an incredible child from a brief sexual effort.

This section has dealt with the formulations of reported speech (mostly direct, but also an instance of indirect) to attend to claims to 'misremembering'. Having to re-tell a story in a new occasioned moment due to a process of 'circling back' (Schwalbe & Wolkomir, 2003) in the interview had the

potential to cause trouble for Chad's original narrative and caused him to enter into a process of revision . In the next section I discuss the implications of these analyses.

Discussion/Conclusion

Positioning the self and others is not an activity in the same way 'disagreeing' is an activity, it is the *product* of activities that not only do social interaction but also do identity (Edwards & Potter, 1992).

These activities allow the participant to relate their actions (both past and present) to Others (sometimes these Others can be previous 'versions' of the self – see Terry and Braun, 2009) and from this invest themselves in particular notions of what it is to be (in this case) 'masculine'. In Chad's case he was drawing on several versions of 'himself', depending on the occasioned conversational context he was in, to present himself as heroic in one place, a victim in another and a man that is responsible and caring, most of all, in others. As Wetherell and Edley (2009) have noted, people's accounts about themselves do not turn up stable or even consistent descriptions of the self. Chad's account demonstrated many examples of variation in the way he spoke of his masculine identity.

This variation in Chad's identity talk worked to deal with several ideological dilemmas (Billig, et al., 1988) that Chad was managing. First, on one hand there was the underlying impression that representing himself as a responsible and caring individual was desirable. This was a position which (as discussed in previous chapters and above) seemed to dominate men's accounting for their decision to have a vasectomy. On the other hand, in wanting to articulate his story, he needed to address the potential for *blame* that may have resulted through his description of events. Without appearing to have too much stake in appearing a particular way, Chad shifted through different versions of the story depending on my reactions and the needs of his account at the time.

Second, heroic masculine positions are usually treated as negative formulations as Wetherell and Edley (1999) note:

More commonly, men portrayed themselves as 'ordinary' in relation to a macho stereotype dismissed as extreme, over the top, a caricature, seen as a sign of immaturity, and as a sign of a man who had not developed his own personal style or who was not comfortable with who he was (p. 351).

So while Chad appeared interested in presenting himself as heroic, this was downplayed through references to his responsible and caring imaginary position and even, a position of 'victim of situational forces'.

Chad's sort of presentation reflected what Wetherell and Edley (1999) referred to as hegemonic sense making. While rhetorically working to give the presentation of a "new kind of man" – the responsible caring partner – it still relied on traditional notions of masculinity to make sense of this new role. Responsibility is *not* the drudgery and day to day of burden contraceptive pill taking (or domestic housework); rather it is a heroic act, something which demonstrates the masculine character invested in the vasectomy, rather than the operation's simplicity and overall lack of impact on the man having it done (Schwingl & Guess, 2000). The difficulties Chad seemed to encounter through the variation in his stories resulted in highly creative rhetorical efforts, hybridising various forms of masculine positioning to suit his purposes.

Summary

This chapter has shown the value for masculinities research of using a more fine grained approach to viewing men's talk about decision making processes. While it is important to keep an eye for the ideological and cultural resources men draw upon, people are as much masters of language as they are its slaves (Billig, 1991; Wetherell & Edley, 1999) and such analysis offers another layer to understanding men's accounts of vasectomy. When combined with the analysis in Chapter 5, it

demonstrates not only that men draw from wider cultural resources (discourses or interpretative repertoires) that help them make (retrospective) sense of their decision making, but also that they rely on skilful application of rhetorical devices when in interaction to manage these ideas. Men will not simply take an idea and embed it always and forever in their understanding of a (recent) historical event or even of themselves, but produce, reproduce, adjust, modify and completely revise the story according to the interactional context. The next chapter will take some of the insights from this chapter and highlight the ways in which men made use of shared masculine sense-making.

Chapter 8: “Overcoming the ‘mental’ hurdle”: Imagining the self in the decision making process

Vasectomy, as has been discussed, is marketed as a simple, straightforward answer to the contraceptive requirements of (usually) a heterosexual couple who have had all their children (referred to by many of the professionals who perform them as the “complete family” (PR2)). Research evidence seems to suggest that for many men/couples the decision making process regarding a vasectomy can take some time: basically between a year and three years after the birth of their last child to complete it (Sandlow, et al., 2001). This statistic has not changed much in the last two to three decades (cf. Mumford, 1983). This theme also appeared in the quantitative data in this thesis (see Chapter 5) with the men who participated, taking, on average, 3.3 years after the birth of their youngest child to have the operation.

In Chapter 6, I discussed the ways in which many of the men, while espousing a rhetoric of responsibility and care, relied on an heroic discourse when discussing the implications of having had a vasectomy. This typically framed the operation as being done for their partners, and constructed ‘taking over’ the contraceptive burden as a ‘big deal’. This seemed to suggest that in a similar fashion to the (becoming) pervasive subject position of the New Father (Ranson, 2001), new forms of masculinity are developing that are more involved and inclusive. Also like the New Father, however, they are being formed within a context that continues to privilege men (Anderson, 2009; Connell, 2005; Connell & Messerschmidt, 2005; McIntosh, 2003).

This was further evidenced by interviews when, despite drawing upon such ideas as altruism and care, many of the men interviewed also spoke of taking long periods of time to get to the vasectomy. This might be compared with expectations that women need to ‘just get on’ with contraceptive

measures for the majority of their relationships and do so without complaint (see Chapter 6 for more discussion on this). Despite these issues, many of the men in this study, like those in Mumford's (1983) work suggested that at a certain point in the decision making process, the vasectomy becomes constructed as 'inevitable'. This effect has also been seen in Amor et al's (2008) recent work, where they suggested that having a vasectomy became *expected* by family, friends and colleagues. Amor et al (2008) argued that this expectation has become a cultural norm that men feel pressure to respond to as a "task of manhood" (p. 238).

This 'inevitability' of men having vasectomies (Amor, et al., 2008) does, however, seem to run in contrast to Oudshoorn's (2004) assertion that orthodox masculinities have little place for contraceptive responsibility. It appears that although we have yet to see (and may never see) a male pill, there have been some shifts in the identities men are investing in that may reflect more inclusive, involved forms of masculinity. Men subscribing to these less traditional, but increasingly hegemonic forms of masculine expression may show interest in contraceptive and reproductive involvement. However, as I have commented in other earlier chapters, this is not the full story. It is more likely that, as with any shifts in the shape of contemporary masculinities we are dealing with "shades of grey within masculine identity formation" (Terry & Braun, 2009, p. 176), rather than wholesale changes. The growing 'inevitability' of vasectomy and an interest in involvement for many men is likely also combined with aspects of orthodox masculine identity (such as self-control, independence and competition).

In this chapter, while there is discussion about the *content* of the data extracts, the primary analytic focus is upon the *strategies* used by men to make sense of somewhat 'troubled' talk (Edwards, 1997). Narrative descriptions of past events has been described as a "privileged communication mode for making sense of the self" (De Fina & Georgakopoulou, 2008, p. 276) particularly during an interview encounter. Such interactional contexts provide opportunity for people to 'try on' different

descriptions of the self (Wetherell & Maybin, 1996), as they provide a novel opportunity to speak at length about 'who one is'. As a consequence of this freedom, however, such interactional contexts can often be 'fraught with risk' especially for men (Schwalbe & Wolkomir, 2003). Many of the men, in the course of being interviewed, made reference to themselves, others and even different versions of themselves in order to explain, justify and manage how they talked about their experience of the vasectomy decision-making process. The next section will discuss the way the men 'imagined' themselves in the interview in relation to *other* men. As such it will draw on Wetherell and Edley's (1999) formulation of imaginary positions, as described in Chapter 4.

"We have friends, for example, and he will not get a vasectomy": Imagining the self in relation to others

The interface between the vasectomy and their masculine identities was a feature of the men's talk regarding the decision making process. Amor et al (2008) have suggested that "there is an intensity of gender role evaluation around this time" (p. 243) and this also seemed to be apparent in the interviews. When reference was made to manliness, masculinity or 'being a man' it was typically raised by the men themselves, as if there was an assumed 'need' to attend to it when discussing their sterilisation. This would perhaps suggest that there was some salient connection between the procedure and masculinity, a culturally shared understanding of vasectomy as a 'threat' to manhood (Amor, et al., 2008; Hofmeyr & Greeff, 2002; Williams, et al., 1980; Ziegler, et al., 1966) and that for the majority of the men, some processing of the issues of being masculine and being embodied was necessary to their accounting of decision-making concerning vasectomy.

The 'masculinity factor' was referred to in different ways, with many of the men articulating denial of any connection between their sense of manhood and the procedure (for example Andy commented: "for me that was all complete crap"). Whether they made such an explicit denial or not, almost all of the men drew from the 'idea' of masculinity, almost as a resource, using it to make

sense of themselves and their decisions. When men referred to 'masculinity' or raised it as a factor in the interview, it was usually done in two primary ways: first, referring to themselves and their masculinity as 'ordinary', locating themselves as 'one of the group' defining their masculine identity as the same as or similar to other men and their decision making processes as therefore typical. Second, and more commonly, men made reference to other men, and forms of masculine expression that could be contrasted, implicitly or explicitly, with descriptions of the self, usually done in a way which emphasised their *difference* from other men (either a significant difference or one of degrees). Irrespective of how they used masculinity as a resource in their talk, what was highlighted was the embeddedness of talking about the self and 'individual' decision making within a relational context. If their masculine self was in some way 'threatened' by the vasectomy, locating themselves in relation to others in a way which (re)validated their masculinity seemed to be an important task.

Being 'ordinary'

Antony's description of his decision making processes located him as a 'typical' male and worked to distance the self from questions of irresponsibility. Antony described his postponement in booking himself in for a vasectomy as a consequence of 'masculine' or 'male' priorities. Within this rubric, men have a different set of concerns to women, and therefore should be excused for not getting on the surgeon's table as soon as possible:

Antony: I think for me um like probably like a lot of guys unless it's really, really, really important it doesn't get done or goes to the bottom of the list and I think it just kept going to the bottom of the list because it wasn't that important to me, um you know ah go and get your vasectomy got and get your vasectomy or go out and relax and play snooker well the snooker will win every time.

Antony later suggested that what had made the vasectomy "really, really, really important" for him was the withdrawal of sex by his partner and 'constant' texts and phone calls. Within his analysis of this situation, Antony suggested that 'as a man' ("like a lot of guys") it was unreasonable to expect

he would prioritise getting a vasectomy when it conflicted with more desirable (leisure) activities. He suggested that he was simply doing what came naturally to him 'as a guy' and, in contrast, his partner's withholding of sex and 'constant' texting was unreasonable but motivating. This sort of account positions "a lot" of men as irresponsible and intuitive, doing whatever is most enjoyable at the time, almost in a childlike fashion. Women (or at least Antony's partner!) are constructed as controlling the decision making process and interfering with men's 'fun' by doing so. They are further constructed as responsible in relation to reproduction and contraception, not motivated by pleasure in the same way men apparently are. This normalised an expectation of women's uncomplaining involvement in the contraceptive burden and structured women's 'pressuring' of men to be involved as undermining men's agency (see Balde, Legare, & Labrecque, 2006).

Snooker, while likely not taking up *all* of Antony's 'spare' time, was presented as a desirable activity that 'guys' like himself would be more invested in than having a vasectomy. Having sex, in contrast, was formulated as a desirable, acting as a motivating force when removed. This sort of accounting referred to an imagined 'guyness' as a resource to make sense of the delay that had occurred. 'Being a guy' worked as a way to shape Antony's description of his own resistance to getting a vasectomy as normative and to be sympathised with. This invocation of men as a group worked to normalise the lack of investment in the operation that Antony described. By locating himself as one of many, the implication is that change (if at all possible) must occur in the whole group, and that resisting the status quo (by showing interest in reproductive concerns) is too much to expect for an 'ordinary' guy.

Being a 'guy' in this account was essentialised as indifferent to reproductive and contraceptive concerns and, to a degree, indifferent to having a reproductive body. This is quite a shift from Antony's claim elsewhere in the interview of self-sacrifice and responsibility (see Chapter 5) and

highlights the contextualised and inconsistent ways in which people talk about their gender identities (see also, Wetherell & Edley, 2009). What was key to this argument is the imaginary position (see Terry & Braun, 2009; Wetherell & Edley, 1999) of the 'normal' or 'ordinary' guy, who should be easily related with and understood. In this particular context, Antony was using the imaginary position of 'ordinary guy' to tell a particular story about himself, in this moment and addressing the concerns of this conversational context. In other extracts, he was invested in a portrayal of himself as slightly heroic, which worked to manage both the 'macro' concern of appearing masculine and the 'micro' concern of telling the vasectomy story.

Although these two positions can have some overlap (he was being heroic because the *truly* 'ordinary' guy would potentially *still* be playing snooker), the purpose of the rhetorical work of 'being ordinary' was to explain a period of delay that needed attending to in this portion of the story, rather than (as it ostensibly appears) to explicate his 'motivations' for having a vasectomy in the first place. At the same time, by locating himself *within* a wider group of ordinary men, his masculinity is not under question, he is a man because he is like other men. In drawing on both heroic language and the ordinary imaginary position, the work being done was to give the best possible impression of Antony.

Being 'extraordinary'

An investment in being 'ordinary' or 'typical' was certainly not the dominant form of sense making found in the data. In contrast to Antony's position, the vast majority of the men interviewed used descriptions of their own, or other men's masculinity as a way to speak of themselves as 'more enlightened' or 'better', rather than 'average', 'ordinary' or 'normal' men. Some did this by referring to 'other men': vague, caricatured imaginary figures against whom they could contrast themselves.

Evan, for instance, was one of the small number of men who said he had taken a very short time to make the decision to have a vasectomy and book himself in. He explained this in the following way:

Evan: so, um, so I had no fears and, um, you know I mean I certainly didn't think that it was going to affect my manhood, or my, um, um, sexual, um, interactions (.) post vasectomy.

The raising of these factors, and the way Evan did so, worked to give the impression that having a vasectomy could have potential for creating anxiety about "manhood" or "sexual interactions" for some men. In this way he presented himself as somewhat 'different' to, or having overcome the weaknesses, of an imagined norm. Evan's emphasis on the word "my" suggested that while Evan claimed to have overcome this particular 'concern' it was likely that many others did not. This sort of accounting distanced Evan from an imagined (and vague) masculinity that associates 'tampering' with a man's testicles as emasculating, and locates masculinity within the male body.

As Evan claimed to have taken a (comparatively) short time to have a vasectomy there was little need for him to attend to any questions of 'delay' and therefore little need to refer to other men or masculinities more specifically. If, however, accusations or questions of being 'under the thumb' were to occur, it could be interesting to see whether this vaguely implicit reference to others would become more specific.

Sam's approach to describing the masculinity he was invested in also made implicit reference to an imaginary group of 'other men', in this case, invested in their fertility as a sign of manhood. He recounted his use of the six month semen check as a source of humour to make this point:

Sam: I had the little, the little A5 piece of paper signed by the doctor on my notice board at work for a little while (laughs) yeah, yeah, I'm sure that means something, um, I have a joke about, I had a joke I don't have the certificate any longer, I decided I didn't need it but I had

a joke about “I’m not a real man and I’ve got a certificate to prove it”, which is (laughs)
which is probably not that, not that common.

This sort of account invoked a valued (for him) form of masculinity, which distanced itself from more ‘traditional’ masculine values. The humour of the account is premised upon a shared understanding of connections between fertility, virility and masculinities. Here, Sam appeared to be investing his own masculine identity in what Wetherell and Edley (1999, 2008) have described as ‘rebellious’ masculinity, presenting the ‘real man’, in contrast, as a position to be avoided. While this sort of joking about the semen test *was* relatively common (some of the other men told almost identical stories), his account presented Sam as somewhat unique, different from some imagined ‘real man’ who still was invested in fertility/virility. He seemed to suggest he was almost revelling in the lack of fertility brought about by his vasectomy, rather than feeling some sense of loss or complaining about being ‘pressured’ into the operation. The ‘uniqueness’ of his position is an important worked up feature of the account, as is the implicit reference to invisible ‘others’ who are the ‘real men’. It portrayed Sam as proud to be different from the majority of men and therefore invested in being unconventional. Even as he ‘played the rebel’ by joking about his infertility, however, there was a strong reliance on and reproduction of orthodox masculine values such as independence and autonomy, and having become more enlightened than ‘real men’.

The willingness to tell this particular story in the interview and the rehearsed nature of it would also suggest that the work being done here was the management of a question that almost ‘needed’ to be answered or accounted for in a complex field of competing discourses about being masculine. Sam, like many of the other men, made reference to various (imagined) forms of masculinity in order to describe his own. As with the accounts above, this one gives some credence to the suggestion that Sam had ‘worked through’ associations between his masculine self and having had a vasectomy and was now able to critique those who had not through his humour. What this suggested, however, was that masculinity per se, was a pervasive concern for men who underwent vasectomy, needing to

be attended to at some point in the process. Both Sam and Evan's accounts relied on a discursive strategy of *implicit* reference to others in order to demonstrate they had accomplished this task, where others likely had not.

'Better' than 'real' men

A more specific use of 'I'm this type of man, not that type' rhetoric did occur consistently throughout the interviews, almost always when explanatory work seemed to be required. One of the men, for instance, who chose to have a pre-emptive vasectomy (but was well into his fifties when this happened) had just outlined why he had taken so long to make his decision not to have children 'final'. Upon completion of this explanation he immediately started a new story about how a friend who came with him to 'research' the operation fainted, which led to my query and his response:

GT: yeah, so what was about, um, the operation that made your friend faint?

Brian: I think it was, ah, um, I don't actually know, I, I think it was, personally, I know the guy pretty well and I think, and he's got kids um, and I think that it was sort of the psych-, the psychology of it, was what got to him [GT: mmn] I don't think that it was the, the fact that it was a medical procedure [GT: mmn] um, I just think, um, he, had some, sort of, his manhood was kind of (.) tied up in there somehow (GT: laughs) a-, and, and that's, that's another thing that I, I think I should mention, is that, um, my reading about vasectomies and talking to people about it, I realise that some guys, their, their feeling of, of who they are as a man is tied up with the sexual prowess, in terms of being able to make a woman pregnant and that, and that has never been the case with me um, I, I haven't felt less of a man since I had the vasectomy.

While this account superficially worked to present Brian's understanding of vasectomy and masculinity, it did so in relation to the invoked masculinities of an imaginary group of men and located his friend within this group. It caricatured this group as having their masculine identities "tied up" with their fertility, which is apparently correlated with their "sexual prowess". There was a

hint that there was something stereotypically masculine about such men or that these men might identify with a more traditional ideas of manhood that might be 'worthy' of some disdain (even, it seems, his friend). Brian's telling of this story worked to ratify that the time it took for him to have a vasectomy would not be marked with concerns about his fertility or sexual prowess. This rhetoric located Brian within a less biologically motivated form of masculinity (i.e. sex and fertility) than such "guys". In so doing it presented his vasectomy as an act unrelated to his masculine identity, and therefore as a legitimately minor procedure.

Even as he launched into this diatribe about vasectomy and other men's masculinities, Brian's own masculinity remained a concern to be attended to. Simply telling the story and reference to his friend and "some guys'" investment in masculinities did not seem enough, even when showing some disapproval. He commented at the end of the extract that "I haven't felt less of a man," and that investment in this 'fertility-based' masculinity has "never" been the case for him. Such emphasis worked not only to locate him within a much more 'enlightened' understanding of masculinity, but also to finally set aside any associations between the time it took for him to have the procedure and any negative correlation with his masculine identity. When he did get around to having a vasectomy it was for his 'own' reasons, not influenced in any way by petty masculine concerns.

In other cases, rather than invoking an *imaginary* group, the participant's referral to specific figures allowed them to make sense of their own position within the masculine 'spectrum'. Chad, for instance, noted:

Chad: we have friends, for example, and he will not get a vasectomy, he absolutely refuses and she reacts badly to the pill, so she's, she's on IUD (clicks tongue), I mean he is pretty, well I wouldn't say he's typical, but he's, he is you know, rural bloke. Not bloody getting a vasectomy, you know, blah, blah, blah, so, yeah I dunno, I don't know. Maybe it's [having a vasectomy] a bit of an awareness thing, maybe it's just a new age guy thing, I don't know.

As seen in Chapters 5 and 6, Chad spent a large proportion of his interview presenting himself as 'aware', 'caring', 'responsible' and here as a 'new age guy'. Unlike Brian, Chad did not present the vasectomy as unrelated to his own expression of masculinity, rather his comparison was with different kinds of masculinities, such as the type his friend embodied. While describing a particular person, Chad made reference to the man being a "rural bloke", a homogenising description of a group of 'Other' men who were nothing like Chad. The description bears some similarity to distinctions made between 'traditional' and 'modern' men by health professionals in developing countries such as Mexico, with the often mistaken assumption that the former will have little interest in birth control and the reproductive process due to the power of *machismo* within that context (Gutmann, 2007).

Within Chad's account, the "rural bloke" was represented as the complete opposite of the (masculine) self he presented. The rural bloke was constructed as letting his partner take an unreasonable burden of contraceptive responsibility, and as completely opposed to being involved in (permanent) contraceptive actions ("not bloody getting a vasectomy"). While not explicitly attributing the labels of 'aware' and 'new age guy' to himself, and using several "I don't know" hedges, the implication in Chad's account was that even despite his delays and the problems caused by these, his own expression of masculinity was positioned as 'better' than his friend's. Simply having a vasectomy (regardless of when) became an indicator of being an 'aware' or "new age" guy, an identity he appears invested in presenting.

Within the interviews there was often reference to different 'types' of masculinities or men, and the use of these portrayals as a resource to explain the values involved in the decision-making process. In order to explain why Chad has had a vasectomy and this other man has not, Chad drew upon the notion that there are different types of men that view the world in different ways. This particular framework was not necessary to make his point; however, it seemed for many of the men,

establishing their choice to have a vasectomy as the product of a 'better kind' of masculine identity than other men was a useful strategy than explicitly speaking of their *own* values.

In Chapter 6, I referred to the notion of the 'economy of gratitude' (Hochschild, 2003). I suggested that when men's involvement in what might be considered stereotypically feminine activities (such as housework or contraception) is discussed it is often constructed as somehow special or extraordinary. Dixon and Wetherell (2004) have argued that rhetorical work done by men (and often their partners) when discussing their involvement or efforts in the domestic sphere is frequently marked by comparisons with *other men* rather than reflection upon ongoing discrepancies between partners. This discursive strategy appeared often throughout many of the interviews, where demonstrating a 'better' masculinity than others was deployed in order to de-emphasise between-partner differences and even to manage potential questions regarding delays in having the procedure.

Similar to Chad, Brent compared himself to two (actual) friends, but in contrast to Chad's account, highlighted the friends' *general* similarity to him (i.e., educated, intelligent, otherwise 'enlightened'). The one area that these men *specifically* differed from him was that their masculinity had 'gotten in the way' of their decision to have a vasectomy:

Brent: me mates who are intelligent (.) people in every other respect who just have this bizarre (inbreath) view that somehow it's going to damage their manhood I don't know whether might have been saying you know (.) ah (.) is my sort of defensive way of saying no I'm still a bloke despite that but it's more around saying that I just think I just think that (.) I disagree obviously that that um you know there's some relationship between masculinity and ability to have sperm in your ejaculate... I can't understand the you know the ingredients you know component of that conversation you know I just think it's silly.

In making sense of his decision to have a vasectomy Brent highlighted this very *specific* difference between him and his friends. He described his process as fairly rapid (a matter of months from decision to the operation), thus locating himself as 'responsible' and having no need to account for any delay. However, his account included the story of these men, who were much like him in many other ways but "bizarre" in this particular way, which suggested that even with no question of his responsibility to attend to, it was still important to refer to other men's different masculine expression.

Brent used contrasting descriptions of these men and their 'ideas' to locate their 'problem' within one particular 'long conversation'²⁰ (see Maybin, 2006) about vasectomy. He worked to portray this conversation as 'inconsistent' with the rest of a 'psychology' he was attributing to these friends. While describing them in respectful terms like "intelligent" and at another point in the interview as "very clever", he commented that despite this, he could not even comprehend the "ingredients... of that conversation". This inability to comprehend was constructed as a problem with the friends' turn in the conversation, not with his own interpretation of it ("I think it's just silly"). Because of their otherwise 'intelligent' point of view and similarity to him, Brent's account portrayed him as struggling with understanding their resistance to having a vasectomy.

What enabled his difference from these men was left unsaid; however, there was no question that it was a difference that made him marginally *better* than these other men. Having had a vasectomy was depicted as a reflection of some positive character trait that they needed to aspire to in order to be less "bizarre" and therefore intelligent in *every* way. In many ways this sort of pattern lies at the crux of much masculine sense-making, referring to other men (see for instance, Wetherell & Edley,

²⁰ The 'long conversation' or 'proto-conversation' (Wetherell, 1998), rather than a single contextualized moment, is the construction of a 'big story' about a situation, based upon multiple smaller conversations, and drawn upon to make individual conversations and experiences intelligible.

2009) or even previous 'versions' of the self (Terry & Braun, 2009) to mark as a contrast to the (current) self.

This section has referred to the men's recurring descriptions of the self in terms of different expressions of masculinity. While these conversations were superficially about vasectomy, the men seemed to be attending to an association between their operation and who they were as men, drawing upon an 'idea of masculinity' to do so. In the majority of the extracts, men compared and contrasted their own decision making processes with those of other men ('imagined' or 'real'), and in doing so seemed to be drawing from a shared understanding of masculinities as multiple and social. When it came to their own identities, however, the masculinities they were invested in were almost always presented as superior to those of the men they were comparing themselves against, done so from the 'safety' of having had a vasectomy which therefore situated them as above reproach in terms of the gendered 'equality' of reproductive responsibility.

In the next section, rather than focussing on the traits that made them *superior* to other men, I will describe another strategy that was followed by the men. In this case it was references to an internal battle going on within the self (most often with reference to the body or some other aspect of the 'self' needing to be 'overcome' by an interior or 'true' self) in ways that allowed diffusion of criticism for taking long periods of time to finalise the decision making process.

"Overcoming the 'mental' hurdle": Imagining a struggle against the self

The body is often constructed as secondary to the place of the rational, interior self in many social constructionist accounts of masculinity. Connell (2005) has suggested in contrast to this that "true masculinity is almost always thought to proceed from men's bodies – to be inherent in a male body or to express something about a male body" (p. 45). While the participants in this study seemed

invested in having a (male) body, it was not always 'true' masculinity that was described as arising *from* it. In fact, for some of the men, the notion of having a specifically male body was drawn upon to help explain inconsistencies in their accounts of the decision-making process. The body was treated by a number of the men as a separate 'actor' in this process, acting as a 'barrier of flesh' to what the men 'really' wanted to do. The comparison in this strategic portrayal was not between themselves and other men, but their 'interior' (real) self and another (embodied) self. This framing of the body or some other aspect of the self operating as an impediment acted in a similar way to men's references to an 'immature self' that I have previously discussed (Terry & Braun, 2009). It also bore some similarity to Pott's (2001, 2002) suggestion that the body (or in her descriptions, *particular* parts of the body) can be referred to as having its own 'mind' and interfering with the decision making ability of the 'interior mind'. At times in the interviews there was even reference to being in 'two minds' about the operation. One mind was always associated with an 'inferior' or 'embodied' mind while the other would be framed as rational, 'interior', able to objectively reflect on past events and continue narration in the present.

Bob, for instance, highlighted the differences between men and women's experiences of having bodies (more specifically, the comparative lack of ongoing medicalisation of male bodies). He argued that an operation at the site of male genitalia was a more novel, and on that basis, a more threatening event than the more 'natural' surveillance of and intrusion upon women's bodies:

Bob: at the end it was overcoming the mental hurdle, of being a male, and actually having someone take a scalpel to your balls effectively, you know, that was, you know, it was a little bit of a challenge because, you know, unlike females men, men tend not to have the bodies prodded and poked at to anywhere near the same degree (laughs).

The psychological implications of "being a male" and having minor surgery on the testicles were heavily hyperbolised in Bob's account, emphasising the (apparently) atypical experience of a man

being 'prodded' and 'poked'. This account portrayed the vasectomy as somehow emasculating, through equating it with what a woman might normally be expected to do or experience. Even the language of having a scalpel 'taken' "to your balls effectively" brings to mind images of castration, which has historically been associated with vasectomy and continues in some cultures today (Amor, et al., 2008; 2006; Ferber, Tietze, & Lewit, 1967; Gutmann, 2007). There is little question that the image of castration is linked with feminisation and conflicts with the expectations of hegemonic masculinity (Aucoin & Wasserburg, 2006).

Using a similar comparison-based structure to the extracts in the previous section, which spoke *directly* about masculinity, Bob here emphasised what male embodiment was for him by comparing it to what it was not (i.e. female embodiment). The implication was that a woman would have no problem with such a minor form of surgery, first, because being 'prodded' and 'poked' is to be expected and second, that there would be no threat to her gendered identity involved. For a man though, it is a "challenge", a consequence simply of being a man in contemporary society.

Bob's account was also framed in such a way as to evoke sympathy for men, and the male experience, likely made possible through the exchange of such ideas with a male interviewer (Schwalbe & Wolkomir, 2001). Male bodies were constructed as not to be 'interfered with' and it was therefore presented as a major consideration for men to have their bodies cut for the sake of contraceptive reasonability. Despite an acknowledgement of the 'poking' and 'prodding' women must undergo, within the wider 'logic' of Bob's argument, women were expected to be 'used to it' and were therefore better equipped to handle the 'distress' of such situations. In this way vasectomy was constructed as a (gendered) 'big deal'.

Bob's (male) body was constructed as an obstacle in his account. While the rational, interior self was described as being able to assess (and agree with) the need to have a vasectomy, the *maleness* of Bob's body created a 'hurdle' that needed to be 'overcome' by the mind. In this way, Connell's (2005) suggestion that 'true masculinity' arises from the body only seems to be telling half the story; 'immature' expressions of masculinity (i.e. avoiding involvement and responsibility) may do so, but more mature expressions rely on the interior self-controlling the 'weaknesses' of the 'immature' body (see also Terry & Braun, 2009).

In Steven's telling of his experience of the lead up to his vasectomy, the decision making process took almost two years. While he spoke of a number of reasons for this delay, he commented that the idea of having any surgery at all was not something he was "comfortable" with:

Steven: I'm not comfortable with it I've got a actually I felt a bit queasy about going there that day, ah, I have never fortunately, I've never had to go into hospital, so I don't have much experience of these things [...] it wasn't sort of like I was saying "I don't want to go through with this", I did want to, but I was sort of thinking "oh god to go through this?"

Being "uncomfortable" and "queasy" at the thought of surgery was directly connected with the novelty of any medical intervention by Steven. Like many of the men in the interviews, Steven showed a high degree of ambivalence in relation to doctors and check-ups in general, let alone operations and hospitals. This described lack of experience of "these things" was similar to Bob's suggestion that women are much more used to being "prodded", but relied on a less gendered, more individualised strategy. Within his accounting for the delays in getting a vasectomy, it was experience specific to him (i.e. his lack of going to hospital, seeing doctors or being operated on) that resulted in him being "uncomfortable" and "queasy". In this formulation the 'inexperience' of his body was a factor that needed to be overcome, made evident in Steven's description of a mental 'argument of selves': on one hand the more 'rational self' was pushing for the operation to occur,

while the 'immature self' was resisting ("I don't want to go through with this"). This argument was tidied up with a retrospective analysis of the process ("I did want to"), which gave a sense of the mature self having 'won' the argument. The voice of the immature self still hovered in the background of the process ("oh god to go through this") with Steven using the hedge "sort of" to reiterate this 'self' having less power than the more mature version.

Chad spoke about the lead up to the operation in terms of a sense of general risk, and implicitly referred to the vulnerability of his own body (as one of many) when explaining the delays in getting a vasectomy:

Chad: the reason I procrastinated on getting a vasectomy, was I was purely and simply concerned about being a statistic because I had a (.) a colleague of mine from years ago, who, who had had a vasectomy, um, I-, you know, when I was probably only in my mid-twenties I guess but he'd had a vasectomy and actually had (.) some problems, but I'd talked to a lot of people that hadn't, but this (.) one (.) particular individual, sort of stuck in my mind, and that was why I didn't want to have a vasectomy I was actually quite concerned about something going wrong.

In his description of his decision making process, the chance of being a "statistic" was used by Chad to justify his initial resistance to the operation. He suggested that while the majority of men that he had spoken to had gone through unproblematic experiences, the one man's account of suffering chronic pain was the story he kept recalling. In this framing of deciding to have a vasectomy, the body is portrayed as being unruly and likely to react badly to the operation. While only a small number of men suffer from problems such as significant chronic pain or haematoma post-vasectomy (Awsare, et al., 2005; Tandon & Sabanegh, 2008), the risks could be, and were, worked up by Chad (and other men) as a justification for delaying (or even outright resistance to) the operation.

Some US researchers have noted that when a decision is being made as to who will carry the contraceptive burden past childbearing, often sterilisation occurs in the body of the partner most motivated to prevent any (more) children being born (Miller, et al., 1991c). While this appears to be changing in the current New Zealand context, some men drew on discourses of risk to their bodies to justify delays in the process. In many cases, an indication of concern “about being a statistic” delaying the vasectomy, such as the one Chad vocalised, might signal a lack of investment in the operation, or in the termination of childbearing (see Chapter 7 for further evidence of this).

Fear of pain was the most common reason offered for delaying the operation (see also, Thompson, et al., 1991), with many of the men commenting that they needed some assurance that it was not going to be a problem. Sam articulated specific concerns about the potential for pain associated with getting a vasectomy, in his case needles. He argued, however, that rather than relying on knowledge about the operation or finding some other avenue to dispel his concerns, he was able to draw upon comparisons with what his wife had undergone to help him get through it:

Sam: I’m like a lot of people I guess I mean I don’t like pain I don’t particularly like needles you know, show somebody getting injected at the movies or something and I’m looking away but, um, ah, you know, those are all kind of low grade background things as far as I’m concerned in that situation [...] but, you know, one of those other things look what my wife g-goes through, in child birth you know nine months of pregnancy and for heaven, you know, for heaven’s sakes three day’s worth of discomfort you know, so what, big deal.

As in the extract from Bob’s interview above, Sam made reference to the bodily stresses a woman ‘naturally’ goes through (in this case pregnancy and labour). He suggested ‘being aware’ of this enabled him to overcome his fear of needles. As with the majority of the men, however, the process of deciding to go through with the vasectomy was one Sam spoke of as needing time for, a period he reported as being just over two years. He noted that what finally “prompted” the decision to get the operation done was an “unplanned” conception occurring (this sort of unplanned pregnancy was

reported by four of the 16 men), a pregnancy which he described his wife as finding “difficult” but which continued to term. As with many of the men interviewed, an internal dialogue is referred to in Sam’s accounting for his delays. One side of this mental debate is the ‘immature’ self’s squeamishness associated with ‘needles’ (which may represent surgery in its entirety), on the other is the more mature, responsible self, who was portrayed as eventually able to get past this impediment, by recognising the suffering of another as greater than his own.

Pain was not always the primary subject of concern for men. As the vasectomy is an embodied experience it was not unusual to hear the men speak of bodily surveillance *after* the operation, perhaps giving insight into their justifications for any delay they may have referred to:

GT: did you find there was much difference in terms of sex compared to when um your partner was on the pill and all that sort of stuff?

Paul: no no um ah:h no, not really. You always think in your mind when they cut it, is [there] any fluid loss or is there any fluid any more or anything, you know, all that sort of thing um and obviously noticed a drop in that that sort of fluid in- that sort of outtake but nothing too major but I noticed there’s been no real I haven’t had any increased libido after it or anything.

This account demonstrates the prevailing power of myths about vasectomy in some men’s talk, particularly when talking about their bodies. Paul mixed positive (raised libido) and negative (noticeable drop in semen) mythological outcomes of the operation, expressing concerns about the embodied outcomes of having a vasectomy. If treated as a window on Paul’s ‘reality’, this account highlighted the need for education and dispelling of the myths concerning the impact of vasectomy on the male body (for instance the drop in volume of seminal fluid is well below sensory ability to register (Crooks & Baur, 2002; Sherwood, 1997)).

At a more discursive level, however, it offers us another example of the integrity of the body being used as a reason for delaying the operation. Sex, in Paul's response to my question, was reduced to "libido" and "fluid" and he referred to having concerns about this issue throughout the decision-making process and immediately afterward ("you always think in your mind"). There were a number of possible answers that Paul could have offered in response to my question (especially as he had already spoken of his wife's dissatisfaction with oral contraceptives), but he attended to the issue of 'hydraulics'.

Vic used the phrase "I had no qualms" a total of five times when speaking about the lead up to the operation. Like Steven, he spoke of limited experience with surgery, and that this was his prevailing issue with getting a vasectomy:

Vic: so no no qualms at all apart from the fact the fact that no one had ever cut me (inbreath) I I'd had you know five stitches here and two here and never even a broken bone, if there was any anxiety it was only about that really

GT: and so [...] anxiety about the particular area you're having operated on?

Vic: the sort of whole man thing?

GT: well yeah

Vic: (laughs) well no I was able to read I was able to talk to people who've had vasectomies who were still sexually active. I was able to know that um you know enough to believe the doctors I suppose, I've always again you believe people who educated about something and tell you sincerely that you won't notice a difference, so I believed what I heard and learnt and knew and had I had no qualms at all [...] I suppose (inbreath) [...] I was interested in how I would be afterwards [...] I had erections quite normally. You have to produce a sample, and I was able to do that.

As with many of the other men, the "whole man thing" seemed to be the most readily drawn upon response to similar questions about surgery on testicles (as opposed to tenderness or the 'private'

nature of the genitals that some others offered). The “whole man thing” was constructed as humorous, as evidenced by his laughter at my acceptance of his interpretation; however, it was presented as a concern that was ‘easily’ overcome through knowledge.

This sort of framing would perhaps imply that he was invested in presenting himself as unaffected by ‘myths’ and ‘stories’ about the impact of a vasectomy on the male body. He was instead a man defined by rational rather than emotional motivations. It also, however, positioned him within an erectile and ejaculatory imperative (as seen in his investment in “producing a sample”), presenting his primary concern as being his ability to get and maintain an erection after the operation.

This extract demonstrated the management of an ideological dilemma (Billig, et al., 1988), a contradictory account of different (but powerful) ideas of masculinity crossing over and into each other to explain a single situation. While there remained some investment in the physical (and thus potentially vulnerable), embodied self in the extract, there was also an ongoing concern with not having “any qualms”, and being an informed and knowledgeable man. Vic’s dilemma was somewhat diffused by qualifying his ‘underlying’ or ‘unconscious’ concerns as being easily remedied through research. This also worked to situate him as not really that serious about his concerns, as he was able to be easily reassured and the concerns dismissed. Having a mature view of the operation was enabled through relying on the expertise (either qualification or experience based) of others, which meant the “man question” could be set aside (especially once a semen test had been produced).

The rhetorical work involved in this presentation was fairly common in the interviews. In many cases, men were ‘making sense’ of a number of contradictory ideas and experiences, and doing so in light of some just as contradictory forms of masculine expression. Being a ‘good and involved husband/partner’ was presented as an important interpretative scaffold for almost all of the men

interviewed²¹, yet at the same time being involved in reproductive/contraceptive decision making has not historically been considered a normative part of hegemonic forms of masculine sense making (Oudshoorn, 2004). Being able to face the possibility of pain and surgery bravely, overcoming fear and concern about possible implications for their bodily (and it seems sexual) integrity also came to the fore in the interviews. Simultaneously, the men subscribed to appearing rational and 'mature' in their retrospective processing of the operation. Being able to rhetorically split the 'self' (either between body and mind, mature and immature or even 'two minds') was a strategy employed by the men to manage this. As Potts (2001) has argued, such formulations are an accepted part of the cultural resources men draw upon to excuse sexual 'bad behaviour', and so would also be accessible when confronted with the more novel situation of talking about the vasectomy.

For some of the men, this mixture of ideas and masculine expectations had the potential to become unsustainable when I asked them to reflect on why they had delayed thinking about, let alone getting, the operation done. For instance, Patrick commented:

Patrick: I was still a bit sort of, you know, I'm going to have to go, and you know, um, should think about getting the snip and just when I thought about thinking about it, you know, sort of, you know, you don't want to do it straight away it's sort of like a sort of a mental block you know.

The notion of a "mental block" may have given Patrick (who also reported his wife becoming pregnant during the decision making process) a strategic resource to make sense of the overlapping and yet sometimes conflicting expectations regarding 'being masculine' and having a vasectomy. A 'mental block' or 'mental resistance' carries the psychoanalytic cultural capital of being associated with trauma or risk (Hoffer, 2006; Wetherell, 1996). Something unconscious (and therefore outside a person's conscious control) has prevented a person from doing something they otherwise might

²¹ The exceptions to this position largely came from the group of men who had not had children.

want to do, but which the mind unconsciously reads as not in their interest. This 'block' then prevents them from doing what they 'want' to do. While not articulating concerns about pain or fear, Patrick was able to draw from this type of discursive resource to excuse or pre-empt any questions about delays he had to account for, especially considering his wife's unplanned pregnancy. Again the notion of the 'split-self' was deployed. In this case it is two mental selves, one unconscious, one conscious and perhaps more 'real' than the other, battling for control over the situation. Important to this strategy was a sense of continuity between the 'real' self who was the 'victor' in the argument and the narrator of the story.

John embedded his concerns about vasectomy more within his 'mind' than his 'body', speaking of the concept of fertility as being important to him "psychologically" and to his sense of masculinity, explicitly speaking of being in "two minds":

John: I was in (.) two minds about it because, it psychologically it's quite a big decision because basically you're going to be rendered infertile you know yeah um and um it's you know you have your like ah um ah sort of like manly pride and all that you know.

Unlike the notions of semen reduction or loss of sexual functioning, the outcome of infertility after a vasectomy is expected (in fact, demanded, and valid). The relationship between men, masculinities and fertility appears to be a complex one. Research is beginning to suggest that men are aware that their bodies are reproductive as well as sexual (see for instance, Malik & Coulson, 2008) and that when a couple's inability to have children is a consequence of male fertility problems, it can be traumatic for the men involved, a trauma that is not always recognised (Dhillon, Cumming, & Cumming, 2000). While this sort of concern would largely be associated with men (or their partners) who are unable to have children, it appeared to be a discourse which John was able to deploy in reference to himself and his decision to have a vasectomy.

Within the interviews a common repertoire of “what happens if my wife dies” was deployed. Working alongside the notion of ‘lost’ fertility as important (for some men), this repertoire operated as another way to manage the discussion concerning having (and delaying) a vasectomy. While it was not spoken about in any great depth by the men, the possibility of death of their partner or a relationship breakdown was described as having ‘entered their minds’ at some point. The validity of wanting children with another partner was treated with the same sense of careful management as the possibility of a child dying. While not many of the men used this as a justification for delays they had previously referred to, it was hinted at and referred to occasionally. The struggle between John’s ‘two minds’ was eventually ‘resolved’ in having a vasectomy. As with the other men, the hold of the ‘immature’ mind, with its concerns about “manly pride” and being “rendered infertile”, was eventually set aside for the claim to ‘responsibility’ and investment in the children he and his partner had at the time.

What was apparent in all of these men’s rhetorical struggles was the complicated (and occasionally unsustainable) practice of describing the vasectomy decision making process as linear and self-directed. Whether it was the form of masculine expression they claimed as their own at the time of the interview, or the handling of possibly contradictory answers to the question of making a final decision, speaking about *deciding* was not as simple as *taking responsibility*. What was framed as simple was the operation itself, with comparisons being made between the difficulties of getting to the table and ease of the process once the man was there. This served the strategic purpose of minimising their experience of the operation, as talk of struggle and difficulty deciding may have put the men at risk of appearing less masculine, and thus creating interactional dissonance (Billig, 1996). Alternatively, another strategy such as favourably comparing the self with others, may have made them appear *too* masculine or *too* heroic, thus needing some form of minimisation to ‘tone down’ their account. It is to this minimisation strategy the next section turns.

It's just a pathetic little operation": Once the hurdles had been overcome

When discussing the lead up to the vasectomy, the men's accounts in general were marked by multiple strategies for explaining, justifying and making sense of the decision-making process and its immediate impact upon them. Some of these justifications included specific and general concerns about the operation, the different choices available to them (e.g., continuing to use 'temporary' contraception), and how their imagined (masculine) self interfaced with the (dominant) constructions of masculinity they associated with the operation. Commonly though, the men spoke of the decision making itself as being the difficult part of the process (the 'big deal'), with the operation reportedly 'no big deal'. Within the interviews, the men reproduced the 'common-sense' rhetoric of the vasectomy as a simple, unobtrusive procedure (Adams & Walde, 2009; Atkins & Jezowski, 1983; Dassow & Bennett, 2006; Schwingl & Guess, 2000; Sparrow & Bond, 1999). The following comment from John exemplified this position:

John: like I say I'm not saying it's a big thing to do. I suppose the decision is bigger than the act if you like. And so once I was happy it was fine, you know, it was something that you did almost like (inbreath), moving house, if you know what I mean.

Despite it being questionable as to whether deciding to move house is harder than the move itself, the concept of the decision being 'hard' and the act being 'easy' was typical of the men's accounts. Some of the men who spoke of a significant delay between the issue being raised and having the operation expressed surprise at how little resemblance the procedure bore to their expectations. Chad for instance commented:

Chad: for the first couple of days, I just remember thinking, God, I can't, I just do not know why I mucked around, it's just such a pathetic little operation, it went so smoothly [...] Everyone that's talked to me about it, I've actually said to them, um, look, it's a really pathetic operation and I think you should get on and do it. I'm pro it, personally I (.) think it's, I, I just pers-, I guess I just think it's just such an easy thing for a bloke to do.

Emphasising the difference between expectation and their experience was a common theme within the data corpus, as was the enthusiasm for speaking about it with others. Having spoken of taking a long time to get the operation performed (as also discussed in Chapters 6 and 7), Chad argued that it was the comparative 'pathetic' nature of the operation that motivated him to now speak of it to others. Advocating for the ease of the operation was presented as a necessary function of 'making up' for his own delays.

When reflecting upon the time that it had taken them to get the operation, many of the men's accounts often had a 'sheepish' undertone attached to having made such a 'big deal' prior to getting it done:

Antony: it was very simple it was five o'clock after f- after work on a Friday in and out and back home by half past six seven o'clock it was (laughing) no major hassles but ah yeah I think it was procrastination for procrastination's sake I think.

This retrospective analysis of the decision making process as "procrastination for procrastination's sake" suggested that the time before the decision and "hassles" leading up to it were unnecessary. Antony's use of a specific time constructed vasectomy almost as a small part of a day's work, a simple task that bore no comparison with the amount of time and potential effort put into deciding.

This sort of formulation occurred frequently within the interviews, as did articulations of surprise:

Mike: I've found (.) I was quite surpr-, I found the operation, I wouldn't even call it an operation actually, I found, whatever, that it was, hardly intrusive, very easy, bit of a, bit of a laugh.

Reference to surprise at the 'lack' of intrusiveness of the operation shows some reliance upon the rhetoric of there being enough difference from his 'expected' to 'actual' experience that he could consider it a "bit of a laugh". While there is no question that having a vasectomy is *minor* surgery (Aradhya, Best, & Sokal, 2005), it is still nonetheless surgery.

What this might suggest, is that rather than being an objective evaluation of the procedure, Mike's version of events (like many of the rhetorical strategies Chad used in Chapter 7), was serving a purpose for that particular moment in the interaction. In Mike's case, we had just discussed the possibility that many men might feel pressured into having a vasectomy; perhaps to alleviate any threat to his masculine identity, this minimisation was necessary.

Discussion

Many of the men commented that talking about the vasectomy was a novel experience for them (compounded by the interview itself being a relatively unusual experience), and as such, the process was fraught with risk (Schwalbe & Wolkomir, 2003). In order to manage this, several strategies were used by many of the men: first, comparing the self with others in order to appear ordinary, or alternatively to appear extraordinary; Second, reference to several layers (or versions) of the 'self', which struggled with each other in the process of deciding to have a vasectomy; Last, minimisation of the operation itself, which helped to 'reset' any risk of appearing too masculine, unmasculine, too heroic or not heroic enough. All of these strategies appeared in different ways across all of the interviews and may thus be indicative of masculine sense-making (Edley & Wetherell, 1997, 2009; Wetherell & Edley, 1999, 2008, 2009).

Oudshoorn (2004) has suggested that "people construct collective identities based on a shared experience with specific technologies – in this case contraceptive technologies" (p. 353). As I have discussed, talking about vasectomy provided a forum for men's accounting for being both masculine and embodied. While vasectomy is far from new as a technology, its high uptake in New Zealand is a relatively recent phenomenon (Sneyd, et al., 2001). For the men involved in the study, especially among those following a 'typical trajectory', the vasectomy acted as a technology around which various (but shared) forms of meaning-making developed. The men relied on various culturally available resources which enabled them to speak relatively fluently about having a vasectomy and its

meaning to them. Yet at times the use of these resources often resulted in ideological dilemmas (Billig, et al., 1988) and other problematic factors that the men had to attend to. Redman (2001) has commented that 'heterosexual masculinities—like all social identities—can be viewed as deeply relational and struggled over, involving intricate assertions of likeness to and difference from key social others, assertions that are sometimes affirmed and sometimes contested' (2001, p. 189). This appeared to be the case with the accounts in this chapter, as men spoke about themselves and their decision, by making reference to the differences between their own masculine identities, those of 'imagined' other men, and even between multiple imagined 'selves'.

The meaning-making related to the decision making process and the operation's aftermath, also seemed to draw from multiple expressions of masculinity rather than an easily categorised 'type'. In contrast to Connell's (2005) clear cut presentation of 'dominant', 'subordinate' 'complicit' and 'resistant' masculinities, the men in this study, when making sense of the decision making regarding their vasectomies, would often blend these various forms, making reference to themselves, expectations of the self and the selves of other men. Even as the men were explaining the ease of actually having a vasectomy, and how this decision impacted upon them, they were also managing the 'hurdles' of different and sometimes competing masculine values that meant they had to hybridise, refer to and build from different imaginary positions. This was a careful balancing act, as appearing *too* heroic might produce incredulity, and not being heroic enough might mean they appeared in a negative light. What was apparent was, in a similar fashion to Wetherell and Edley's (1999) findings, the imaginary position of 'being an ordinary guy' was constructed by most men as the default to which they seemed to be invested in aligning to. By shifting between various (shared) strategies the men were able to 'make sense' of their vasectomy in the novel context of the interview and keep returning to this 'default'.

Also common were somewhat reflexive references to expectations concerning masculinity (theirs and others) which were deployed to demarcate their own expression of masculine identity. This was usually managed in a way which suggested that, while not dominant, traditional masculine distancing from the reproductive arena was still an ongoing factor in these men's decision-making processes. On that basis, some reference was made to the 'difficulties' that are encountered by 'becoming involved' in reproduction/contraception, in ways that historically men have not. In this way, while perhaps not hegemonic in the sense of being idealised or expected (Connell, 2005), the masculinity the men spoke of seemed to 'demand' an answer, even if that answer was negative.

As a product of this, 'newer' expressions of masculinity seemed to be coming to the fore in the men's talk as they spoke around sites historically demarcated as 'feminine', such as reproductive concern (Oudshoorn, 2003, 2004). In this way, the language used showed a lot in common with notions of the 'New Father', or the involved, active male parent who at least at face value is invested in the emotional wellbeing of his children (Ranson, 2001). While such masculinities are not necessarily transferring into wholesale material changes for women (see for instance Johansson & Klinth, 2008; Ranson, 2001; Renshaw, 2005; Wall & Arnold, 2007), what is evidenced in these accounts is the potential for some shifting in the way men are talking about these kinds of social sites, let alone the fact that they are speaking about them at all! These sorts of accounts add to the available cultural resources men draw upon in the formation of masculine identity, not only in terms of the content they reproduce as their own, but also shared strategies for doing so.

Summary

In much research on vasectomy, the focus has tended to be on the decision making process for individual men (e.g., Amor, et al., 2008; Mumford, 1983). Often men are constructed as self-contained, rational individuals making such decisions *for themselves*, as opposed to being a part of a couple or from within a broader social context. Knowledge about the operation is thus considered

imperative to making a 'good decision' (Balde, et al., 2006; Mumford, 1983). What has been evidenced in this chapter is that talking about the operation provided an opportunity to make sense of the self and decision making processes in relation to currently dominant forms of masculinity. It is not as simple as being complicit with one form of masculinity or another however; it is a highly relational, contextual and struggled over process that forces men to draw from often inconsistent and unstable strategies to discuss.

Chapter 9: “Sticking my finger up at evolution”: Unconventionality, selfishness, resistance and choice in the talk of men who have had pre-emptive vasectomies

“Having children is not just a personal, private decision: it is also a public act, fundamental to the perpetuation of the species in the society we live in. Births and deaths connect each of us individually, and all of us collectively, with the unknown, with the past and future, in ways which no other human actions can” (Cameron, 1997, p. 193).

Vasectomy, to this point in the thesis, has been discussed in regard to the men who followed a ‘typical trajectory’ for the operation, or: “suddenly bang one day there’s commitment with a woman and then suddenly bang there’s children and... bang there’s a vasectomy and it’s bang you’re getting old and it’s bang you’re retired and it’s just another one of those steps in life” (Antony). There were, however, a number of men who participated in this study who had decided to hurdle over the “bang there’s children” point in their life course, and move straight to the vasectomy. These men chose to have a vasectomy ‘pre-emptively’, to avoid having children at all. As discussed, men who underwent a vasectomy in more ‘typical’ circumstances tended to treat it as a somewhat heroic act, describing making the decision out of a sense of responsibility for contraception and an interest in the welfare of their partners. This second group (the ‘pre-emptive’ group)²² seemed to follow a very different line of self-description when speaking of their reasons for vasectomy and it is to their accounts to which this chapter turns.

²² There is some difficulty in ‘labeling’ this group fairly and yet without becoming too cumbersome. While I have some reservation with the terms ‘pre-emptive men’ or ‘pre-emptive group’, I will use them on practical grounds to distinguish them from men following a ‘typical’ trajectory.

This chapter, as discussed in Chapter 4, uses an approach to discourse analysis informed by feminist poststructuralism (Gavey, 1989, 2005). Within it I am interested in the power of *discourse* to make certain 'ways-of-being' or *subject positions* available (Allen, 2003). In the 'spectrum' of discourse analysis Wetherell (1998) has proposed, the analysis in this chapter is at the opposite end to the analysis performed in Chapter 7, more interested in the global than the fine grained, in discourse than rhetoric. By discourse, I refer to "organised systems of statements that provide the socially understandable ways, or rules almost, for talking about something and acting in relation to it....Discourses are multiple and offer competing, potentially contradictory ways of giving meaning to the world" (Gavey, 2005, p. 84-85).

Subject positions are those configurations of particular discourses that constitute a person's 'selfhood' or experience of the world; they are the way in which the social becomes 'individual'. Subject positions may be 'taken up' or 'resisted' depending on a number of factors (including exposure to 'alternative' discourses and subject positions), but are generally considered a limited number of 'self-expressions' that people have available to them at a particular time and place (Davies & Harré, 2001).

The position of the 'kiwi bloke' can be described as a subject position (although when used as a caricature or a point of departure, Wetherell and Edley's (1999) notion of the 'imaginary position' also applies). Bound tightly to historical and cultural narratives about the ways men 'are' and 'should be' in New Zealand, the kiwi bloke is defined by 'hardness', drinking, rugged independence, homophobia and sport (Allen, 2007; Phillips, 1996; Terry & Braun, 2009). While this subject position is now 'on the wane' (Phillips, 1996) it still has significant power in shaping men's experiences of being men in New Zealand and is still 'taken up' by a number of them.

Another subject position, one that is perhaps less understood than many others, is that of the voluntarily childless (or to use the term preferred by the individuals involved, childfree) person. Research on people who identify themselves as childfree is relatively sparse, and this is especially so in relation to men (Halford, 2006). Even among this group, it is quite unusual for a man to take the 'final' step of having a vasectomy (Lunneborg, 1999). Somewhat recent work has indicated that less than one percent of vasectomies in New Zealand are 'pre-emptive' (Sneyd, et al., 2001), which suggests that such a permanent solution to a decision to be childfree is still unusual. It is also perhaps a decision that has the potential for a sense of marginalisation from the general population due to social structures that privilege those who have children.

Certainly, much of the emphasis of existing research has tended to focus upon the marginalised status and sense of stigma among the childfree (Callan & Que Hee, 1984; Campbell, 1999; Gillespie, 2003; Halford, 2006; Lunneborg, 1999; Magarick & Brown, 1981; Mawson, 2006; Park, 2002; Rowlands & Lee, 2006; Somers, 1993). One of the earliest studies with men who had had pre-emptive vasectomies focused on the question of whether they tended towards social or personal 'pathology' (Magarick & Brown, 1981). The authors concluded that these men fit within the 'normative range'; however, they noted that they were less traditional and placed more value on relationship with their partner and a greater interest in flexibility of lifestyle than men with children. Although these sorts of attributes are not particularly stigmatising, the whole study was driven by concern about the 'differences' of childfree people, especially those that go through the process of sterilisation. This shows some connection to research that has focused upon gay and lesbian parenting, where there is often an assumption of an essential difference between heterosexual and same-sex parents (Clarke, 2002). Clarke (2002) has noted that while there is some strategic value in such formulations: "Difference arguments are often also misinterpreted and achieve the undesired effect of providing ammunition for anti-lesbian/gay claims" (p. 218). The same might be asked of

research with childfree men who have vasectomies: why is difference often expected rather than similarity, and who gains from these assumptions of difference?

Pronatalism and the 'new father'

Post-structuralist theorising has suggested discourses maintain the status quo through the exercise of power (Willig, 2001). Dominant discourses establish what is hegemonic or 'commonsense' through their entrenchment within discursive fields such as the legal system, religion and the family. As they legitimate existing power relations and structures by defining what is 'normal', 'alternative' or 'oppositional' subject positions are not usually perceived as desirable or even possible (Davies & Harré, 2001). Subject positions are formed within the context of discourse, with some of these discourses being more dominant than others. What is dominant is portrayed as 'natural', and this is certainly the case when it comes to heterosexual couples and having children. While there is a 'grace period' for people in heterosexual relationships, becoming a parent is constructed as the normative life course in the 'developed' West. Nentwich (2008) has noted, however, that even for couples who choose to have children, experience is both constrained and produced within the relatively limited discursive field created by the disciplinary action of pronatalist, heteronormative discourse.

'Pronatalism' is an ideological stance with hegemonic status, which encourages reproduction, exalts the role of parenthood, and has traditionally been a prevailing influence on newly married couples in American and other Western societies. Baker (2005) has commented that:

"Social research clearly indicates that procreation is considered intrinsic to heterosexual marriage, gender identity and a 'normal' life. Researchers have found that most parents see pregnancy and childbirth as a natural outcome of adulthood and marriage rather than a conscious choice" (p. 524).

Not just restricted to more conservative notions of 'marriage', the suggestion that heterosexual (and increasingly many gay/lesbian) men and women both expect and are expected to be parents at some stage in their lives is both 'normal' and expected. Prior to the mid twentieth century, the option to delay or limit having children was somewhat limited due to lack of contraceptive technologies, and certainly the option of *choosing* not to have children is even more recent a phenomenon (Campbell, 1999; Lunneborg, 1999; Rowlands & Lee, 2006).

Pronatalism not only exists in the more invisible and taken for granted assumptions that are hallmarks of hegemony, but is also evident in government initiatives and incentives, especially in countries concerned about 'low replacement' (e.g., 'baby bonuses' in Germany and Australia). One of the more recent developments of this powerful discourse is the way many men in the West have become positioned in relation to it, through the increasing power of the 'new father' subject position (Johansson & Klinth, 2008; Ranson, 2001). This position, which lies at the intersection of pronatalism and discourses that inform socially valued expressions of masculinity, is a relatively recent construct that emphasises the notion of men's engagement and involvement in child rearing (as discussed in Chapters 3 and 6).

Ideologically at least, the new father position has joined the 'breadwinner' position, which defined fatherhood up until the (relatively recent) past (Ranson, 2001). The breadwinner position drew from discourses that made it more unusual for men to 'opt-in' to engaged parenthood (i.e. fatherhood is best experienced through provision). This traditional model of fatherhood was of an emotionally distant provider, whose career advancement through hard work, long hours and loyalty was considered integral to the wellbeing of his children. While this sort of subject position still underlies many men's experiences of being a father (Johansson & Klinth, 2008; Ranson, 2001; Wall & Arnold, 2007), the new father position has the potential to significantly shift the way men experience being

fathers, to more align with the social expectations constructing women as carers and nurturers (Gillespie, 2003). This position might also impact upon how men who cannot be fathers or choose not to be fathers articulate their experiences. While men in the West must respond in some way to pronatalist discourse due to its power, the story of a man who has a vasectomy when he has no children might provide a counter-narrative to these dominant discourses that normalise the nuclear family and the normative life trajectory of many men.

Despite its growing pervasiveness ideologically, the new father has yet to completely supplant the remaining power of the 'breadwinner' subject position. It has been described as reflecting a cultural rather than a conduct shift (Wall & Arnold, 2007) that gains a man esteem rather than necessarily benefitting his female partner. Research in the area (e.g., Everingham & Bowers, 2006; Johansson & Klinth, 2008; Nentwich, 2008; Wall & Arnold, 2007) has consistently supported Ranson's (2001) statement that "those who were more willing to challenge workplace demands directly to be more involved fathers, were also the ones who had fulfilled their career goals, who had 'arrived'" (p. 24) and what Hochschild (2003) has referred to as an 'economy of gratitude' – where any involvement by men in childrearing and domestic duty is met with praise and value far above the contributions made. These sorts of tensions and fissures in the dominant status of this approach to fatherhood are of particular interest when discussing men who have rejected fatherhood in apparently any form.

Deficit Identity or resistance to the status quo?

In research on singleness in relation to 'couple culture' – another phenomenon that disrupts normative notions of heterosexual life trajectory – Reynolds and Taylor (2005) developed the concept of deficit identities. These are positions of selfhood within a person's narrative that can be recognised by what they are *not* rather what they *are*. In Reynolds and Taylor's (2005) work with single women they noted that:

“What is common to the varying definitions (chaste, divorced, never-married, childless, not co-habiting) is that they state what the single woman is not: not sexually active, not married, not a parent, not living with a partner. It is a deficit identity, defined by lack and by the shared conception of single women as outside normal family life and ordinary intimate relationships” (p. 198-199).

Orthodox expressions of masculinity are inevitably tied to fatherhood (Connell, 2005; Donaldson, 1993) and so to choose *not* to be a father may well similarly be constructed as a deficit identity. Foucault has argued, however, that: “as soon as there’s a relation of power there’s a possibility of resistance. We’re never trapped by power: it’s always possible to modify its hold, in determined conditions following a precise strategy” (Foucault, 1980 as cited in Allen, 2003, p. 216), so it is possible that not having children and finalising it through the act of a vasectomy might just as well be constructed as ‘resisting’ the status quo. How a man who has had a pre-emptive vasectomy might frame his choice (or even that it was a choice at all) is dependent on more than one dominant discourse. Men who have vasectomies, with children or without, take up subject positions within a discursive environment that is funded by neoliberal discourse as much as it is pronatalist. The notion of the rational, autonomous, choosing social actor has been readily taken up readily by Pākehā in New Zealand (Hodgetts, et al., 2004) and would likely inform any subject positions available for men in this category.

This chapter is based upon accounts of 12 men talking about the decision to not have children, and about making this decision permanent through sterilisation. Data were analysed thematically initially, with follow up analysis with an eye to the shared systems of meaning making and cultural resources used by the men to make sense of their choices. From this analysis a broad and often repeated pattern of self-description was noted, marked by three features, which did not always co-exist but occurred enough in concert that their interaction with one another was clear:

- A willingness to identify themselves as being either selfish or somehow lacking the 'character' to have children – a 'deficit identity'. This was expressed in a variety of ways, with some presenting traits such as selfishness in a positive light, others treating it as a flaw.
- Identification with a lifestyle that is unconventional or quite different from what is considered a normative life-trajectory by 'society'.
- Highlighting or emphasising the inability of people to easily understand their choice not to have children.

Each feature will be discussed in relation to the discourses that it is drawn from, what Foucault (1977) has referred to as the cultural conditions of possibility (see also, Gavey, 2005), or the ability to speak meaningfully about certain ways of being and acting. Broadly, this discussion will focus on the intersection and relationships between pronatalism, neoliberalism and masculinities. Some attention will be drawn to the relationship between having a pre-emptive vasectomy and the (becoming) dominant masculine subject position of the 'new father'.

Selfishness and sterilisation

In the limited research that has been done on the choice to be childfree, one of the more common criticisms many express experiencing from others is that of an individualistic self-centredness or selfishness (see for instance Gillespie, 2000; Halford, 2006; Lunneborg, 1999; Rowlands & Lee, 2006). Therefore it was not surprising that one of the most common responses from the men when asked to describe themselves, was to follow this 'party line', referring to themselves as 'selfish' or 'self-centred', typically placing emphasis on 'flaws' in their own character as the basis for them not becoming fathers. Recent research with childfree women, has also similarly reported that the negative attributions associated with the choice came from the women themselves (Carmichael & Whittaker, 2007). Stan exemplified this pattern with the following:

Stan: um, I suspect that I'm quite a selfish person really and so, I just, I like to please myself and I have a very full and busy life [GT: mmn] and um a lot of the things that I do if I had a family I would certainly wouldn't have been able to do them in the early years and even in the later years I think it would I think it would have it would have restricted me even with sort of with teenage (.) kids [GT: mmn] so I suppose that that would be, that it it's so it's part of yeah a commitment thing that I would shy away from [...] some of the more mundane things of having young kids around um dirty nappies and vomiting on the carpet [GT: mmn] um having a house that's very untidy [GT: yeah] it's something that um that that would drive me crazy.

The taking up of such 'deficit identities' (Reynolds & Taylor, 2005) is relatively common in situations where identities are formed in resistance to dominant discourses (in this case pronatalism). Rather than problematising any social pressures to have children (although this happened occasionally), often men like Stan seemed to simply picked up the descriptors *stereotypically* used to describe the childfree.

Many 'lifestyle choices' are framed as being made in the name of self-fulfilment or self-improvement (Rose, 1996), however, the choice to be childfree, let alone 'clinch' it with a vasectomy, was one that Stan associated with moving beyond self-fulfilment into selfishness. On one hand the cultural resources he had to describe his choice were ones drawn from within a pronatalist context, which have a tendency (as discussed above) to associate having children with selflessness and as contributing positively to society (needed to motivate couples because of its difficulty and 'unnaturalness' for many perhaps!). On the other hand, as with almost all identity work within a neoliberal context, a (self) interest in presenting himself as unique, individual, self-defined and as autonomous as possible was also at play (Rose, 1996).

Stan's account drew the focus onto the 'weaknesses' in his character and portrayed the difficulties and stress of having children as beyond his personal resources. This framing of his relationship to children is particularly interesting when analysed in relation to the development of the relatively recent 'new father' subject position over the last two to three decade (see, for instance, Ranson, 2001). As discussed in the introduction to this chapter, ideologically (if not necessarily in practice), this position has a high degree of imaginative power in shaping the qualities of 'fatherhood' that are expected of men contemporarily. What seemed to be at stake in Stan's case is not so much reproduction or biological fatherhood, but rather the way he would be expected to father a child in relation to this reproduction. Being an engaged 'co-parent' was what Stan seemed to be resisting, as it would draw him away from activities he enjoyed.

Many of the accounts of men who had pre-emptive vasectomies worked like this, highlighting the huge impact a child would have upon their lives and their interest in avoiding such an impact. The taking up of this sort of position has some potential to denaturalise parenthood through offering an 'alternative' to the 'normal' adult trajectory. However, it relied heavily on gendered notions of parenthood in order to work particularly well. Due to the highly gendered nature of child rearing, men's choices to be childfree do not seem to evoke the same sorts of challenge to pronatalism, as women's do. Nurture and care for others are often constructed as feminine attributes, as is an investment in eventual motherhood, which is "still considered to be a primary role for women and women who do not mother either biologically or socially are often stereotypes as desperate or selfish" (Letherby, 2002, p. 7). Letherby (2002) goes on to argue that men are not subject to the same discursive pressure that women are, with fatherhood unlikely to be as key to a man's identity as motherhood is to a woman's (see also, Parry, 2005; Ulrich & Weatherall, 2000).

In Stan's account it seemed relatively easy for him to identify with a lack of ability, or with having the wrong temperament. However, research has suggested that for many childfree women this is harder to do when explicating their choices (see, for instance, Gillespie, 2003). Stan could work within a framework of 'I'm just not good at that kind of thing' because this sort of discursive resource is much more available to men (fathers or not) than women, when it comes to the issue of childrearing (Sunderland, 2002). It showed some similarity with the gendered nature of the 'singleness' subject positions of the 'swinging bachelor' and the 'sad spinster' of previous generations, and also to similar arguments used by men to justify imbalances in domestic share (Sunderland, 2002).

Many of the men in the pre-emptive trajectory group made reference to difficulties of raising children, for example:

Tony: it looked like, you know, just a big financial hassle and, um, and judging from the kind of hassles that I'd given my parents, it looked like it was going to be an emotional hassle as well.

Johann: if they're really young or when they're really noisy (laughs) or [...] if you have to live with them twenty four twenty four hours a day, that's really what scares me.

Other men made reference to the prospect of unwelcome change and loss being a factor in choosing to have a vasectomy:

Steven: I see people's lives you know dramatically affected by having children um and for me it's not something that that appeals, or has ever really appealed.

Geoff: I mean fine, I'll get married and all that sort of thing and that's *not losing myself for something else*[...] but we're talking about such a radical life change and I don't think honestly that I could deal with it (italics mine).

Almost all of the men referred to themselves as selfish at some point to 'explain away' why they were unable to engage in dealing with these difficulties. These sorts of accounts also stressed the 'mundane' nature of raising children, and subtly placed their own lifestyles and sense of self as superior to that of parents. Their 'selfishness' allowed them to avoid the noise, dirty nappies and opportunities to do the things they wanted and that made their lives 'better', or less mundane, than those of parents. Many of the men made a point of commenting that they liked children, it was simply that they liked their current lifestyles *more* than any pressing need to reproduce. Steven, who described his leisure time as defined by 'gaming', commented:

Steven: you know mum dad and feedings [GT: mmn] and cleanings and that for me would just drive me round the twist [GT: mmn] I can understand how Brooke Shields [got] post natal depression and has to deal with it with drugs [GT: (laughs)] it'd be like I'm sitting there and I'm shooting down the aliens and the kid cries and it's like bugger it I don't want to hit pause.

For Andrew and his partner, it was not that they could not afford children, or did not like them, but rather that it would become a financial sacrifice to have them. Again, rather than being explained in light of children just not fitting into their particular lifestyle aspirations, the issue of selfishness is again raised:

Andrew: In the t-twenties and thirties it was, it was a, it was an absence of the decision [GT: mmn] um it was just not a decision we (.) we made I suppose at the back of our minds the possibility was there if we changed our minds [GT: yeah] we could do it but financially it was never an option it would have been too big a sacrifice [GT: mmn] and when we did discuss it my wife said no she's just too selfish [GT: yeah] we'd have to give up the money and the lifestyle.

Some of the men, however, made it quite clear that a large part of their reasoning for not having children was their dislike of children. Neill stated:

It's clear in my conversations and my reactions whenever I see a child... I have a fair level of disdain for them even being in my presence most of the time.

He went on, however, to use the same sort of 'selfishness' self-positioning as the other men to justify his lack of willingness to tolerate them "in his presence":

Neill: I'm a selfish person, and I know it (laughs) I have no desire to share anything with children [GT: mmn] and (.) (inbreath) yeah, no it was a pretty clear cut I just didn't want to have them, I had no space in my life for [...] uncontrolled objects around me which is (.) children seem to be the most uncontrolled.

In Neill's description of his reasons, his vasectomy was intrinsically tied to his lack of interest in sharing his life with children who he "disdained". While his tone did not carry the same sense of focussing on his 'flaws' as Stan's did, and had nothing positive to say about children (or contemporary modes of parenting), he still positioned himself and his choice in light of the selfishness trait. Strategically, Neill could well have chosen to maintain a focus on the negative attributes of children in this self-presentation, however, it is likely that the dominance of pronatalist, pro-child discourse within Western society is such that even a person who is repelled by children 'needed' to explicate this rejection of children in terms of 'being selfish'.

References to more altruistic or global concerns as explanations for their vasectomy were relatively rare in the interviews. While climate change and overpopulation were noted from time to time, usually this was done (relatively reflexively) as a post-operation justification, to help explain their decision to others in a way that was more likely to be socially acceptable. For the most part, however, explanations tended towards individualised accounts of choice, personal agency and freedom.

The 'selfishness' formulation seemed to rest upon two almost contradictory ideas: first, child rearing was framed as being inherently positive. Those who *do* have children are constructed as doing so purely for altruistic reasons. Second, it was relatively common for the men to comment on their friends who chose to have children isolating themselves and getting caught up in the task of parenthood, and not enjoying their 'previous' lives. The men often spoke of their "breeder friends" (Don) having "baby brain" (Steven), being "different" (Neill) after the birth of a child, or having their lives "dramatically changed" (Stan). Thus, the issue became whether the man (or couple) wanted to 'contribute' or to maintain their current approach to life. Occasionally, possibly as an outcome of this dilemma, counterarguments were developed by the men that seemed to be attempting to turn many of the common tropes about the childfree on their heads. For instance, Jeremy commented:

Jeremy: I've always, in the back of my mind, I've thought having your own kid is kind of a bit of an ego thing a bit of a selfish thing you want to see a little part of yourself in that little person [GT: mmn] you know you want to kind of replicate yourself [GT: mmn] and you know you want to shape this person to be like you sort of thing [GT: mmn] so it's almost a you know selfish ego thing.

While there is potentially some value in making such counter-hegemonic statements, because such statements might operate in a way that challenges the dominant status of pronatalism, these occurrences of 'resistance' were typically built from the same discursive resources as the statements typically used to 'vilify' the childfree. Rather than being statements of the positive values of not having children, or even a degree of indifference to expectations of 'society', some of the men felt the need to go on the counterattack, and used the same sorts of discursive tools used to 'attack' those who do have children. Neill provides another example of this sort of approach:

Neill: they'd always go, but what if you change your mind and you want to have children? [GT: mmn] and I said to them if someone came to you and said they were pregnant would you

ever say to them what if you change your mind and you don't want children? [GT: mmn] of course not you say congratulations on the choice you've made.

Both of these counter-arguments (that people with children are *more* selfish than those without and that people may regret having children) do much more than (just) challenge the dominant nature of pronatalism, they also highlight the self-positioning of these men as *different*. Resistance to normative pressure to have children is thus associated with difference from the mainstream, which, in this case, can be assumed to be those people who have children, want children or have never questioned that they will have children.

Unconventionality as 'positive'

Another way many of the men framed their choice to have a pre-emptive vasectomy was through their situating themselves as generally different from the 'masses'. Reference by the men to themselves as 'unconventional', 'different' or 'outside the norm' was common throughout the interviews. For instance, Jeremy commented on the ways in which he differed from the "average kiwi bloke". The subject position of the kiwi bloke (as discussed in Chapter 3 and the introduction to this chapter) is a fairly common identity that New Zealand men can identify with, articulate as a point of departure, or even do both (see Terry & Braun, 2009). It is New Zealand's expression of 'traditional' or 'retributive' masculinity (Rutherford, 1988), an investment in times when men were really men, and currently symbolised by individuals such as former All Black (rugby player), Colin Meads or iconic 'hard man' characters used in advertising such as Barry Crump or the Speight's Southern Man. In this case, it provided Jeremy with a way of demonstrating his choice to have a vasectomy as one that was unusual or unconventional. When asked to describe the type of person that has a pre-emptive vasectomy he replied:

Jeremy: you know I'm just in lots of ways I'm not really into um sport and stuff like that [...] I'm not really a sort of New Zealand blokey sort of guy I'm I'm more into sort of um I don't know

mental pursuits and um you know more into thinking about life and that [GT: mmn] rather than just getting pissed and watching the rugby and [GT: mmn] and shagging [GT: yeah, yeah] you know it seems to me there's more to life than that [GT: yep] so I definitely don't fit into the into the male stereotype (laughs) [...] yeah I think I'm probably pretty unconventional maybe a bit strange you know but that's cool.

Neill noted (apparently contradictorily) that he was more proactive in being a "promoter" of vasectomies to men who have had children than to those without. This was because he felt only a very small number of people could make the same decision he had, commenting: "I think you have to have a unique (.) way of... understanding of yourself to go that way". This sense of uniqueness was qualified further by his later suggestion that many men who have children have vasectomies because they are pressured to ("nagged at for three or four years"), a marked difference from the presentation of his own self-motivated and directed choice. Neill suggested that the 'drivers' that motivate him in contrast were 'selfish', and that because of this he had nothing in common with the 'typical' men except the specific operation used.

Many of the men also made reference to the 'conventional' people around them, marking out their own difference in opposition to Others. Some men, like Geoff, simply noted that no-one else in his office was like him: "most are married, most have children, the ones that aren't married are either young [or] single and have decided not to settle down yet". Others like Andrew referred to a 'conventionality' around him that was in stark contrast to his own 'lifestyle choices' and then went on to discuss what was particularly unconventional about him and his wife:

Andrew: well maybe because I like to think, I suppose [GT: (laughs)] (laughs) I retired at forty five [GT: yep] um, I chose to live remotely out of the way to, um, living a semi self-sufficient life. Although we're not fanatical about it [GT: mmn] um, there's a little bit of survivalism there I would think [...] but we're not Greens [GT: yep] um, I think the Green ethos is one or two

children full stop [GT: mmn] but I wonder about that [GT: yeah] replace yourself and leave it at that, but there are more and more people replacing.

Andrew contrasted his own lifestyle choices with those of the “conventional, married with children” group, emphasising his isolated-ness with reference to “survivalism”. Andrew and his partner lived outside the main in many ways, a point that was highlighted when he lost power during the (telephone) interview, an occurrence he described as “not unusual”. He was explicit, however, that this ‘semi-sufficient’ lifestyle did not make him a Green Party supporter, as he defined such people as being still being inclined to have children, a factor which apparently lends a quality of the ‘mainstream’ or conventionality to them. He argued that his lifestyle was only possible because of the choice not to have children, as he and his wife were able to retire young. Other men commented along similar lines:

Jeremy: the other thing is I’ve done a lot of investing and that sort of thing, so for a couple of years I haven’t actually worked, I’ve just been kind of retired [GT: yeah yeah] so people find that really odd as well so I’m totally out of the mainstream really [GT: yeah] just recently I’ve got back into work again but um yeah no I’m not your average sort of person I think.

Precisely because of the statistically small number of men choosing a childfree life and an even smaller number who have a pre-emptive vasectomies, men in the interviews seemed to be adopting positions of resistance to ‘society’ in general, and used stereotypical notions of the ‘mainstream’ or the ‘conventional’ in order to position themselves. While only a few of the men were able to retire early, or at least had the capacity to do, many of them described their lifestyles as vastly different in comparison with ‘the rest’ of society who could not make the same sorts of choices as them. In Jeremy’s case, he was able to make investments with funds that he suggested would have been tied up in the child rearing process or more conservative options if he had chosen to be a father. Through periods of hard work, long hours and a lifestyle that was not ‘child-rearing friendly’ he was able to have longer periods where he could focus on his personal project of self-improvement. Jeremy

emphasised that many people just ‘fall into’ the process of having children and the financial difficulties that can occur with reduced incomes. He commented, relying on a particularly neoliberal rhetoric:

Jeremy: you know people have the power to create their own lives and do what they want with it and [GT: mmn] and you know if you find yourself in a crappy situation then you- you’re able to get yourself out of it, you know. People aren’t just victims.

In contrast to Andrew, Jeremy and others, Tony framed his choice to not have children as arising from his lifestyle rather than vice versa. There was little room for children in the way of life he had chosen, a suggestion he gave some evidence for by describing communities of like-minded people that he had been a part of:

Tony: My collection of friends was, was, was kind of more the educated, uh, people, people who were artistic, people who were, ah, unconventional [GT: yeah] a:and, um, a lot of those people actually, um, didn’t, didn’t have kids [...] they’ve always been really well educated (.) people, or, you know, super adventurous types, like, you know, I, um, I basically (.) moved onto a sailboat when I was in my late thirties and cruised around the world for seventeen years on a boat [GT: mmn] and, um, you know, most of the people that I met on boats, they didn’t have kids [GT: mmn] or if they did, they, the kids were grown up.

Tony, like Andrew, emphasised actually living on the *physical* fringes of ‘mainstream’ society, initially in a rural community, later amongst people who chose to live on sailboats. In contrast to Andrew’s description of a much more personal unconventionality, Tony talked about being on the fringe within the context of communities of like-minded people. The types of people who lived within this type of community, people Tony depicted as his friends, are not only unconventional but also “really well educated, or... super adventurous types” with the implication that these people (and clearly himself) choose this life of unconventionality precisely because of their education and adventurousness. Several times throughout the interview, Tony emphasised that children would undermine the enjoyment of this lifestyle and were, in fact, contraindicative of a certain level of

education. This group was framed as being among the 'cream' of society, but marginal because of their lack of interest in "settling down" and having children in a similar fashion to the majority of heterosexual couples.

Unconventionality, across the interviews, was almost always framed within a positive light. These constructions made much of being childfree as a state of choice and, for the individuals involved, a capacity to extend themselves beyond the normal or average person. The 'average' person in this construction simply followed along with whatever construct the interviewee relied on to explain the 'way things are'. In Andrew's case, this extension of self carried through to resisting the very 'pressures' of 'evolution':

Andrew: (laughs) I can, how can I best put this, yeah, it was (outbreath) in a sense, me, sticking my finger up at evolution [GT: (laughs)] no, not evolution, ah (outbreath) at life [...] as I've grown older, I've become much more aware [...] of the sex drive as a (outbreath) as a manipulation [GT: mmn] it's, you know, if you like, in quotes, life doing its thing [GT: mmn] but it's, using evolution, using organisms as a tool, that kind of thing, I've always vaguely resented that [GT: (laughs)] and I was aware it, when I had the vasectomy I was, I was quite aware of slipping (unclear) there, you know (.) it's p-putting the fingers up at the gears of evolution (laughs) [...] me saying you know "take that!" [both laugh] evolution [GT: yep] you're not manipulating me anymore (laughs) it's my revenge.

Andrew portrayed the processes of evolution as a machine that uses humankind as a vehicle for the continuation of life²³. He uses machine imagery to describe the way life forces itself upon humankind while simultaneously anthropomorphising it as something that can be resisted, challenged and even mocked ("take that!"). Andrew's account suggested that he and his wife, through the act of having a vasectomy, were finally able to step outside (or at least provide enough distance to give evolution the finger) what has largely become understood as the 'natural order'. He thus established himself

²³ He borrowed quite openly from Richard Dawkin's (1976) notion of the selfish gene for this account.

as unique, somehow different from the majority of humanity by being able to resist this global, powerful and natural force. Andrew and his wife managed to offer this resistance by not falling for evolution's 'manipulation' by having children, but in order to do so, had to manage his 'unruly' body, which still had the potential to be 'used' by evolution (in terms of his 'sex drive') – hence the vasectomy.

This portrayal, however, as it was in almost all of the other men's, across all groups, relied heavily on dominant discourses that define penetrative sex within intimate relationships as both 'natural' and difficult to question. These discourses normalise coital sex as the only 'real sex' and have been ratified more recently by the hegemonic status of socio-biology and evolutionary psychology (Gavey, et al., 1999; McPhillips, et al., 2001). Such heteronormative discourse was pervasive in Andrew's account, where his description of 'evolution' presented it as a force which naturalises heterosexuality and in particular heterosex through coitus.

Not having children, while a minority decision among heterosexual couples, is still common enough that exposure to, and deployment of, a 'resistance discourse' was a viable option for Andrew. Challenging the essential aspects of heteronormativity (i.e. coital sex), however, was seemingly too naturalised to allow for the same type of resistance. This was a prevalent feature of the interviews with all of the men in this research project: the power of heteronormative assumptions and rhetoric to make it invisible and unchallenged, even by those describing themselves as 'unconventional' and 'different' (see Chapter 10 for more discussion).

All of the men's accounts of difference and unconventionality also relied heavily on a neoliberal (individualised) discourse of choice (Budgeon, 2003; Rose, 1996), heavily emphasising the man's own unique capacities as enabling this choice to occur. The vasectomy was constructed as both enabling, and being enabled by, choices that the majority of people were not in the same position to make, or

even comprehend. The next section deals with this latter construction, which further facilitated the men's self-positioning as unique, unconventional and stigmatised.

The construction of the 'incredulous' or 'resistant' Other

While the men who chose to have pre-emptive vasectomies generally expressed satisfaction with the decision and the life it had provided them, another common theme was of the men describing having to deal with people's reactions to their operation. This sort of reporting seemed to work to allow the men to locate themselves and their choice in relation to the 'rest of society'. Many of the men referred to those around them finding the finality of their decision difficult to understand and it was more often than not expressed as something they had to constantly explain. This 'need' for explanation was compared with the 'normality' of having children, which the men argued did not have to be explained in the same way.

The 'standard story' of "who will look after you when you're old?" (see also Cameron, 1997; Lunneborg, 1999) did occur. For instance, Jeremy noted: "a couple of women have said but you know you're going to end up old and alone and die in misery (laughs) and be a twisted old man". When such occurrence was reported, it was structured as of no real concern and easily (and quickly) countered with reference to the greater likelihood of support from friends and partners. In one more extended case, one of the men (Dominic) used stories of elderly people he worked with to justify his vasectomy. He commented that many of these people complained bitterly of the stress their adult children continued to cause them, and emphasised that many of these elderly people were visited only infrequently by relatives.

Countering this 'old age argument' was relatively rare in the interviews. Greater emphasis was instead placed on accounts of *disbelief* or *challenge*, with descriptions of people finding their choice

completely foreign. When this type of framing occurred in the interviews, the vasectomy operation itself was often portrayed as the final straw in incomprehensibility to friends, family, acquaintances, or even in some cases, people who had just met them. The technology²⁴ of pre-emptive vasectomy in these accounts required much more explanation than a 'simple' lack of desire to have children. Also common were stories of others struggling with a definitive "never" to questions of when a couple or individual might be having children, usually in cases when the issue of a vasectomy had not yet been broached. Sometimes this explanatory work was described as having to be done in the face of hostility: "and the guy lost it, he totally lost the plot, he started screaming at me" (Tony), or occasionally laughter: "she absolutely cracked up laughing and she thought that was that the most hilarious thing she'd ever heard" (Jeremy).

One of the men, Neill, described such a reaction as he was explaining his 'infertility' to his parents-in-law. He argued that their response was one of long lasting incomprehension:

Neill: the in-laws suggested well you could adopt children [GT: mmn] because they didn't understand that someone [...] I don't think that to this day that they fully understand that someone could not want children [...] it just doesn't make any sense to them.

According to Neill, the choice to have the vasectomy was something he undertook *prior* to meeting his current partner. He described the vasectomy as having been negotiated with an earlier partner who (initially) seemed willing for Neill to go ahead with it and (initially) showed no interest in children. The concerns expressed by the parents of his new(er) partner, over Neill's "vasectomy-related infertility" (Jequier, 1998, p. 1757), was in Neill's description, "a cultural thing", due to his new wife and her family being of Chinese descent. This framing of his parents-in-law as culturally 'outside' seemed to run in contradiction to his own position as 'different'. It seemed that within his talk, Neil was invested in being 'different' to anybody and everybody, in some occasions as a

²⁴ I use 'technology' here in the Foucauldian sense (see Rose, 1996), a 'technology of the self' that enables one to refer to or 'ground' the self in particular ways.

‘minority’ and in others taking the ‘majority position’ when it was important explanatory tool in his story.

Neill’s account of his parents-in-law’s ‘pressure’ bears some similarity to accounts of men who remarry after having a ‘typical trajectory’ vasectomy. Often these men describe feeling some desire (or pressure) to have a reversal in order to ‘cement’ the new relationship (Jequier, 1998). Such ‘permanent’ decisions as vasectomy made within a previous relationship, or even outside of any relationship (as many of the pre-emptive men described), may be seen to impact on the potential to ‘freely’ make decisions (as a couple) within the newer relationship, decisions which are also seen to impact upon an entirely new web of relationships and contexts. In this particular case, the new parents-in-law treated Neill’s ‘infertility’ as a relatively understandable problem that could be remedied by adopting children. Neill placed emphasis on the *choice* not to have children being incomprehensible to his in-laws, with the outcome of this choice being marked as simple ‘infertility’ rather than sterilisation.

This account worked to position Neill as unique and autonomous, unaffected by social conventions. This sort of construction of the unconventional, unique self was drawn on time and again by Neill, often with illustrations of his awareness of the impact of counter-hegemonic arguments. For instance, in the earlier quote from Neill in the section on selfishness, he offered a counter argument to questions about regret from his co-workers (“what if you change your mind and you don’t want children”). What is analytically useful about this exchange, aside from its counter-hegemonic value, is that it emphasised the ‘permanent’ status of the operation as being the cause of consternation. While being childfree potentially had the capacity to generate this type of reaction, it was the choice to have a vasectomy that initiated this back and forth between Neill and his co-workers. When an

individual is as invested in unconventionality as Neill appeared to be, the finality of a vasectomy may well have played as much a part in the decision making process as a disinterest in having children.

Stan also found that the choice to have a vasectomy was a crucial factor in problems he began having with some people. He described his father measuring the operation in terms of 'insanity' or inadequacy:

Stan: I did get quite a strong reaction from my father [GT: mmn] um and when I told him I remember quite clearly, he said that I was mad (laughs) [GT: (laughs)] so he obviously felt quite strongly about it. We didn't have an argument or anything but he just made it quite clear that he, that he, that he thought that I'd gone insane.

While it was more common for men to report that people simply found it difficult to understand, some of the men commented that they had chosen not to reveal they were thinking about or had had a vasectomy to their parents, other family members or friends, because of fear of a strong negative reaction: "I think my mother wouldn't be happy" (Stephen), "I didn't discuss it with my parents" (Geoff), "I haven't told my parents... or anyone in my family, I don't think" (Jeremy). The decision to hide their choice was framed as strategically necessary to avoid the complication and risk of disrupting family harmony or friendships that the men argued might somehow be put at risk. The decision to have a pre-emptive vasectomy was often portrayed as independent of the influence of friends and family, their reactions as potentially inhibitive or as having the potential to impact on the enjoyment of their choice. This is quite a contrast to the accounts of some of the men who had 'typical' vasectomies, who spoke of pressure from partners to have the operation (see Chapter 6).

When it came to actually getting the vasectomy, a number of the men stated they had been forced by medical professionals to wait to 'think further' about the decision or to convince the doctor of their seriousness. Typically, the waiting period for a vasectomy is limited to the surgeon's waiting

list. However, many of the men in the pre-emptive category spoke of having to wait for a much more extended period because of the gatekeeping actions of medical professionals. In order to bypass this possibility, Steven commented that he had fabricated his background to better fit the 'typical' model of patient:

Steven: I was a bit cautious when I was [...] talking with a doctor and I hesitated to say that I was single. I said that I had children [GT: mmn] and had a family [...] that was certainly a concern, I thought that they may refuse the procedure [GT: mmn] if I was single and being you know relatively young I guess [GT: mmn] to make such a permanent decision [GT: mmn]. And you know the question that that um the doctor kept asking is your, is your family complete? [GT: mmn] [...] so I sort of just made up that I had two children [GT: mmn] and a and a wife and [GT: right] living happily and you know in the suburbs.

Steven suggested that the prevailing notion of the 'complete family' as being 'settled' with 'two children in the suburbs' was enough to prevent him from even trying to get a vasectomy 'truthfully'. This was not something that the doctor articulated, it was what Steven "thought the answer they would want would be". Steven emphasised throughout this story that his concerns leading into the pre-operation interview were valid, as borne out by being repeatedly asked about the 'completeness' of his family.

The notion that men who choose vasectomies pre-emptively have a *less* valid story attached to their 'need' for the operation was also potentially combined with reproductive/contraceptive concern being associated with women rather than men (Oudshoorn, 2004). Men are often treated as 'outsiders' within the domain of contraceptive and reproductive technologies (e.g., Darroch, 2008; Gutmann, 2007; Malik & Coulson, 2008; Oudshoorn, 2004), which has the potential to create consternation among health professionals. It seems that being a man who takes responsibility for his reproductive choices, and sees his own body as a site of personal (and even social) change, is (still)

not a readily accepted position. These sorts of accounts of men downplaying or hiding the 'nature' of their interest in a vasectomy from others also worked, however, to stress the unusual nature of what they had chosen to do.

Also common in the interviews was wrestling with the suggestion that getting a pre-emptive vasectomy *was* less reasonable by comparison to, and needed more checks and balances than, a 'typical' scenario. A number of the participants spoke of extra measures they needed to take to convince their doctor, or, as with Dominic, simply "had trouble finding someone willing to do it". Neill argued that his doctor making him wait over a year from the first interview to the operation was a 'reasonable' response to his 'unreasonable' request:

Neill: the doctor wouldn't do it. He said that if I came back each six months for the next year and (.) was still just as keen each time [GT: mmn] then he'd do it [...] I think I'd already expected it because I knew they would be very reluctant to do it [GT: yep] in fact the time that he stipulated was less than what I was expecting so I was relatively comfortable with the way it was panning out.

While the situation was expressed by Neill as one that actually required *less* waiting than he expected, the acceptance of any (atypical) wait at all, perhaps reinforces the validity of the positioning of vasectomy as (really) a 'family man's' operation. While it is one of the few options available to men for reproductive 'control', and certainly the only 'hands free' option, discourses of the 'complete family' work to define 'appropriate' and 'inappropriate' candidates for the operation. These categories may have some validity for 'typical' applicants (in the sense of the vasectomy's permanence); however, they can work to marginalise men who wish to remain childfree and may have done so for many years previously. While this doctor was eventually convinced of Neill's sincerity in this account, the presentation of a "fixed process" as something that had to be overcome, and Neill's apparent willingness to go through this process without complaint, likely

indicates the power of pronatalist discourse to impact even his own framing of the situation. Whereas an outright lack of understanding on his parents-in-law's part seemed to be less forgivable in Neill's earlier account (framed as irrational and "cultural"), the doctor's wariness is legitimate, evidence of a rational approach to a 'unique' situation. This may, in part, be due to the doctor's position not being as absolute as Neill's parents-in law, with the former just needing to be convinced of Neill's sincerity, rather than a blanket 'refusal' to understand. Regardless, it still legitimates the idea that having a vasectomy without having children needs to be thoroughly tested.

This sort of structuring of the 'right kind' (and 'wrong kind') of resistance to his pre-emptive vasectomy draws attention to the values Neill (and many of the other men) seemed to attach to being permanently childfree. Neill's stories, and similar types of accounts, highlighted several factors: first, they help construct an expectation that very few people are capable of making the type of decision that men like Neill have. The imperative to have children (whether social or biological) is powerful and 'normal' and only particularly unique or special individuals have the capacity to resist this imperative. Second, questioning of the decision, and making a person wait for the vasectomy, was constructed as 'rational' and 'appropriate' by the majority of the men. However, those people who were presented as having the 'right' to challenge the individual's interest in a vasectomy (i.e. medical professionals in contrast to 'interfering family'), must have been doing so for 'rational' and 'appropriate' reasons. Third, the decision to have a pre-emptive vasectomy is something framed as chosen and followed through on despite a lack of support or understanding from partners, parents, doctors and society in general. However, it was a decision that needed to be valued in spite of this lack of understanding, and that there needed to be changes in the way others think about normative trajectories of adulthood.

In this way, not only are these men telling stories about the difficulties they might have experienced as a 'marginal group', they also 'take on' the language offered to them and about them. In doing so, these men also reproduce certain discourses and through this, identify with and take up the subject positions made available by these. The next section will discuss the formation of this sort of subject position as it relates to the complexities of resistance to, and yet, complicity with, several dominant discourses and subject positions.

Masculinity, neoliberalism, resistance and complicity

As discussed in the introduction to this chapter, a key idea in Foucault's work was his suggestion that where power exists, where discourses are dominant, there is always the potential for resistance, usually found within the dominant discourses themselves, he noted: "it's always possible to modify its hold, in determined conditions following a precise strategy" (Foucault, 1980: 13). At face value, the men's accounts seemed to be working to present them as challenging (or at least resisting) the dominant discourse of pronatalism within Western societies. Having a pre-emptive vasectomy is still a non-normative choice in New Zealand, and the men who have had this type of operation indicated that their experience of marking their bodies with such a permanent 'solution' was one which caused consternation among others or at the very least had to be justified or explained. These men argued that choosing an alternative to the otherwise invisible and yet intense pressures of pronatalism was only possible through personal traits such as unconventionality, a degree of 'selfishness' or a capacity to see past the expectations of society and/or culture (or even evolution!).

What is of particular analytic interest were the ways in which the majority of the men interviewed used these sorts of descriptions as a "precise strategy" in presenting their 'case'. The cultural resources men tapped to justify their choice were often acts of complicity with discourses of neoliberalism and many of the values of certain types of hegemonic masculinities (Connell, 2005;

Wetherell & Edley, 1999). Neoliberalism is the current taken-for-granted explanation for the way the West operates, a philosophy that, while an *economic* rationality, has been responsible for the formation of subjectivities within that climate, producing a neoliberal actor: rational, guided by choice, taking personal responsibility for both the successes and failures of those choices (Brown, 2003) (unsurprisingly this shows some significant overlap with Connell's (2005) theorising of hegemonic masculinity). Notions of control, autonomy, personal responsibility and transcendence were commonly drawn upon by the men, facilitating accounts that called attention to what made them different to others rather than highlighting commonalities.

Many of the accounts worked to emphasise the men's status as unique and different from the norm, challenging even the 'gears of evolution'. References were made to monolithic constructs such as 'society', 'others', 'instinct' and 'evolution', presenting a sense of perpetual and irresistible motion or pressure. Yet these men constructed themselves as somehow resisting such things as individuals, to some degree free from social constraints. More than once a participant referred to their lack of interest in 'breeding' as moving beyond the animalistic, instinctual side of 'human nature' towards self-actualisation, clarity of the mind or 'intellectual pursuits' or not 'buying into' societal pressures to have children for the sake of doing so.

This sort of structuring seemed to highlight the men's privilege rather than the sense of stigmatisation that much of the previous research (e.g., Gillespie, 2000, 2003; Halford, 2006; Magarick & Brown, 1981; Mawson, 2006; Park, 2002; Rowlands & Lee, 2006) has presented as salient to a choice not to have children. Access to discursive resources that allow 'challenging' the status quo and notions of unrestrained choice concerning the issues involved in family shaping underscore more than anything these men's relatively high levels of education and capacity to situate themselves within subject position defined by 'internal locus of control'. The fact that these

men can 'choose' to not become parents also obscures that they have no real constraints placed upon their capacity *to* have children (barring medical conditions and other such factors). Where *antinatalism* exists, it is usually in relation to "preventing teen pregnancy... [and] also discourages low income earners, lesbians and gay men, and physically and mentally disabled individuals from becoming parents" (Park, 2002, p. 23). As such, these heterosexual (mostly) Pākehā men benefit from both the neoliberal climate and the current gender order, which benefits men in general, but particularly men such as themselves (Connell, 2005). This privilege is largely invisible, however (McIntosh, 2003), and so they can make a claim to personal qualities, rather than social status, being at the heart of their choice.

Despite the apparently negative self-descriptions of selfishness, this very trait functioned to enable (both discursively *and* materially) a greater choice of lifestyle options and volitional freedom. As Walkerdine (2003) has noted, the neoliberal subject is constructed as self-supporting, self-defining and someone "who has to understand their position in essentially personal and psychological terms" (p. 241). When called upon to explain the reasons for the vasectomy, it was done almost exclusively in terms of individual agency and the limits children place on that agency. On the flip side of this, the use of negative self-labels became necessary at times, as the power of pronatalist discourse meant a choice not to have children, when explained in psychological terms, had to be described in terms of lack or what was missing. However, the majority of the accounts also seemed to be missing any sense of tension or regret about the choice not to have children, and there was not much evidence of any *struggle* to finalise the decision through a vasectomy (quite unlike the 'typical' men I interviewed!). Much of the research evidence suggests that "family formation is intimately negotiated, rationalized and experienced through dynamic interplay between material conditions, personal aspirations, gender relations, social values and biological limitations" (Carmichael & Whittaker, 2007, 140). What instead seemed to have been brought to the fore in these accounts were the agentic qualities of the men involved and the choice as securing their (desired) lifestyle.

In contrast to this, one of the men interviewed who had had his pre-emptive vasectomy reversed, spoke of his original vasectomy as being driven more by his partner's lack of interest in children. When this relationship dissolved, however, he commented that he found himself wondering whether he did in fact want children, a concern that became more salient when he entered into a relationship with a woman who did want children. He argued that:

Peter: in terms of being able to realise something that was very important to my new wife and I've and um I guess became very important to me because I didn't (.) um as much as we were in love with each other I didn't want her to I didn't want to be the one... compromising (.) it's not quite what I'm trying to say [GT: mmn] but um that as much as we have discussed what would happen if the vasectomy reversal hadn't worked um I know that it would've brought considerable pressures on the relationship as strong as it is.

Intrinsic to Peter's story was the premise that the relational context shaped the way in which Peter made both his first decision to have a vasectomy and the later one to have it reversed. Many of the men treated the permanent status of their 'infertility' as the most important reason for choosing vasectomy over other options such as condoms, non-coital sex or reliance on less permanent female controlled methods of contraception, irrespective of changes that might occur in present or future relationships. In this case, Peter referred not to his own individuality and a construction of rational choice as primary, but instead the situatedness of his self within relationships, with choice being made as a couple, not as singular entities. Peter's account portrayed vasectomy decision making as more complex than a 'simple' desire to not have children, and offered a counterpoint that draws attention to some of the consequences of highly individualised decision making processes. It also shows more in common with the men who had 'typical' vasectomies.

Discussion

The accounts in the previous sections show some similarity with what Wetherell and Edley (1999) have referred to as 'rebellious' masculinity, which is largely described in terms of its challenge to more conventional forms of masculinity. However, the stories of men who have had pre-emptive vasectomies could be a valuable frame of reference to help reshape some of the limitations of conventional masculinities. There seems to be a great deal of reliance on particular (neoliberal) forms of masculine sense making that to all intents and purposes continue to perpetuate the notion of idealised masculinity as defined by unrestrained, autonomous choice. Wetherell and Edley (1999) have commented that hegemonic forms of sense-making are those which are "consensual although contested, which maintain male privilege, which are largely taken for granted, and which are highly invested" (p. 351) and argued that:

sometimes one of the most effective ways of being hegemonic, or being a 'man', may be to demonstrate one's distance from hegemonic masculinity. Perhaps what is most hegemonic is to be nonhegemonic! – An independent man who knows his own mind and who can 'see through' social expectations (pg. 351).

This certainly seems to describe the men in this study, with 'agency' being key to the decision making process concerning having a pre-emptive vasectomy and the capacity to choose often presented as a consequence of their willingness to defy expectations and social convention. This 'rebellion' was almost always a highly individualised one, however, depoliticised and more about their own experiences and lifestyle rather than any attempt to change society. Also, while partners were often involved in the process of having a vasectomy (or at least the choice to be childfree), the value gained was usually constructed as benefitting (just) the men themselves. This was in sharp contrast to the men in chapter 6, whose primary justification for vasectomy was their partners' wellbeing and interests.

I would like to (tentatively) suggest that the dominant expression of masculinity that these men are 'resisting' (if they are in fact resisting anything at all) is the current ideal of fatherhood: the 'new' father (Everingham & Bowers, 2006; Johansson & Klinth, 2008; McGowan, 1998; Nentwich, 2008; Ranson, 2001; Wall & Arnold, 2007). The prevalence of this form of masculinity would make it easily recognised as the most likely form of fatherhood they would engage in. Fathers as fully involved in the 'parenting' process, devoting significant amounts of their time and energy to the raising of children is steadily becoming the accepted (and expected) norm. Although many men can still retreat to the position of 'breadwinner' to some extent, its power may be reducing and is certainly not an excuse for distant and uninvolved fatherhood (Johansson & Klinth, 2008). Many women continue to sacrifice much in the way of career and lifestyle in order to become mothers, and it seems that, while there is still much work before true equality exists in this domain (Wall & Arnold, 2007), men are also beginning to feel pressure to sacrifice certain aspects of their lives that they have determined are important.

While concerns about the impact of children on finances *were* readily drawn upon, they were not as prevalent among participants as accounts of the impact on lifestyle, time, choice and personal growth, perhaps indicating the issue for many of the men was less about provision and more about a loss of 'self'. This loss of self motif only really makes sense in light of the growing influence of the new father subject position. The men presented the key elements of their current lifestyles as immediately lost through a change of status to parent, and suggested that these were too precious to give up lightly. In fact, many of the men seemed less focused on the issue of not having children, and more on the possibility of losing their current lifestyle. Being 'selfish', being unconventional meant that being an engaged, involved parent would be far too difficult for the majority of these men and for some of them, impossible.

This chapter has focused upon the accounts of men who have had 'pre-emptive' vasectomies, finalising a decision to not have children at all. Similar to the accounts of men who have had 'typical' vasectomies, men who had pre-emptive vasectomies spoke in highly individualised ways about the decision to have a vasectomy and their reasons for doing so. Many of these men took this individualisation a step further, however, as even those within relationships spoke of the decision being primarily about their own lack of interest in having children, and a reflection of personal character traits (such as selfishness, unconventionality and rugged independence). In contrast to the men who had 'typical' vasectomies, most of the men described in this chapter spoke of the decision making process as easy (for them), as internally motivated and needing to be justified to others rather than to themselves. Poststructuralist analysis has highlighted the discursive resources men drew upon and the subject positions they had taken up as reflective of their social location (i.e. male, affluent Westerners) and their privileged status in being able to make such decisions 'easily'. This offers an alternative account to research which has focused upon the stigma of being childfree.

Summary

This chapter was based on interviews with men who had 'pre-emptive' vasectomies. It is thus not only a story about vasectomy, but also about the 'lifestyle choice' of childfreedom. Many of these men took up a subject position defined by three characteristics: 1) descriptions of themselves as flawed, particularly as selfish, 2) descriptions of themselves as 'unconventional', which led to 3) descriptions of the decision as difficult to understand for most people. Much of the research on childfree people has tended to focus on discourses of stigma and marginalisation, in this chapter, however, I have told a different story. Many of the men's accounts drew on discourses (and formed subject positions within these discourses) less defined by *stigma* and more by *privilege*. Primary to these were neoliberal discourses of individualised choice and personal responsibility.

Chapter 10: Concluding Considerations

This thesis has primarily used different forms of discourse and thematic analysis to highlight the ways in which men have talked about having a vasectomy and its impact on their relationships with their partner, themselves, their own body and others. Key to all of these was the connection to the men's masculine identities, and the ways in which they took up certain positions within contemporary discourse about manhood. The thesis has also drawn on some quantitative analysis, which portrayed a similar, but broader picture to the qualitative data, demonstrating that even when limited to pre-formulated questions, men drew from the same types of cultural resources to provide answers.

A brief summary

Chapters 2 and 3 gave some background to the 'story' I have told about men and vasectomy in New Zealand. Chapter 2 gave us an account of what we know about vasectomy, the research that has explicitly focused upon it, and the creation of a 'vasectomised male' in psy-discourse (Parker, 2002); a psychology largely defined by anxiety about the body and sexual concerns. Chapter 3, relying on the insights of critical masculinities theory, aimed to provide an 'intellectual home' for the rest of the thesis, and located men's experiences of, and talk about, vasectomy within the social construction of masculinity. It also provided a discussion of the socio-cultural (as opposed to biological) relationship between men and contraception/reproduction.

Chapter 4 gave some 'method to my madness'. In it I discussed the use of a pragmatic approach to mixed methods applied within the thesis (both in the QUAL-quant relationship (Yardley & Bishop, 2008) and also between the various forms of qualitative analysis). I also discussed the

appropriateness of each of the methodologies used for the data being analysed and how they were applied in the analytic chapters.

Chapter 5, while not a classic example of quantitative research in psychology (lacking many of the markers of 'good' positivist research, such as hypotheses and claims to generalisability), gave a broad overview of men's experiences of vasectomy from the responses of a sample of over 150 men. Of importance to the rest of the thesis were several themes: the men being positive about contraceptive use, the men expressing interest in involvement in reproductive/contraceptive concerns, and a generally positive view of the operation and their experiences post-vasectomy. Other implications of this analysis were reliance on neoliberal discourses of personal responsibility and individualism.

Chapter 6 and 7, were twin (albeit fraternal twin) chapters that discussed the ways men spoke about 'taking responsibility' and the vasectomy as somewhat 'heroic'. Chapter 6 was a thematic analysis of the interviews with men who had 'typical vasectomies'. It highlighted the way language of responsibility for the reproductive and contraceptive burden was inscribed with discourses of orthodox masculinity for these men. Chapter 7 took three extracts from the account of one of the men referred to in Chapter 6 (Chad), and offered a fine grained analysis of these. It focused on the way Chad managed an investment in being heroic and responsible and having to deal with parts of his story which contradicted these values.

Chapter 8 drew on insights from critical discursive psychology to analyse the *strategies* men used to retrospectively make sense of the decision making process. Men relied on shared forms of meaning-making in order to manage instability and inconsistency in their self-productions when speaking of having a vasectomy. While tending toward the 'default' of being 'ordinary guys' many of the men

shifted between various descriptions of the self (and others) to manage occasions where they may appear in a negative , or even a 'neutral' light.

Chapter 9 was poststructuralist in orientation, and focused analytically upon the interviews with men who had 'pre-emptive' vasectomies. The chapter discussed the some of the discourses men drew upon and the subject positions they took up in relation to these. The key finding within this analysis was that the subject positions taken up were defined less by stigma (as previous research has shown) and more by the privilege afforded them within hegemonic forms of masculinity and intelligibility.

A caveat on 'being critical'

While at times the tone of the discussion and lead up to this conclusion have been explicitly critical, I need at this point to reinforce that what I have been critical of are the *cultural resources* that constitute and shape contemporary masculinities, certainly *not* the men that gave up their time and stories for the benefit of this project. The tendency when speaking of 'the men' or when quoting specific men (the Chad's of the world), is to follow Western assumptions and think explicitly of the individuals involved, pinning qualities or traits to them as people, based on critique I have offered. Individualised or trait based responses to certain social phenomena, such as high uptake of vasectomy, have not been the focus of this thesis. Instead I have attempted to pinpoint some of the "historically contingent regime[s] of the self" (Budgeon, 2003, p. 41) that produce certain ways of being masculine, and being a male partner in a heterosexual couple, with or without children.

Masculinities: personal, social and hegemonic.

Vasectomy, in many of the men's accounts seemed like an individual, personal, or more occasionally, a couple based decision, but in this thesis I have argued it is far more than that. When these sorts of decisions are constructed as individual (as they have been historically), and the talk (or survey

answers) describing the decision making process as directly mirroring the mental processes of men, there will always be limits on the capacity for understanding the place of such phenomenon in people's experience, and this will certainly reduce the possibility of any necessary critique. A social constructionist reframing of the research on vasectomy has been needed, particularly in the West. As long as the subject of vasectomy remains limited to the men themselves, a "psychology of the vasectomised man" (Wolfers & Wolfers, 1974, p. 227), then vasectomy will remain just one of many options that couples can choose from when they finish having children (or not having them at all).

The cultural resources drawn from in the formation of the personal *are* political, particularly in such a gendered regime as reproduction and contraception (Inhorn, et al., 2009). These resources manage the status quo through constant repetition and integration into people's lives, and through people being limited to certain types of subject positions they can 'take up' within them (Davies & Harré, 2001). Appeals to individual choice (and even groups of men 'taking responsibility') deflect attention from a status quo that is still premised upon male privilege, particularly within heterosexual intimate relationships (Jackson & Scott, 2004).

Increases in vasectomy uptake and the way men describe their decision making about it, must therefore (in my estimation) fall firmly within the study of hegemonic masculinities (Connell, 2005), and even more specifically within the domain of masculine sense-making (Wetherell & Edley, 1999). When theorising the place of vasectomy becomes intertwined with a discursive understanding of masculinities, then analysing talk about vasectomy and the cultural resources that support that talk, can become an avenue for "disrupting and displacing dominant (oppressive) knowledges" (Gavey, 1997, p. 53). To attempt to theorise vasectomy uptake and the like without this frame of reference will give limited scope to understanding why some contexts produce high uptake and others do not. I will keep the notion of disruption and displacement in mind as I turn my attention to the overarching themes that this research project has addressed.

Individualised accounts

Men in the interviews often relied on highly individualised accounts of the vasectomy decision making process and its impacts. There was a strong influence of neoliberal discourse on men's accounting for vasectomy that prized their individual responsibility and choice and downplayed the 'couple work' that may exist in the decision making process (especially among the men who had pre-emptive vasectomies). Rose (1996) has suggested that the self produced within discourse in the contemporary West is "coherent, bounded, individualised, intentional, the locus of thought, action, and belief, the origin of its own actions, the beneficiary of a unique biography" (p. 3) and this was more apparent within the interviews than any other theme.

Accounts (from both qualitative and quantitative data) downplayed or ignored the 'cultural conditions of possibility' (Gavey, 2005) for the choices, focusing instead on the men's own individual characteristics and qualities. While this is understandable, as the men were simply being 'good cultural members' and drawing from the cultural resources available to them, such accounts also tend to be indicative of men's capacity to draw privilege from almost any avenue. The co-opting of the long term commitment and obligations many heterosexual women have been under (and in many cases remain under), with regard to reproduction and contraception, should not be as easy as a simple 20 minute operation and not a moment's thought afterward.

Hints of inclusive masculinities?

Even as the men (often) emphasised their own choices and downplayed or even disregarded their partner's efforts in 'managing the mundane' (Dixon & Wetherell, 2004), there were also 'positive' signs, suggestions that discourses supporting more inclusive masculinities (Anderson, 2009) were beginning to develop around the 'technology' of vasectomy.

We may be some way off from the realisation of a utopian vision of gender equality, but I would (guardedly) argue that many of the cultural resources that men were beginning to reproduce in their interviews were (at least at face value) shifting in the 'right' direction. Henwood and Procter (2003) have argued with reference to fatherhood that:

The cultural image of the 'new man' or 'new father' seemed to have opened up an identifiable space for men to occupy in the complex and changing landscape of family life. By occupying this space, men and fathers were able to strengthen their own and other people's confidence in the importance of fatherhood and their own self-perception as fathers (p. 349-50).

The same can be said of men's involvement in the not-so-changing landscape of reproduction and contraception: space seems to have opened and continues to open, providing men with opportunities to shape their identities in (positive) new ways. This has been evidenced in the different outcomes in research over the last several decades, for instance if we compare Thompson et al.'s (1991) conclusions with Sandlow et al.'s (2001), we see less attempts to *justify* men's lower uptake of sterilisation than women's, and greater associations with vasectomy being valued and unstigmatised.

The masculinities that appeared to be *most* hegemonic in this project's interviews, were, for the most part drawing upon non-orthodox, even inclusive values. While I have, following Correa (2000), pointed to the hazards of wholesale acceptance of terms like 'responsible' and 'involvement', the manifestation of such inclusive values in the talk of the men interviewed (particularly the men following a 'typical' trajectory to vasectomy), is something that should create *some* optimism. I have suggested in other writing that:

increasing the availability of discourses of egalitarianism... and suggesting alternative imaginary positions for men that help them to (re)position themselves in ways that more directly benefit women, may well offer some way forward into the re-shaping of Kiwi (and other) masculinities... that are informed by themes of justice and equality (Terry & Braun, 2009, p. 176).

What is promising was that many of the men spoke of their interviews as novel experiences, in some cases the first time they had spoken to anyone other than their partners about the operation, and certainly the most in depth conversation they had had about it. The resources that were readily drawn upon in this 'new' context of the interview, while containing elements that were 'typically' orthodox (such as control, autonomy and heroism), at times demonstrated inclusive masculine values (such as care, responsibility and an interest in domestic share) being deployed. This perhaps implies that even when there is potential for less 'rehearsed' versions of the experiences and motivations regarding vasectomy, men's first recourse was to rely on egalitarian discourse in the construction of their accounts.

This is not to say that the movement between orthodox masculine values and more inclusive ones is a linear process that shifts from blatant misogyny to outright egalitarianism, but rather that the configuration of gender practices these men engaged with included and valued egalitarian discourse. Certainly with the insight of the 'long conversation' (Maybin, 2006) about vasectomy, the differences between articulations of the 1960s and 1970s, and the work within this thesis, show there have been some positive shifts (at least in how it was reported!). How this might manifest in 'material practice' and increases or decreases in positive male behaviour with regard to contraception and reproductive activity, is still anyone's guess. When a man is invested in such positive categories of responsibility and involvement (as many of the men in this study seemed to be), this investment has the potential to create some degree of inevitability for the operation (Amor, et al., 2008), but, as seen in this thesis, the operation is still one that men are able to contest, struggle over and imbue with heroic language.

Also notable were the accounts (despite the prevailing neoliberal rhetoric) that did not seem to be producing consistent or stable versions of the self. There were instead repeated manifestations of

managing, shifting, convoluted expressions of selfhood (see especially Chapter 7) that were deployed for the purpose of these interviews on the particular topic of vasectomies. Masculinity was often recognised by many of the men I interviewed as a construction (see Chapter 8) and unstably so. The way men were able to refer to their own masculinities and those of other men would suggest that the notion of multiple masculinities is now becoming a part of the discursive fabric men form their identities from. This provides evidence (and scope) for change, rather than the notion of fixed masculine traits that are difficult to challenge.

It is likely, as has been suggested in my own work (Terry & Braun, 2009) and others (see for instance, Henwood & Procter, 2003; Holland, et al., 1998) that the social location of the long term relationship is a valuable resource for egalitarian shifts in men's language (and behaviour). This location also provides the space to unravel less desirable self-constructions that are often a consequence of homosocial arrangements (Flood, 2008; Terry & Braun, 2009). Men are often struggling to make sense of competing demands of masculine behaviour, particularly when it comes to domestic involvement (Dixon & Wetherell, 2004; Edley & Wetherell, 1999). Long term relationships can then be constructed as a 'safe space' where men can do the work of unravelling these sorts of dilemmas and then invest in masculinities which enable them to 'transform themselves in order to attain a certain level of happiness, purity, wisdom, perfection or immortality' (Foucault, 1988, p. 18).

This transformation, however, may never be complete, always shifting between orthodoxy and inclusiveness depending on context and the stability of regulatory structures and relationships and the availability of particular cultural resources to make sense of these (Anderson, 2009). To manage this continuing shift in the 'right' direction, the disruption of discourses that privilege men and increasing those that benefit women must remain an ongoing task within domains that is still (despite the rhetoric) highly gendered.

Privilege and the economy of gratitude

While there *are* positive signs in masculine identity formation building around such social sites as contraceptive involvement, there is a need to problematise this mixture of masculinities, even as it is encouraged. Hegemonic masculinities are resilient, and as the advent of 'postfeminism' has shown us, can absorb critique and diffuse its power (McRobbie, 2004), remaining hegemonic and still benefiting men (Connell, 2005). I would suggest that while the masculinities of partnership and fatherhood have begun to shift rhetorically in more egalitarian directions, with the men who take them up showing willingness to caricature, challenge and resist some of the values of orthodox masculinities, there is still a drawing upon some of those very orthodox values (such as control, independence, heroism) to do so.

I am not alone in making such suggestions, Segal (2007) has pointed out that while men are getting more in touch with their 'feminine side', or as Anderson (2009) suggests becoming less misogynistic and less heterosexist in expression, in every facet of life men still dominate women. Robertson (2006) has argued that shifts toward what could be described as 'inclusive' masculinities could be seen as a:

contribution to a new hegemonic masculinity that expresses a rhetorical commitment to rejecting previous male stereotypes, yet that contributes nothing to changing actual material practices; that does nothing to affect the 'patriarchal dividend', the advantages that accrue to men through current gendered structural equalities (p. 315).

Masculine privilege is still maintained by and in most social structures, and even where they are beginning to form, inclusive forms of masculinity are not free of this advantage-producing power (Anderson, 2009). Connell (2005) describes men who benefit from structural inequality, even as they speak in an egalitarian fashion as still being *complicit* with hegemonic masculinity:

Marriage, fatherhood and community life often involve extensive compromises with women rather than naked domination or uncontested displays of authority. A great many men who draw on the patriarchal dividend also respect their wives and mothers, are never violent towards women, do their accustomed share of the housework, bring home the family wage, and can easily convince themselves that feminists must be bra-burning extremists (p. 79-80).

Such compromises often seem to fall within an economy of gratitude (Hochschild, 2003). Even as the historical male role of the sole breadwinner has been challenged through the advent of women's involvement in the workplace, its power has not completely waned. Being a breadwinner often excused men from active participation in the domestic arena, and as I have argued in this thesis, this has included involvement in reproductive and contraceptive 'mundanities'. While men in the West have become more involved in various aspects of child rearing and domestic tasks, they often do so with an expectation that their partners will be especially grateful for this involvement (Hochschild, 2003). I would argue that until there is a greater sense of the normalising of male involvement in contraceptive (and other 'domestic') tasks, then male privilege will still be the defining motif of heterosexual intimate relationships.

Men and reproduction redux

As some evidence of this continuation of male privilege, we have been, it seems, always 'one step away' from the development of a male pill or some other new example of 'male controlled' contraception, at least since the 1970s (Oudshoorn, 2003). Much of the decision making concerning men's involvement in reproductive responsibility, particularly as defined by pharmaceutical companies, is still driven by the values of orthodox masculinities (Oudshoorn, 2003). Vasectomy and condoms continue to be the only viable options for men wanting to engage in reproductive involvement (Naz & Rowan, 2009), and yet they can be 'chosen', 'refused' or even 'disdained' in ways that women's reliance on contraceptive technologies, to the same degree, cannot. As discussed, the *rhetorical* climate of this 'choice' has seemingly moved in a positive direction over the

last decade, however, vasectomy remains the only long term contraceptive technology regarding which many men can (or are willing to) 'demonstrate' their responsibility and interest in involvement (however varied and indirect this might be).

Condoms continue to be available as a male controlled contraceptive option; however, more often than not they persist in being constructed as annoying, frustrating, pleasure reducing and even indicative of a lack of trust in a relationship (Flood, 2003; Willig, 1995, 1997). On that basis, such contraceptive technologies offer little scope for positive redefinitions of the self and more often than not are constructed as having nothing to do with the self (see Chapter 6). This is a troubling situation, as vasectomy is limited to those who do not want any (more) children and therefore men can only take up this option (and the identity work that goes with it) at a particular point in their life trajectory. Promisingly Weston et al (2002) have commented that:

the strong correlation between willingness to try MHC [male hormonal contraceptives] and acceptance of vasectomy suggests that there is a population of men who are either more willing to take an active role in controlling fertility or are forced to consider male methods of contraception because of the unacceptability or failure of female methods of contraception (p. 210).

The continued state of male hormonal contraceptives as 'a long time coming' is not so easily changed through some men showing interest. It is likely a consequence of a number of factors, as suggested by Oudshoorn's (2003) claim that changes in the reproductive arena rely upon disruptions to a complex socio-technical field. Not only must willingness for contraceptive responsibility among men be considered, but also so must material changes, such as investment in contraceptive technologies by pharmaceutical companies.

Such changes, as Oudshoorn (2003) and Naz and Rowan (2009) have argued, have not and will not happen easily. Naz and Rowan (2009) have commented: "Several pharmaceutical companies have

withdrawn from this field because of lack of potential profitability, long-term investment, and medico-legal reasons” (p. 268-9). In response to this disinterest, Darroch (2008) has argued that a market for MHC needs to be ‘activated’ rather than formed out of perceived demand, suggesting that the status quo continues to benefit men and while they are benefited they will show little interest in changing it.

Guttmann (2007) has also highlighted the ways in which professional discourse and assumptions about men and their willingness to be involved and be responsible can sometimes be the barrier to increased uptake and demand for newer contraceptive options and this certainly continues to be the case in this area (see also, Landry & Ward, 1997). Provision of new male methods of contraception is important to produce a culture of normalised (rather than heroic) male involvement in the reproductive burden. As long as men’s use of contraceptives is occasional or limited to a certain point in life trajectory there will be little scope to modify the over-valuing of men’s contributions when they occur. Darroch (2008) has argued that in order for positive shifts to occur in men’s ‘attitudes’ to reproductive involvement, there needs to be a process of integration into the long term share of the reproductive burden, rather than the current model of substitution.

Contributions of this research

Critical masculinities theory

Connell’s (2005) theory has given us the knowledge that a society structured by hegemonic masculinity will continue to perpetuate a status quo that benefits men. The work of critical discursive psychologists (e.g., Edley & Wetherell, 1997, 1999, 2009; Wetherell & Edley, 1999, 2008, 2009) on the other hand, has shown us how that privilege manifests in the lives of individual men. Feminist poststructuralism (Gavey, 1989, 2005) has highlighted the location of this privilege within discourse and has called for its continual disruption and displacement by newer, alternative, more egalitarian discourses.

I have drawn extensively on the work of Margaret Wetherell and Nigel Edley in this project and others. Their work has been a significant influence on my thinking concerning masculinities and in understanding how heterosexual men make sense of many (often mundane) features of their lives. Important to their theorising of masculinities has been the principle of *synthesis*, not limiting their work to one 'gold standard' or another, their recent research has been defined by incorporation of insights from micro and macro approaches into a newer form of discourse analysis (e.g., Edley, 2001a, 2001b; Edley & Wetherell, 1997, 1999; Edley & Wetherell, 2001; Edley & Wetherell, 2009; Wetherell & Edley, 1998, 1999, 2001, 2008, 2009). This is an approach that has begun to develop some influence (e.g., Kamada, 2008; Korobov, 2009; Noone & Stephens, 2008; Terry & Braun, 2009).

I have hoped to take their approach a step further in this broad analysis of the social practice of vasectomy: drawing upon Connell's (2005) broad understanding of hegemonic masculinity (and Anderson's (2009) modifications of it), Wetherell and Edley's (2009; 1999, 2008, 2009) own attention to the discursive formation of identities through masculine sense-making, and poststructuralism's call for disruptive discourse analysis. This thesis contributes to the wider understanding of men and masculinities by drawing upon all of these areas to one degree or another, synthesising them to shine as much critical light on men's decision to have vasectomy as possible.

This thesis has also offered some understanding of masculinities and health related behaviour, especially the ways in which men make sense of health when they are *healthy*. While there has been some social constructionist work in the area of masculinities and men's health (e.g., Courtenay, 2000; Hodgetts & Chamberlain, 2002; Noone & Stephens, 2008), there remains a large hole when addressing the way men think about their bodies *in health*. Vasectomy is an act of medical

intervention on otherwise healthy bodies and, as such, offers a window on an aspect of men's identities which remains under theorised.

Men and reproduction (in particular vasectomy)

Given the dearth of research on vasectomy, it seems that almost any contribution to knowledge in the area might be considered worthwhile! This project, however, was intended not only to add to knowledge but also to add a critical enhancement of much of the existing research on men and reproduction.

Much of the early research on vasectomy might be characterised by a theme of wariness about the procedure. Concerns about post-vasectomy sexual performance, health risks, negative impacts upon the psychology of men seemed to pervade early research and to some degree persist today (see for instance, Dilbaz, et al., 2007; Hofmeyr & Greeff, 2002). This research was intended to draw out and address many of the weaknesses of previous work and add to the (more recent and useful) contributions of researchers such as Sandlow et al. (2001), Gutmann (2005, 2007) and Amor et al. (2008).

It also was intended to offer a critical psychological treatment of the place of vasectomy in a Western context. Much of the recent research on men and reproduction has been based in anthropology, and as a consequence perhaps of the UN's (1994) mandate to involve men in reproduction, has tended to focus upon 'squeaky wheels', or the contexts where men's non-involvement in the domestic (and through this the reproductive) sphere has had the most impact on women's sexual health and rights (see for instance, Inhorn, et al., 2009). While this non-Western focus is (very) important research, I would argue that this can sometimes give the impression that the West has been 'won' and women's equality in the reproductive arena established. I would argue

that this is far from the case, even in a context with such high rates of vasectomy, and that New Zealand has thus provided a perfect environment for a critical evaluation of men's involvement in 'sharing' the contraceptive burden.

Limitations of this research

While this thesis has contributed to a more textured understanding of vasectomy in New Zealand, it is built upon a theoretical framework that needs a relatively high degree of explanation among the general public. This is particularly true of criticism of humanistic constructions of personhood; most people 'experience themselves' as singular, unitary and constant (Crossley, 2003), and so to challenge this in the contemporary context may confuse more than it helps. Furthermore, while I have done some limited quantitative research, further development of this type of research is still needed, following the work of researchers such as Sandlow et al. (2001). I have done little to contribute to 'mainstream' understandings of vasectomy that will potentially be more readily absorbed into public discourse.

Another area that might be described as a limitation is the critical approach taken to masculinities. Largely the changes that need to occur in gender relations are ones which are, for the most part, invisible to many men *and* women. Often critical (particularly feminist or (pro)feminist) work has resulted in backlash tendencies among groups of men, with men advocating these sorts of tendencies becoming organised in many parts of the world (Flood, 2004). While this is no reason to suggest that this work is limited, there is the danger (in fact likelihood) that it might be interpreted as critical of men, rather than critical of their privilege and the social structures that scaffold that privilege.

As I write this I am reminded of an email I received from a man who had initially expressed interest in the project. After doing a Google search on my supervisors and I, he became aware of the

'feminist tendencies' of our work and pulled out. His parting shot was that his story, while certainly of 'great interest', would not be told in the 'anti-masculine' environment of my project. Such stories, while a little at the extreme end of the spectrum, are not isolated, and so I would express my regret that this current project will be of little interest to such men, or even to some of the men who *did* involve themselves in the research.

Conclusion

While there is much strategic value in continuing to promote New Zealand's status as having one of the highest rates of vasectomy in the world, there is still some way to go in the reshaping of contemporary discourses of masculinity and the men that draw from them. Use of statistics and rhetoric that highlight men's involvement in more inclusive masculinities, and tying these to positive identities such as the 'caring and responsible partner' have the potential to positively mould the cultural conditions of possibility, enabling greater egalitarianism within heterosexual relationships.

This 'phenomenon' of high vasectomy uptake, which seems to imply a greater sense of reproductive and contraceptive responsibility in this country than potentially exists, does however, continue to ratify the privileged status men enjoy and the continuing prevalence of an 'economy of gratitude' (Hochschild, 2003) within heterosexual arrangements. A balanced suggestion that men are 'improving', rather than 'improved', in this area, and that positive shifts may well be occurring has more credence than a wholesale acceptance of men's completed transformation. This lies in contrast to the recent writings of some apologists (see for example, Synnott, 2009). Gender inequality continues to be the primary way the world is ordered (Connell, 2005) and while it is important that men are recognised for their efforts to 'opt in' to areas they have previously neglected (i.e. involved parenting, contraception), the risk is that men as a group *co-opt* these areas and gain more privilege in the doing so.

Appendix A: Press Release and News stories

2007 Press Release

The popularity of vasectomy in NZ

23 January 2007

A study at The University of Auckland is looking at the reasons behind New Zealand's high rate of vasectomies.

New Zealand is one of only a few countries where male sterilisation is more frequent than female sterilisation. It has one of the highest rates of vasectomy per head of population in the world. The University research is investigating why vasectomy is so popular in New Zealand and the factors that men consider prior to having the procedure.

"Vasectomy is an extremely popular form of contraception in New Zealand, with around 18% of men having had the operation, and nearly 25% of married men," says Gareth Terry, the psychology PhD student conducting the research. "Most men take over a year to come to a decision about whether or not to have a vasectomy. We are looking at the decisions they make before committing to or deciding against sterilisation."

The study is looking for men who would be willing to be interviewed about their decisions before and after having, or considering, a vasectomy, particularly those that had a vasectomy without fathering children. The study would also like to speak to anyone currently considering a vasectomy. Men who would be willing to be involved in the study should contact Gareth Terry on 09 373 7599 ext 86309 or g.terry@auckland.ac.nz

To take part in an online version of the survey, please click [here](#).

Contact

Emma Timewell, Communications Adviser

Ph: 09 373 7599 ext 83258

Email: e.timewell@auckland.ac.nz

Gareth Terry

Ph: 09 373 7599 ext 86309

Email: g.terry@auckland.ac.nz

2007 Newspaper articles

nzherald.co.nz

Sex, blokes and vasectomies - leg-crossing kiwi research

2:40 PM Tuesday Jan 16, 2007

An Auckland University researcher wants to know why more men in New Zealand are having vasectomies than just about anywhere else in the world.

At 18 per cent of all men, 25 per cent of all married men, and a leg-crossing 55 per cent of 40-49 year-olds, New Zealand's vasectomy rate towers above places such as the United States, where just 7 per cent of men have gone under the knife.

Auckland PhD psychology student Gareth Terry now wants to talk to some of those New Zealand men and find out what prompted them to go under the knife.

Mr Terry said he was curious as to why, given the good Kiwi bloke stereotype, so many were willing to be sterilised.

"The traditional blokey bloke is not interested in stuff that's related to reproduction, children, all that sort of thing, but yet we seem to have this quite high rate, so I'm very keen to tap into that a little bit more and see how much of that traditional idea is a myth," he said.

It had been suggested that the high vasectomy rate was because New Zealand men were under the thumb from female companions.

"That's certainly something that's come up a bit, particularly when I talk about it with wives and girlfriends.

"We were one of the first countries in the world for women to get the vote, and things like that. Women are quite strong in New Zealand.

"I imagine that could play a part in it -- I don't know whether that means (men) are under the thumb."

It had also been suggested New Zealand men, after having children, were keen to take a turn at responsibility for contraception, and also to care for their partner.

Very few men were having vasectomies without having children first but Mr Terry had one interview subject lined up who had undergone a "pre-emptive" operation.

Mr Terry hopes to interview about 20 men who had had vasectomies, as well as their partners.

Men willing to be interviewed about their decisions before or after a vasectomy, or those considering a vasectomy, can contact Mr Terry on 09 373 7599 ext 86309 or email g.terry@auckland.ac.nz

-NZPA

Queuing to talk about snip

5:00 AM Saturday Mar 3, 2007



New Zealand blokes are not only unbuttoning their trousers in world-high numbers to have vasectomies, they are queuing up afterwards to talk about it.

An Auckland University PhD student investigating why New Zealand men chose to have vasectomies hoped to find 20 men to talk to him.

Within days of making a media call in January for interview subjects, Gareth Terry was deluged with responses.

"I had 300 emails in the first three days and I'm still getting emails at the moment. I didn't have the structures in place to handle it," he said. "Obviously it hit a nerve to some extent."

Mr Terry said he had been forced to spend two or three weeks just replying to the emailed offers of help.

He had now heard from about 350 men but had narrowed that down to about 30.

New Zealand's vasectomy rates are in the top three in the world, with Britain and the Netherlands.

At 18 per cent of all men, 25 per cent of all married men, and 55 per cent of 40-49 year-olds, New Zealand's vasectomy rate towers above places such as the United States, with just 7 per cent.

Most men in New Zealand who have vasectomies do so after having children but Mr Terry said the high number of responses to his research had enabled him to broaden his research - about 16 men who had undergone "pre-emptive" vasectomies had contacted him.

He had already spoken to some men in both the with and without-children groups. A common feature of those who had had a pre-emptive vasectomy was a strong ability to articulate why they had done it, along with the relationship and societal pressures to have children.

"One guy who I interviewed recently, his relationship ended up breaking up and [his partner] claimed at the time it wasn't to do with the vasectomy but when she broke up with him, within two years she was having her first child, so clearly it was an issue," Mr Terry said.

Some of the pre-emptive vasectomy men had also expressed strong ecological views and were very aware of over-population in the world.

Mr Terry expected his PhD research would take about three years

-NZPA

Appendix B: Transcript of interview with Michael Laws on Radio Live

Radio Live interview

- Laws: we are fan-tastic at self sterilisation apparently in my age group forty to forty nine fifty five percent of all New Zealand men have had a vasectomy (.) uh and about twenty five percent of all married men across all ages (.) um it is an ongoing trend in fact as I say we we lead the world apparently and um somebody is doing some research on this at the moment and hoping to do a lot more leg crossing research it's been titled and I'd have to say that's so true here's Auckland PhD psychology student Gareth Terry he joins me on the line now good morning to you Gareth
- GT: good morning
- Laws: you said (.) or you're quoted as saying (.) that one of the reasons in your discussions with the wives and partners of men who have had vasectomy may be that women are more assertive in this country
- GT: yeah there there's been um some research to show that um you know that New Zealand women are particularly strong there's also been some historical evidence as well um also there is an association with um education and um you know the higher an education a woman has the woman has the more likely their partner is to have a vasectomy as well
- Laws: so (laughing) I'm sorry but just drawing those correlations together that means if I met a stropo university graduate as a partner I mean leakly more lately well uh more likely to get gelded at some time in my future is that right
- GT: that's probably quite likely if you're going to draw those correlations (unclear)
- Laws: (overlaps) awww I think I'll start going out with checkout operators if that's the case
- GT: (laughs)
- Laws: alright now um on that though why do men in this country I mean you mention a fascinating stat here that something like twenty five percent of all married men in New Zealand have had a vasectomy and that that is an ongoing trend
- GT: mmn
- Laws: but only seven percent in the US is there something else within the New Zealand psyche
- GT: I don't know perhaps it's um you know a willingness to to have more egalitarian relationships um perhaps um less of a conservative sort of um focus in terms of the the way society is set up in terms of the simple you know black and white male female roles things like that um yeah um this is part of the reason why I'm doing the research I want to find out what exactly it is about New Zealand men particularly that that makes them different from from other men
- Laws: yeah well you've certainly touched on one of it and we're under the thumb more uh I guess though um it would be interesting thing is what about ethnic breakdowns do what on the basis of what you've just said so far one would assume that university educated white males are more likely to have vasectomy than any other group
- GT: ah yeah there the research has not been there's not been a lot of research in the area so because of that you know it's not as as clear cut in terms of of clear defining lines
- Laws: well I I'd hazard a small guess straight away that Muslim men have less rate of a vasectomy than agnostic white liberals
- GT: ah I mean that's a guess and I'm sure it's quite possible that that's the case I don't ah have any clear stats in front of me in terms of Muslim men in New Zealand so um (unclear)
- Laws: (overlaps) but you'll be doing that research as part of your PhD
- GT: um I'm um the the research I'm doing will be a smaller sample it won't be focussing on percentages and crunching numbers and things like that it's it's more about um (outbreath) having conversations and and um sort of analysing the the sort of conversations afterward so it's more of a qualitative rather than quantitative focus

Laws: you can get a PhD in this country just interviewing twenty people I can't believe that you must be doing something more for your PhD

GT: ah yeah there there's a bit more to that that's just the first phase of the of the um of the um process so there's a (outbreath) there's the twenty or so men for the the sample and then I'm hopefully going to be able to interview some of their partners um and also try to interview men who um not had vasectomies had chosen not to have vasectomies (.) very distinctly

Laws: you say we're one of the highest countries in the world for vasectomies are there other countries that have comparable rates

GT: yeah the um the sort of the top three tends to be the UK the Netherlands and us and we sort of fight it out for the top spot but um recent research that I've read seems to indicate that Australia's wanting to um you know try and take a top spot as well so they've started coming along behind and so we're still ahead (unclear)

Laws: (overlaps) ahh so we can't flee the Tasman either

GT: (laughs) no

Laws: we'll get chopped there too (inbreath) listen the other things that comes out about this is um this remarkable stat about the forty to forty nine age group that over half of New Zealand males have had a vasectomy

GT: yeah

Laws: do you think that perhaps there's a critical mass that builds up that enough men talk to each other and say ahh mate (.) nuthin' that that gives if you like the green light for other men that age group in that peer group to go ahead themselves

GT: yeah yeah I think that that's a an important um factor I also think it's um I mean the biggest surge of vasectomies happened in the nineteen seventies and that's also around the time that the uh the peak of or one of the big kicks for the feminist movement began as well um

Laws: (overlaps) (outbreath) mmn you see I don't like that correlation

GT: (laughs)

[cuts me off phone line]

Laws: thank you very much the very best of luck with your research that's Gareth Terry if you want to contact him just email him and you've had it once no this is what Gareth wants to talk to men who have vasectomies basically as for the reasons why and yes you can be honest it'll be totally confidential and say 'cause the partner demanded it I do it um g.terry@auckland.ac.nz g.terry@auckland.ac.nz

Appendix C: Sample Consent Form

CONSENT TO PARTICIPATE IN RESEARCH (Vasectomy)

THIS CONSENT FORM WILL BE HELD FOR A PERIOD OF SIX YEARS

Title of project: 'Vasectomy among New Zealand men'

Researchers: Gareth Terry, Virginia Braun, Nicola Gavey

I have been given and have understood an explanation of this research project. I have had an opportunity to ask questions about the project, and have them answered. I know that my participation in this project is entirely voluntary.

I understand that I can withdraw from the interview at any point, and that I am under no obligation to answer any particular questions. I also understand that I may withdraw any or all of the information I provide at any time up to 19 December 2007 without giving a reason.

- I agree to take part in this research
- I agree/ do not agree for the interview will be audio taped
- I agree that a person hired specifically for this purpose can transcribe my interview if necessary.

Signed:

Name:
(please print clearly)

Date:

Appendix D: Information Page for Survey

SURVEY PARTICIPANT INFORMATION SHEET (Vasectomy)

'Vasectomy among New Zealand men'

My name is Gareth Terry. I am a Doctoral student in the Department of Psychology at the University of Auckland being supervised by Dr. Virginia Braun and Dr. Nicola Gavey. I am conducting a research project looking at the place and meaning of vasectomy among men within New Zealand society.

As part of this research men will be able to participate in a web based questionnaire and give responses that best reflect their experiences. If you have had a vasectomy, I would like to invite you to participate in this part of my research. The questionnaire would take no more than thirty minutes to complete and will cover a range of topics related to sexuality and reproduction, including questions related to past and current sexual/ reproductive practices. As this questionnaire will be an examination of a personal topic, there is a slight chance you might find it upsetting in some way, although I hope you will find it enjoyable and interesting. In the unlikely event that you do become upset due to the material or discussion in the interview, all participants will be given information (with this Information Sheet) outlining support services that are available.

As this is a web-based questionnaire, without encryption, responses cannot be considered anonymous. However, *no personally identifying* information is collected - I have no way of knowing who has completed returned questionnaires. Similarly, confidentiality of the data cannot be absolutely *guaranteed*. Electronic data will be stored as password-protected files, and deleted when all interest in the data has passed.

Your participation is **voluntary**. I hope you will complete the entire survey, but if there are particular questions you do not want to answer, you are free not to answer them, and you are free to stop at any time if you change your mind. By completing the survey and submitting it online, you indicate that you understand the nature and purpose of the research, are aged over 16, and have given your **consent** to take part in this study. As I have no way of knowing who has taken part, you will not be able to withdraw from the research once you have returned your completed questionnaire.

If you do wish to participate in this survey, please click on the "I want to take part" button below. Thank you very much for your time and help in considering taking part. If you have any queries before or after completing the questionnaire, please contact me via email at g.terry@auckland.ac.nz. Alternatively you could contact one of my supervisors, Virginia Braun via email at v.braun@auckland.ac.nz.

The Head of Department is: *Associate Professor Fred Seymour*, (Tel. 373-7599 ext. 88414).

For any queries regarding ethical concerns, please contact: *The Chair*, The University of Auckland Human Participants Ethics Committee, (Tel. 373-7599 ext. 87830)

Appendix E: Sample Consent Page for Survey

Title of project: 'Vasectomy among New Zealand men'

Researchers: Gareth Terry, Virginia Braun, Nicola Gavey

I hope you will complete the survey as fully as possible, as it will help me with my research. The survey is in seven sections. **Please read the instructions**, and follow them, as you may not need to answer all questions in each section. When filling in the questionnaire, please **tick** the box that *most accurately* represents your answer.

To begin, read the following statements, and tick the appropriate boxes:

- I have read and understood the information describing the aims and content of the following questionnaire.
- I am 16 years or older.
- I understand that, by submitting this questionnaire electronically I agree to take part in this research under the terms indicated in the information supplied.

BEGIN

Appendix F: Sample of Survey

Vasectomy in New Zealand Questionnaire

This questionnaire is part of a research project investigating men's opinions and experiences regarding their decision to have a vasectomy.

The questionnaire is anonymous, so no individual responses can or will be identified. Please read each item carefully and answer in a way that reflects your 'gut' reaction to the question or item.

There is no right or wrong answer. We are only interested in your personal opinion and perceptions, whatever they may be.

Basic Demographic Information:

1. Age: _____

2. Occupation: _____

3. Ethnicity:
 - Pakeha/NZ European
 - Maori
 - Pacific Island (please specify) _____
 - Asian (please specify) _____
 - Other (please specify) _____

4. Region currently living:
 - Northland
 - Auckland
 - Waikato
 - Bay of Plenty/Hawkes Bay
 - Taranaki/Manuwatu
 - Wellington/Wairarapa
 - Nelson/Marlborough
 - West Coast (South Island)/Fiordland
 - Canterbury
 - Otago/Southland
 - Other _____

5. Religious Affiliation:
 - Atheist/None
 - Agnostic
 - Catholic
 - Protestant _____ (please specify)
 - Buddhist _____ (please specify)
 - Muslim _____ (please specify)
 - Other _____

6. Highest Level Education:
 - High School – no qualification
 - High School - with qualification (i.e. NCEA, Bursary)
 - Tertiary – Certificate/Diploma
 - Tertiary – Bachelors
 - Tertiary – Masters

Tertiary – PhD/Named Doctorate (i.e. MD)

7. Personal Income/Year:

- <\$10,000
- \$10,001 – 19,999
- \$20,000 – 39,999
- \$40,000 – 59,999
- \$60,000 - 79,999
- \$80,000 - \$99,999
- \$100,000+

8. Political Affiliation (Party whose views most closely match your own):

- National
- Labour
- Greens
- Maori Party
- Act
- NZ First
- Other _____

9. How many sexual partners have you had in your lifetime (approximately)? _____

10. How long have you been sexually active? _____ years

Children/Birth Control:

11. How many biological children do you have? _____

12. How many stepchildren or foster children do you have? _____

13. How many adopted children do you have? _____

14. If you have biological children, were you present at their births?

- Yes No Some/Not all

15. Prior to your vasectomy, who was *primarily* responsible for birth control?

- Me My Partner(s) Both

16. What forms of contraceptives/birth control have you or your partner(s) used in the past (tick all that apply)

- The Pill IUD Condoms
- Cervical Cap Norplant Depo Provera (Injection)
- Diaphragm Withdrawal Natural Family Planning
- Emergency Contraceptive Abstinence from penetrative sex
- None Other _____

Questions about the vasectomy:

17. How long has it been since your vasectomy? _____ years

18. Who first suggested vasectomy to you as a contraceptive option?

- Wife/Partner Male Friend Female Friend
- Colleague Relative Physician

- Other _____
- 19. Did you have *at least* one semen sample with a negative result after your vasectomy?
 - Yes
 - No
- 20. Did you freeze semen before the operation?
 - Yes
 - No
- 21. Has your vasectomy been unsuccessful at any time (i.e. you had a child after the operation)?
 - Yes
 - No
- 22. Have you had a reversal at any time?
 - Yes (go to Q. 23)
 - No (go to Q. 24)
- 23. Why did you have a reversal?
 - New wife/partner Decided we wanted more children
 - Diminished sex drive Felt that I had "lost something"
 - Pain/problems Other _____

Reasons for the vasectomy:

Please indicate to what extent you agree or disagree with each of the following statements. Please select the number (ranging from 1 to 7) that best reflects your opinion PRIOR to your vasectomy.

1=Strongly Disagree

2=Disagree

3=Slightly Disagree

4=Neutral/No opinion

5=Slightly Agree

6=Agree

7=Strongly agree

- 24. I chose to have a vasectomy because we could not afford another child
 (Strongly Disagree) 1 2 3 4 5 6 7 (Strongly Agree) N/A
- 25. I chose to have a vasectomy as it was cheaper than female sterilisation (i.e. tubal ligation)
 (Strongly Disagree) 1 2 3 4 5 6 7 (Strongly Agree) N/A
- 26. I chose to have a vasectomy because of emotional pressure from my
 wife/partner
 (Strongly Disagree) 1 2 3 4 5 6 7 (Strongly Agree) N/A
- 27. I chose to have a vasectomy because of I felt it was my turn to take responsibility for the birth
 control
 (Strongly Disagree) 1 2 3 4 5 6 7 (Strongly Agree) N/A
- 28. I chose to have a vasectomy because my wife/partner asked me to
 (Strongly Disagree) 1 2 3 4 5 6 7 (Strongly Agree) N/A

29. I chose to have a vasectomy because of the health risks to my partner if she got pregnant
(Strongly Disagree) 1 2 3 4 5 6 7 (Strongly Agree) N/A
30. I chose to have a vasectomy because of health risks associated with the pill or other
contraception my wife/partner was using
(Strongly Disagree) 1 2 3 4 5 6 7 (Strongly Agree) N/A
31. I chose to have a vasectomy due to the invasiveness of the female equivalent
(Strongly Disagree) 1 2 3 4 5 6 7 (Strongly Agree) N/A
32. I chose to have a vasectomy due to the recovery time needed is much less than for the female
equivalent
(Strongly Disagree) 1 2 3 4 5 6 7 (Strongly Agree) N/A
33. I chose to have a vasectomy due to the possibility of genetic problems
that may be passed onto a child
(Strongly Disagree) 1 2 3 4 5 6 7 (Strongly Agree) N/A
34. I chose to have a vasectomy because we felt that our family was complete
(Strongly Disagree) 1 2 3 4 5 6 7 (Strongly Agree) N/A
35. I chose to have a vasectomy due to suggestions from a male friend
(Strongly Disagree) 1 2 3 4 5 6 7 (Strongly Agree) N/A
36. I chose to have a vasectomy because I feel it is the masculine thing to do
(Strongly Disagree) 1 2 3 4 5 6 7 (Strongly Agree) N/A
37. I chose to have a vasectomy because I feel the earth is over-populated enough as it is
(Strongly Disagree) 1 2 3 4 5 6 7 (Strongly Agree) N/A
38. I chose to have a vasectomy in order to better invest time in my relationships (wife/partner,
existing children, family, friends)
(Strongly Disagree) 1 2 3 4 5 6 7 (Strongly Agree) N/A
39. I chose to have a vasectomy in order to have more time for my own interests/pursuits
(Strongly Disagree) 1 2 3 4 5 6 7 (Strongly Agree) N/A
40. I chose to have a vasectomy because I doubted my abilities as a potential father
(Strongly Disagree) 1 2 3 4 5 6 7 (Strongly Agree) N/A
41. I chose to have a vasectomy because having children was not one of my life goals
(Strongly Disagree) 1 2 3 4 5 6 7 (Strongly Agree) N/A
42. I chose to have a vasectomy because I had priorities other than child rearing in my life, such as
a career or travelling
(Strongly Disagree) 1 2 3 4 5 6 7 (Strongly Agree) N/A
43. I chose to have a vasectomy because my partner and I wanted the convenience of not having
to worry about contraceptives on a daily, weekly or monthly basis
(Strongly Disagree) 1 2 3 4 5 6 7 (Strongly Agree) N/A

44. I chose to have a vasectomy because I felt it was the right thing to do
(Strongly Disagree) 1 2 3 4 5 6 7 (Strongly Agree)

45. I chose to have a vasectomy for other reasons (please specify)

(Strongly Disagree) 1 2 3 4 5 6 7 (Strongly Agree)

Concerns prior to vasectomy:

Please indicate to what extent you agree or disagree with each of the following statements. Please select the number (ranging from 1 to 7) that best reflects your opinion PRIOR to your vasectomy.

1=Strongly Disagree

2=Disagree

3=Slightly Disagree

4=Neutral/No opinion

5=Slightly Agree

6=Agree

7=Strongly agree

46. I was concerned about the vasectomy, as it is not considered an appropriate means of birth control in my religion
(Strongly Disagree) 1 2 3 4 5 6 7 (Strongly Agree) N/A

47. I was concerned about vasectomy, as it is not culturally appropriate to have one
(Strongly Disagree) 1 2 3 4 5 6 7 (Strongly Agree) N/A

48. I was concerned about what my friends would think if they found out I had a vasectomy
(Strongly Disagree) 1 2 3 4 5 6 7 (Strongly Agree) N/A

49. I was concerned about what my family would think if they found out I had a vasectomy
(Strongly Disagree) 1 2 3 4 5 6 7 (Strongly Agree) N/A

50. I have felt the need to hide that I have had a vasectomy from other people
(Strongly Disagree) 1 2 3 4 5 6 7 (Strongly Agree) N/A

51. I was concerned about the pain associated with having a vasectomy
(Strongly Disagree) 1 2 3 4 5 6 7 (Strongly Agree) N/A

52. I was concerned about a loss of feeling/sensation during sex
(Strongly Disagree) 1 2 3 4 5 6 7 (Strongly Agree) N/A

53. I was concerned about possible future health risks
(Strongly Disagree) 1 2 3 4 5 6 7 (Strongly Agree) N/A

54. I was concerned that we might want to have more children
(Strongly Disagree) 1 2 3 4 5 6 7 (Strongly Agree) N/A

55. I was concerned that if I were to have a new wife/partner we might want children together
(Strongly Disagree) 1 2 3 4 5 6 7 (Strongly Agree) N/A
56. I was concerned that if one of our children died then we might want to have another child
(Strongly Disagree) 1 2 3 4 5 6 7 (Strongly Agree) N/A
57. I was concerned that I would feel less of a man after the vasectomy
(Strongly Disagree) 1 2 3 4 5 6 7 (Strongly Agree) N/A
58. I was concerned that I was being pressured to have a vasectomy
(Strongly Disagree) 1 2 3 4 5 6 7 (Strongly Agree) N/A
59. I was concerned that I would have less interest in sex after a vasectomy
(Strongly Disagree) 1 2 3 4 5 6 7 (Strongly Agree) N/A
60. I was concerned I would feel depressed after having a vasectomy
(Strongly Disagree) 1 2 3 4 5 6 7 (Strongly Agree) N/A
61. I was concerned about having a vasectomy for other reasons (please specify)

Post vasectomy:

Please indicate to what extent you agree or disagree with each of the following statements. Please select the number (ranging from 1 to 7) that best reflects your experiences AFTER your vasectomy.

1=Strongly Disagree

2=Disagree

3=Slightly Disagree

4=Neutral/No opinion

5=Slightly Agree

6=Agree

7=Strongly agree

62. My post-op recovery was exactly as described by the surgeon/physician
(Strongly Disagree) 1 2 3 4 5 6 7 (Strongly Agree) N/A
63. I had no more pain than I expected
(Strongly Disagree) 1 2 3 4 5 6 7 (Strongly Agree) N/A
64. The post-op pain lasted no more than a week afterward
(Strongly Disagree) 1 2 3 4 5 6 7 (Strongly Agree) N/A
65. My wife/partner was verbally appreciative of my choice to have a vasectomy
(Strongly Disagree) 1 2 3 4 5 6 7 (Strongly Agree) N/A
66. My wife/partner was physically appreciative (i.e. hugs etc., not sex) of my choice to have a vasectomy

- (Strongly Disagree) 1 2 3 4 5 6 7 (Strongly Agree) N/A
67. I found that I have enjoyed sex more after the vasectomy
(Strongly Disagree) 1 2 3 4 5 6 7 (Strongly Agree) N/A
68. My wife seems to enjoy sex more since the vasectomy
(Strongly Disagree) 1 2 3 4 5 6 7 (Strongly Agree) N/A
69. We have sex more frequently since the vasectomy
(Strongly Disagree) 1 2 3 4 5 6 7 (Strongly Agree) N/A
70. I have regretted having the vasectomy
(Strongly Disagree) 1 2 3 4 5 6 7 (Strongly Agree) N/A
71. My wife has regretted me having the vasectomy
(Strongly Disagree) 1 2 3 4 5 6 7 (Strongly Agree) N/A
72. I have concerns about how my family or friends view my decision to have a vasectomy
(Strongly Disagree) 1 2 3 4 5 6 7 (Strongly Agree) N/A
73. I have regretted my choice **to have** children
(Strongly Disagree) 1 2 3 4 5 6 7 (Strongly Agree) N/A
74. I have regretted my choice to **not have** children
(Strongly Disagree) 1 2 3 4 5 6 7 (Strongly Agree) N/A
75. I have had the following experiences after my vasectomy not covered above (please specify)

(Strongly Disagree) 1 2 3 4 5 6 7 (Strongly Agree)

Appendix G: Sample of Participant Information Sheet

INTERVIEW PARTICIPANT INFORMATION SHEET (Vasectomy)

'Vasectomy among New Zealand men'

My name is Gareth Terry. I am a Doctoral student in the Department of Psychology at the University of Auckland being supervised by Dr. Virginia Braun and Dr. Nicola Gavey. I am conducting a research project looking at the place and meaning of vasectomy among men within New Zealand society. The research also focuses on ideas about sexuality and sexual/reproductive behaviour as they relate to ideas of male health and psychological well being. The project aims to examine contemporary meanings of sex and reproduction within society, and how these affect individual men who have chosen to have a vasectomy.

As part of this research I will be interviewing men about their experiences. If you have had a vasectomy, I would like to invite you to participate in my research.

Participation would involve a single confidential interview, conducted by myself. This would last between one and one and a half hours, and take place at a time and location that suits you (or it may be by telephone if you are outside the Auckland area). Interviews will cover a range of topics related to sexuality and reproduction, including discussion of past and current sexual/ reproductive practices. As this will be an in-depth discussion of a personal topic, there is a slight chance you might find it upsetting in some way, although I hope you will find it enjoyable and interesting. In the unlikely event that you do become upset due to the material or discussion in the interview, all participants will be given information (before the interview starts) outlining support services that are available.

The interview would, with your consent, be audio tape-recorded, and will be transcribed by myself or a third person hired specifically for this purpose. This person will be required to retain strict confidentiality regarding the information transcribed. Some demographic information will also be collected. All information will be stored on password protected computers and in locked filing cabinets in the Psychology Department at the University of Auckland, accessible only by Gareth Terry, Virginia Braun and Nicola Gavey.

Participation in this research is entirely voluntary, and you would be able to withdraw from the research, without giving reasons, prior to, and during, the interview. You would also have the opportunity to withdraw all or part of your interview material from the study for up to one month after the interview has taken place. The information you provide will be reported in a way that will not identify you as its source. Identifying information will be changed, and a pseudonym given to any of your data used in publications arising from this research. Information you provide will be retained for as long as my interest in the area is maintained, and I am in a position to store it securely.

If you do wish to be interviewed, please let me know by phoning me, or I will contact you again in about a week to see if you are interested. Thank you very much for your time and help in considering taking part. If you have any queries, or wish to know more, please contact me:

Gareth Terry

Email: gareth.terry@gmail.com

Tel: 373-7599 extn 86309

Mail: Department of Psychology, The University of Auckland, Private Bag 92019, Auckland

This project has been funded by a University of Auckland Doctoral Scholarship.

My supervisors are: Dr. Virginia Braun and Dr. Nicola Gavey, Department of Psychology, The University of Auckland, Private Bag 92019, Auckland, Tel. 3737-7999 extn 87561 (Virginia), extn. 86877 (Nicola).

The Head of Department is: *Associate Professor Fred Seymour*, Department of Psychology, The University of Auckland, Private Bag 92019, Auckland, Tel. 3737-7999 extn 88414.

For any queries regarding ethical concerns, please contact:
The Chair, The University of Auckland Human Participants Ethics Committee, The University of Auckland, Office of the Vice Chancellor, Private Bag 92019, Auckland. Tel. 373-7999 extn 87830

Appendix H: Jeffersonian Transcription Conventions

[]	Square brackets mark the start and end of overlapping speech. They are aligned to mark the precise position of overlap as in the example below.
↓	Vertical arrows precede marked pitch movement, over and above normal rhythms of speech. They are used for notable changes in pitch beyond those represented by stops, commas and question marks.
<u>Underlining</u>	indicates emphasis; the extent of underlining within individual words locates emphasis and also indicates how heavy it is.
CAPITALS	mark speech that is hearably louder than surrounding speech. This is beyond the increase in volume that comes as a by product of emphasis.
° I know it, °	‘degree’ signs enclose hearably quieter speech.
“I’m on the pill”	“quotes” enclose directly reported speech
(0.4)	Numbers in round brackets measure pauses in seconds (in this case, 4 tenths of a second). If they are not part of a particular speaker’s talk they should be on a new line. If in doubt use a new line.
(.)	A micropause, hearable but too short to measure.
she wa::nted	Colons show degrees of elongation of the prior sound; the more colons, the more elongation.
Hhh	Aspiration (out-breaths); proportionally as for colons.
.hhh	Inspiration (in-breaths); proportionally as for colons.
y’know?	Question marks signal stronger, ‘questioning’ intonation, irrespective of grammar.
Yeh.	Full stops mark falling, stopping intonation (‘final contour’), irrespective of grammar, and not necessarily followed by a pause.
bu-u-	hyphens mark a cut-off of the preceding sound.
>he said<	greater than’ and ‘lesser than’ signs enclose speeded-up talk. Occasionally they are used the other way round for slower talk.
solid.= =We had	Equals’ signs mark the immediate ‘latching’ of successive talk, whether of one or more speakers, with no interval.
(laughter)	Voiced laughter. Can have other symbols added, such as underlinings, pitch movement, extra aspiration, etc.

Appendix I: Summary of Interview Questions (Vasectomy)

These general areas will be developed into specific questions.

- Length of current sexual relationship, birth control practices during this time
- Length of time since vasectomy and whether this has changed/affected relationship etc.
- Experience of vasectomy, thoughts prior and post
- Emotional reactions?
- Decision making process around vasectomy (whether participant considers it a “free choice” or one ‘imposed’)
- Decision making assistance: Did you get it, did you want it?
- Vasectomy and others – intimate relationships, relatives and friends knowledge
- Stories about friends
- Popular ideas/stereotypes about vasectomies
- Any other meanings aside from an operation to you? (i.e. commitment)
- Day to day of relationship. How are decisions made? Finances etc.
- Decision to have children? Made, decided for, sort of fell into it?
- Sexual Relationship. How is this managed? (i.e. who initiates, why?)
- Importance of equality/being egalitarian
- Enjoyment of sex as a couple - sex a significant part of relationship (typical sexual experience)
- Feelings/thoughts about sexuality and specific sexual behaviours (i.e. necessity of coital sex)
- Decision to have children, was there an option towards childlessness?
- Feelings/thoughts about children and childbirth. Involvement (if at all) in birthing process
- Fatherhood as an experience/concept
- Differences between current and previous sexual relationships in terms of reproductive practices
- Impact of experiences of vasectomy on understandings of sexuality, reproduction and sex

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