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Article Title: Men, masculine identities and childbirth

Year of publication: 2011

Link to published article:

<http://dx.doi.org/10.1111/j.1467-9566.2011.01349.x>

Publisher statement: The definitive version is available at [www.wileyonlinelibrary.com](http://www.wileyonlinelibrary.com)

## **Men, masculine identities, and childbirth**

### **Abstract**

In recent years, father's experiences during childbirth have attracted much research and policy interest. However, little of this work has been grounded in the first-hand accounts of men and there is a lack of theory-based research to help understand men's thoughts and practices around childbirth. This paper is based on qualitative research undertaken with first-time fathers and health-care professionals. It draws on Connell's (1995) conceptualisation of hegemonic masculinity to explore how men construct masculine identities within the context of pregnancy and childbirth and also how health-care professionals construct masculinity. The paper highlights the ways in which men can find themselves marginalised within the context of pregnancy and childbirth, but are still able to draw on identifiable markers of masculine practice which enable them to enact a masculine form congruent with dominant masculinity. It also illustrates how health-care professionals' constructions of masculinity enable them to predict how men will behave and allow them to position men in ways that involved minimum disruption to their own practice. The paper also highlights how men's marginal status is embedded in the dynamics of the social structure, which produce and reproduce dominant masculine identities within the context of childbirth.

## **Men, masculine identities and childbirth**

### **Introduction**

In the UK, father's experiences during childbirth have attracted increasing research and policy interest (DH 2007; Mander 2004; Draper 2003). This expansion mirrors father's increasing involvement in childbearing. Today, almost all fathers-to-be are present at the birth and men appear not only welcome, but also expected to participate in the labour and delivery (Dex and Joshi 2005). Great claims have also been made about men's attendance at childbirth, not only for the sake of the mother and child's health but also for their own health and to facilitate the relationship between father and baby (Bartlett 2004). In contrast, others have questioned the assumptions made about the beneficial involvement of men in childbearing and suggest the childbirth process is often an ambiguous and sometimes problematic experience for men (Mander 2004).

Despite the surge in interest around men's childbearing experiences, our knowledge relating to this which is grounded in the first-hand accounts of men themselves remains scarce (Dellmann 2004). Not only is the qualitative research base limited, there has also been little in the way of theory-based research to help understand men's thoughts and practices around pregnancy and childbirth (Draper 2003). In short, much of this new activity appears to overlook the fact that fathers are men too, and, as such, we need to bring the relationship between social constructions of masculinity and men's experiences around pregnancy and childbirth more centrally into focus.

Connell's (1995) theory of 'hegemonic masculinity' is promising in this regard, having been used extensively in recent gender research and construction of masculine identities (Courtenay 2000).

This paper is based on qualitative research undertaken with first-time fathers and health-care professionals working in a large maternity unit in the UK. It draws on Connell's (1995) conceptualisation of hegemonic masculinity to explore how men construct masculine identities within the context of pregnancy and childbirth and also how health-care professionals construct masculinity. To date, few studies have explored health-care professionals' conceptualisations of masculinity and how this may influence how men are 'positioned' during childbirth. Evidence from primary care in the UK (Seymour-Smith et al 2002), suggests health-care professionals often focus on stereotypical masculine traits, which has implications for how they engage with men. Incorporating the views of health-care professionals offers insights into professional perspectives on men and masculine identities and how this may inform men's own constructions of masculinity during childbirth.

### **Hegemonic masculinity**

The notion of 'masculinity' as an essentially fixed or unitary concept has been contested (Whitehead 2002). Recent theorists have started to conceptualise 'masculinities' as plural, influenced by histo-socio-cultural factors; i.e. open to change in new or differing circumstances, and dependent on other aspects of identity and wider social structures (Paechter 2003). Central to these developments has been a growing interest in the concept of 'hegemonic

masculinity' (Connell 1995), which has become a 'profound and pervasive' theoretical framework with which to understand men and masculinities (Coles 2009: 30).

Connell's theory of hegemonic masculinity is premised on differences in gendered power. He identifies a 'culturally idealised', or hegemonic, pattern of masculinity, not just in relation to other men and masculinities (e.g. subordinated or marginalised), but in relation to the gender order as a whole; 'the configuration of gender practice which ... guarantees ... the dominant position of men and the subordination of women (1995: 77). Currently it is the values and attributes associated with white, upper/middle class, heterosexual men which set the standard for other men. Many men therefore align themselves with characteristics such as stoicism, displays of self-confidence and the denial of weakness and seek to emulate hegemonic forms of masculinity that are equated with being successful, capable and in control (Courtenay 2000). Alongside men's endorsement of hegemonic ideals is their rejection of feminine ideals; i.e. 'not being like women' (Kimmel 1994: 126), which contributes to the construction of hegemonic masculinity and the oppression of women and less powerful men. Although hegemonic masculinity may not be the most common form of masculinity practiced, it is supported by the majority of men as a means of defending patriarchal dominance (Coles 2009).

The strength of hegemonic masculinity as a theoretical tool lies in its ability to describe a hierarchical range of masculinities and how these develop not as

isolated acts but as 'configurations of gender practice' generated in particular situations (Connell 1995: 81). Differing configurations of practice are associated with different forms of masculinity dependent upon whether men are enacting hegemonic, marginalised or subordinated forms. In other words, where men are denied the social power and resources necessary for constructing hegemonic masculinity, they will seek to employ other strategies for constructing gender identities that validate them as men, albeit within subordinated and/or marginalised positions. Among groups of working class men, for example, masculinity may be exemplified by physical strength (Dolan 2011). Importantly, however, Connell's conception is not intended to form a checklist or 'character typology' to identify particular traits, but emphasises how hegemonic forms of masculinity inform and structure the ways in which men construct themselves as masculine.

Furthermore, there is no single pattern or form of hegemonic masculinity, rather there are 'multiple, context-dependent strategies for doing hegemonic masculinity' (Noone and Stephens 2008: 713). Equally, it is possible for dominant masculinities to exist within subordinated or marginalised positions; 'it is possible to be subordinated by hegemonic masculinity yet still draw on dominant masculinities and assume a dominant position in relation to other men' (Coles 2009: 33). Clearly, therefore, these are not intended to be viewed as mutually exclusive or 'fixed' categories. Men may differ in how strongly they hold hegemonic masculine attitudes and beliefs and they may move back and forth between hegemonic, subordinated or marginalised positions dependent upon particular social contexts. As Messerschmidt has pointed out;

'masculinity is never static or a finished product. Rather, men construct masculinities in specific social situations' (1993: 31)

In summary, Connell's (1995) influential conceptual framework has been used extensively in research across the social sciences and humanities. It facilitates an understanding of masculinities as fluid but also hierarchical; certain configurations of practice gaining dominance at the expense of other configurations that become subordinated to and/or marginalised from hegemonic forms.

### **Study design**

The findings reported here are drawn from a small qualitative study conducted with first-time fathers and health professionals working in a large maternity unit in the UK. The choice of in-depth interviews as the research method for this study reflects concern regarding the lack of male narratives or 'voices' within this field of research (Draper 2003) as well as philosophical assumptions; ontological and epistemological, about individuals and the contextual conditions that shape and embed their perspectives and experiences (Popay and Groves 2000). Thus, interviews allow us to explore first-time fathers' and health-care professionals' subjective and experiential constructions of masculinity in relation to pregnancy and childbirth from within their own life context. Interviews also allow us to interrogate the explicit interpretation of meanings attached to first-time fathers' and health-care professionals' actions and thereby reveal more of the complexities surrounding how men construct masculinity in the context of childbirth. The

decision to concentrate on first-time fathers was based upon the notion that these men would be at their most sensitive and aware to the 'newness' of their situation having not experienced childbirth before.

Ethical approval for the study was obtained from the NHS local research ethics committee and men were recruited through face-to-face contact whilst attending antenatal appointments with their partners at the research site.

Those men expressing an interest and meeting the eligibility criteria (first-time expectant fathers) were provided with standard participant information sheets and gave written informed consent prior to their involvement. However, recruiting first-time expectant fathers into a study which asked them to share their thoughts and feelings in detail and to be interviewed twice proved to be difficult and time consuming. Dozens of men were approached but few expressed an interest in taking part in this study. We can only speculate as to why this was the case; men's anxieties and fears around childbirth may well have been a factor though men's general reluctance to take part in qualitative research studies is well documented (e.g. Cornwell 1984).

Five first-time fathers were recruited to the study. These men were each interviewed on two separate occasions, once shortly before the birth (between four and eight weeks) and once shortly after the birth (between four and eight weeks). All of the men who took part described themselves as white and four were in manual employment. The men ranged in age between 28 and 33 and all were in stable relationships with their partners. Following the recruitment of the men, five health professionals were recruited to the study. As a means of



accessing the wide variety of disciplines within maternity services, this group included a consultant obstetrician, a midwifery manager, two senior midwives and a health visitor with a strong background in midwifery. The health professionals were interviewed once, after the interviews with the men were completed. The decision to interview men twice was largely influenced by the wish to capture temporal aspects of men's transition to fatherhood. Many studies exploring men's views and experiences around this time have been entirely retrospective in nature with men reflecting on their experiences of fatherhood childbirth from the vantage point of having assumed a parenting role (e.g. Eriksson et al 2007). Consequently, expressions of men's active desires and concerns around the impending birth of their child are largely missing from these studies.

On average, each interview lasted for approximately one-and-a-half hours and was carried out at a time and place of the participants' choosing; the majority took place in the participants' own homes but some of the professional interviews took place at their place of work. Both authors conducted the interviews. The two authors are experienced interviewers and sought to ensure interviewer consistency by using the same semi-structured interview schedule and, where possible, agreed probes. The interviews with men focused on their subjective experiences 'as men' of the pregnancy, labour and birth while the professional interviews concentrated on current practice in relation to men and also drew upon issues raised by the men themselves during their interviews.

All of the interviews were recorded and anonymised. Following full transcription of the interview data, a coding schedule was developed through systematic reviews of the data conducted by hand by each of the researchers. The coded data were examined to identify variations or contradictions in accounts. This independent manual analysis of the data led to inductively derived categories based on commonalities, themes or patterns of talk. The congruence and reconciliation of these themes were then subsequently developed within research team meetings. Only those themes, evident across the majority of accounts were considered for inclusion in the findings. These themes were then conceptually advanced and linked to theory and existing empirical data. In presenting this data the confidentiality of participants has been protected by using pseudonyms and changing place names which could lead to their identification.

Before the paper moves on to present its findings it is pertinent to point out this study has certain limitations. Firstly, the number of men recruited was small and limited to first-time fathers, so the findings may not be applicable to all men. Secondly, the number of health-care professionals who participated in this study was also small, so again the views held by the health-care professionals in this study may or may not be representative of all colleagues working in the field. Thirdly, it was carried out in a single maternity unit serving a particular population, so the findings cannot be extrapolated to other areas. However, despite these limitations, the authors adopted several measures to ensure rigour and thereby establish confidence in the findings (cf. Mays and Pope 1995). Critical reflection was used throughout the research process to

build self-awareness concerning the roles of the researchers. Field notes captured thoughts and observations of interactions with study participants during and after interviews. Repeat interviews helped establish rapport and trust and thus build confidence in the certainty of the data. The data was analysed in a thorough and exact fashion. Therefore, although this was a relatively small scale investigation, the level of engagement of the men and health-care professionals concerned and the rigor of the research process suggests that the findings are trustworthy. Additionally, many of the findings of this study are consistent with those of previous investigations within the field of men and masculinities which is reassuring.

## **Findings and discussion**

### **Setting the scene; men's experiences of the pregnancy and antenatal care**

The first interviews began by asking men about the pregnancy and their reactions to becoming fathers; went on to discuss their views about childbirth and experiences of antenatal care; and asked about their concerns and hopes regarding the forthcoming birth. Across the range of responses it was clear that men drew upon values associated with hegemonic masculinity to provide substance to their versions of appropriate male attitudes and behaviours during this time. When asked about their initial reactions to the pregnancy, for example, the perceived positive relationship between being male and the ability to father children was evident in the men's accounts:

Over the moon. ...I suppose it's like a man thing. It's like you feel more of a man in a way. I know it sounds a bit weird but you feel more a man. ...You feel everything's working and you're alright. So I was over the moon, overjoyed. (F. 4)

Two men talked in terms of 'relief' and compared their sense of masculine fulfilment with the experiences of male friends and relations who were in infertile relationships; "It's nice to say you're going to be a father. ...It's something to be proud of. ...I have a brother, he couldn't have children. ...These men who do miss out I feel ever so sorry for them. It must be terrible' (F. 1). A small but growing body of work has highlighted how men's bodies play a key role in demonstrating hegemonic masculine identity (e.g. Watson 2000). To date, this has generally focused on the 'functional', 'heterosexual' and 'potent' male body, which implicitly, rather than explicitly, includes 'fertile'. Interestingly, research into the connections between masculine identities and fertility has generally been confined to studies which have examined men's responses to infertility (Throsby and Gill 2004). Here, the male body was strongly implicated in men's responses to pregnancy; promoting the notion of fertility as a core aspect of hegemonic masculinity.

Men's bodies were also implicated in another theme evident in men's accounts; maintaining health to meet the needs of forthcoming dependents. The reality of the pregnancy appeared to ignite certain anxieties related to the health of their partner and unborn child as well as their own health. Men described how they had cut down on their alcohol intake and exercised more;

“I’ve started going to the gym again ... I want to be there for them when they’re older” (F. 1). These changes in health-related behaviour were also linked to their role as primary economic providers; “I’m not one for boozing all the time. ...But work has to come first now. I have another person to think about now. ...There's no two ways about it. You have to change” (F. 3). Men also described new fears related to negative financial consequences should they fall ill or worse:

I have thought a lot more about it to be honest with you. I have thought a lot more about death. I have took out loads of (Life Assurance) policies. ...It’s not something you really think about before you have a family. ...And now, I am thinking about it a lot. ...I hope that will stop. I think it will stop once I get used to it. (F. 2)

As reported elsewhere (Robertson 2006), concern with health and limiting excess does not mean men abandon hegemonic ideals. Rather other hegemonic ideals, such as taking control and being the main material provider, are drawn on to support change. Thus, to be dutiful partners and fathers required men ensure adequate provision for their new dependent, which also led them to think about their own health and well-being; i.e. men sort to legitimate changes in their health behaviour in order to maintain their masculine identity. The ideals of hegemonic masculinity may therefore shift as men’s position in the lifecourse changes (cf. Robertson 2006). Importantly these shifts may occur earlier than perhaps previously thought, in response to pregnancy rather than childbirth.

All of the men interviewed intended to be at the labour and birth. Their reasons for this tended to portray childbirth as a shared experience; “It’s my baby too. ...I wouldn't miss it for the world” (F. 4), though one man suggested that men were compelled to attend by the ideals of hegemonic masculinity; “I think it’s expected of men these days. ...I think you’re frowned upon if you don’t” (F. 3). Talking about the forthcoming birth, men tended to draw upon widely available discursive resources to construct a particular masculine identity which portrayed men’s role as ‘instrumental’/‘active’ (cf. Somers-Smith 1999), as well as being the focal point for women’s expression of pain and discomfort:

Just be supportive I'd say. ...Take the abuse [laughs]. Just to be supportive and just to do what she wants me to do basically. (F. 4)

I'll be there ... doing what she wants when she needs it. I'll block me ears when the foul language comes out. (F. 1)

I've seen all the movies and all the things on the TV. ...I'm going to be there to hold her hand ... I'm sure I'll get told off! (F. 5)

Importantly, these responses also illustrate how particular social contexts influence the construction of hegemonic masculine identities (Coles 2009). The ideals men considered hegemonic within the context of labour and childbirth, such as attentiveness and concern for others, are traditionally

considered feminine characteristics. Moreover, men presented themselves as the willing recipients of 'abuse'; whereas in many environments male aggression in the face of insults and foul language are typically ways in which men enact and sustain hegemonic masculinity and prevent themselves being relegated to subordinated positions (Dolan 2007b). In short, therefore, within the context of childbirth, men redefined hegemonic masculine identities to include features ordinarily considered to be feminine and/or associated with subordinated groups of men.

All of the men attended antenatal appointments and some 'parent craft' classes. There was general agreement that the focus was primarily on mothers and babies, which was deemed understandable and appropriate; "That's natural like. Because she's carrying the baby" (F. 5). However, this also informed their lack knowledge about childbirth and what it would be like for them as men; "It could be a bit more directed towards fathers. As regards information. ...There could be a bit more for fathers. There could be a little booklet telling you all the information you need" (F. 4). Alongside and linked to this, a range of male anxieties were identified; including not knowing how long the labour would last and how they would react to seeing their partner in pain (cf. Hallgren et al 1999). Essentially, as first-time fathers, it was the uncertainty surrounding childbirth which caused most concern:

I suppose a bit nervous and frightened. Because I don't know what to expect. Well I do and I don't. But it's the first time so I don't know really what to expect until it actually happens. (F. 1)

Dominant social constructions of masculinity also appeared to heighten male fears and concerns around childbirth. The emphasis placed on physical/emotional control and the denial of weakness/vulnerability, which are prescribed as important components of hegemonic masculinity (Dolan 2011), were particularly apparent here. A major concern was the possibility that they themselves might not cope well with aspects of the labour and birth; “I’m a little worried I might faint or something. ...I’m sure I’ll be fine. ...Lads I work with they’ve all had kids and they were all fine” (F. 3), which was underpinned by the notion that some men can handle the environment whereas others cannot:

I want to be up the head end. ...I don’t want to see any of that end at all because I don’t like it, at all. ...That’s the only thing I’m worried about. (F. 2)

First and foremost I hope I don't pass out. Because I don't like needles and all that sort of stuff. ...It just sends me a bit funny. ...I'm hoping I won't pass out anyway. But you never know. (F. 1)

The first of these quotes echoes other findings, which suggest male anxieties around childbirth may be related to fears about female reproductive functions and women’s ‘leaky’ bodies (e.g. Draper 2003). The second quote suggests men’s fears may actually be related to their own experiences of health and health care settings. Men’s understandings around health and utilisation of



health care appear to be integrally tied into their gendered identities; interpreted as essentially feminine territory which results in men lacking knowledge and experience across a range of health settings (Doyal 2000).

Men's conceptualisations around health and health care may, therefore, inform their anxieties in relation to childbirth. Two men, for example, talked about their "hate" of hospitals; "There's that smell. ...I don't know how to explain it. ...It freaks me out" (F. 4). To date, however, childbirth has not been framed as a 'health' issue for men; primarily because men's health is not the focus. However, childbirth does raise health-related concerns in terms of their partner and child, and also requires men to engage with health-care professionals within a health care setting, and therefore has the capacity to indicate 'weakness' and thereby assign men to lower-status positions.

Also apparent were the ways in which men tended to orientate their accounts away from potentially 'uncomfortable' masculine positions to construct more 'respectable' masculine identities. Men commonly achieved this by incorporating values associated with hegemonic masculinity into their narratives. Thus, while they admitted to feeling "scared" and "anxious", they had not seen the necessity to share these concerns and fears with health-care professionals or others. Though they asked questions and engaged with midwives none admitted disclosing personal difficulties which was considered to be weak and egotistical within the context of childbirth; "That would be selfish. ...It's her they're looking after ... not me" (F. 3). The following quote, with its emphasis on control, entitlement and responsibility to others,

powerfully illustrates how men sought to construct a male identity congruent with the ideals of hegemonic masculinity:

I have concerns and worries about things. ...But I don't have the right to share those because she's going through all this. She's going to have all this pain and everything else. ...My little worries are not really that important in the light of things (F. 5)

This quote echoes other evidence which suggests that many men regard physical pain as more legitimate than emotional distress (cf. Dolan 2007a; Bendelow 1993). Thus, in the context of childbirth, pain with a physical cause has a respectability and authenticity not available to men, which can have a significant impact on the way men relate to and communicate with those around them. For example, these men did not talk in any real depth with male friends, colleagues or family members about their concerns or uncertainties; "No, I'm not a person for sharing my problems with other people" (F. 5); "Not directly. No. Sort of like an indirect question say. ...Just indirect questions. Just to get a feel" (F. 1). Men's social relationships were defined as more superficial and often frivolous; "They just take the micky really ... keep telling me my life as I know it is over [laughs]" (F. 2). Whereas, women's social relationships were perceived to be more extensive and beneficial; "I tend to find that women stick together and they talk about girlie things and babies and stuff. And they tend to keep it to themselves" (F. 1). Importantly, these men felt their experiences were similar to other first-time fathers-to-be; "Most men wouldn't let others know things were affecting them. ...[Later in the interview] I

want them to be worried about [partner] than myself. ...Than about my worries” (F. 3). Thus, culturally idealised forms of masculinity, which construct men as stoical and self-reliant, appeared to be magnified within the context of childbirth; where men are ‘not patients’ and women experience ‘real’ physical pain.

Alongside men’s accounts, interviews with health-care professionals highlighted how hegemonic constructions of masculinity influenced professional expectations regarding men during pregnancy and how they recounted men’s actions within antenatal settings. All felt positive strides had been made to engage with men and to take on board their “needs” during pregnancy:

We start from the woman because it’s her that the baby is growing in and we want the best for mum and baby. ...But he is very important to that as well. ...If they are there ... they are included. ...I always ask ... are there any questions he’d like to ask? (HP. 4)

However, as implied in this extract, lack of male involvement across a range of antenatal environments was a recurring theme within professional accounts. In making sense of men’s absence, their accounts focused on dominant aspects of masculinity which they felt prescribe and presume that many men will absent themselves from what they consider to be feminine/health environments. For example, one of the main reasons given for the relatively low numbers of men attending ante-natal appointments was the

fact these settings were perceived by men to be essentially female-health orientated; “I think they think it's women's business and it's nothing to do with them” (HP. 1).

Professional accounts also highlighted potential difficulties facing men who did attend; “I don't think they're particularly welcoming for men ... to be faced by a room full of women” (HP. 5). Many noted the restrictions placed on men's behaviour which was exemplified by men's inability to relax as they would in other more “comfortable” environments; “They're not happy. ...They fidget. They can't sit still ... It's painfully obviously many don't want to be here” (HP. 1). One indicator of men's apparent discomfort was the scarcity of male conversations; “Men don't tend to say much. ...It's more common to hear women talking to each other about their experiences” (HP. 2). Typically men did not seek to talk to other men and tended to be excluded or to exclude themselves from ‘female’ conversations; “They're not rude or they're not impolite ... they just sit ... their heads are down and they won't contribute ... they don't look to talk” (HP. 3). One possible solution to men's disquiet was to shift antenatal classes out of hospitals into more ‘traditional’ male environments:

I think really away from the hospital would be best. Some community venue where men already meet. Possibly a rugby club, social club, those sorts of places. ...We need to go where the men are. Seek them out. ...Find the places where they're comfortable. (HP. 2)

It was apparent therefore that antenatal settings present men with certain challenges and have the potential to assign men to marginalised positions; their lack of 'voice' restricting the means by which they could perform masculinity. Alongside action, men use discourse to demonstrate masculinity; i.e. men construct dominant male identities as they talk (Wetherell and Edley 1999). Research has shown that in environments where men are present but in small numbers the opportunities for men to construct dominant masculinities may be restricted or denied (Lupton 2000). Here, not only were men few in number, they also found themselves in an essentially 'feminine' space (cf. Robertson 2007), which increased their sense of unease and limited their ability to use talk to confirm masculine identities with those around them.

Moreover, on occasions when men did talk, it was their lack of "emotional expression" which signified dominant forms of masculine identity. Health-care professionals made constant reference to the prevailing norms around masculinity and femininity, which demarcate men's and women's responses to pregnancy and childbirth. For example, while it was considered common for women to talk about the complexity of emotions invoked during pregnancy, the familiar suggestion was that men focus predominately on the informational/mechanical aspects of pregnancy and childbirth:

Men want to know the mechanics of things. ...Which is typical man isn't it really. They want to know how things work. If they understand how it

works then they're happy. ...That's the difference between men and women. (HP. 1)

This technical-orientated approach was deemed to reflect masculine ideals, which also dictate why many men found it difficult to concede their fears and admit vulnerability; “Especially around psychological issues ...they don't speak about things when they're boys and that goes through into manhood. ...They feel they've got nowhere to go” (HP. 5). Thus, maintaining a masculine identity clearly limited the range of ‘gender appropriate’ responses that men were comfortably able to express in relation to pregnancy:

They do talk about things ... [but] it's more how they were coping with their other half's emotions. ...Rather than their own emotions. ...Men don't get a chance to do that ... talk about how they feel. ...Women are very good at counselling each other. ...Men don't do that. ... It just doesn't happen. (HP. 1)

Evidently, therefore, men’s apparent preoccupation with self-reliance and stoicism was perceived to be problematic in the context of pregnancy.

Although this often left men alone with their concerns, because it was a societal problem it was not easy to resolve; “I think there is an appreciation amongst professionals ... to try to connect with [men]. ...But it’s hard. ...Its hard for a lot of men to change (HP. 1).

### **‘Being there’: men’s experiences of the labour and birth**

All of the men interviewed were present at the labour and birth of their child. Four of the men’s partners had natural births and one birth was by caesarean operation under local anaesthesia. Fears and concerns expressed by men in the first interview that they would not be able to cope during the birth did not materialise. When recounting their experiences, it appeared evident that men sort to reconstruct a valued sense of themselves and their own masculinity in contrast to their earlier accounts. For example, one of the men highlighted earlier, described how his phobia of hospitals had not prevented him supporting his partner: “I’m not the greatest person with needles and blood. ...But I was fine. I was more focused on [partner] and how she was feeling than thinking about what I was feeling (F. 1). Another of the men highlighted earlier, combined more obvious masculine imagery with humour to indicate how he had conquered his fears in a courageous fashion: “I was there. ...I was fine. ... A true hero [laughs]” (F. 2). Thus, men appeared to be seeking to re-establish control and highlight their responsibility to others and what had been a potentially subordinating situation was reinterpreted in ways consistent with hegemonic masculinity; i.e. presenting themselves as valiant and heroic.

One aspect of childbirth which did not feature in their first interviews was the cutting of the umbilical cord, which appears to have become a key part of the birth process for men; often portrayed as an ‘initiation ritual’, which helps to facilitate and affirm men’s bond with their child (e.g. Dixon 2000). However, those types of responses were not apparent among the men in this study. The following quote is illustrative of men’s attitudes towards this task:

They delivered him and I cut the cord. ...I'm not squeamish. I don't really mind the sight of blood or anything like that. ...I was a bit dubious about what I'd feel like cutting it. ...But it was just like cutting bacon really. ...It was probably my duty to do it. (F. 4)

As is powerfully demonstrated in this extract, the process of 'cutting the cord' was generally defined in more instrumental, down-to-earth and emotionally detached terms. In this example, language ordinarily associated with butchery; "just like cutting bacon", is used metaphorically to render the material reality of cutting the cord as objective and dispassionate, and, thus, free from sentiment. Meat by definition is something that is deprived of feeling and, as such, the umbilical cord may be seen as another piece of meat to be cut or butchered like any other piece of meat. This construction is also important because of the way it demonstrates a sense of control and mastery over the situation, which enabled this man to fulfil his responsibilities; i.e. 'cut the cord'.

In many ways, men's experiences during the labour and birth resembled the 'instrumental'/'active' role which they had constructed for themselves in their first interviews; "I mopped her brow and I helped with the gas and air (F. 3). Also noticeable, however, was the extent to which men did not appear proactive in their actions, nor did they seem to anticipate the needs of their partners. Rather, they continually seemed to be directed by their partners and maternity staff, even in the most basic of actions:



I dabbed her face with a wet towel. And got told off for wetting her fringe [laughs]. But I was there by her to be fair. ...Doing what she wanted. ...And taking instructions off the nurses as well. ...”Put your arm behind her” and “Grab onto her hand”. That’s what they were saying. “Do that for her”. “It’s better for her”. I was just there for her basically. ...You've just got to be there. (F. 4)

Alongside this, there were also occasions when men’s presence appeared to be at the behest of a particular health-care professional rather than something men insisted upon. The man whose child was born by caesarean, for example, did not feel he had the “right” to be present. Rather, his presence during the epidural and the birth was the personal gift of the anaesthetist; “They don’t normally let the fathers come in” (F. 1). It was also not uncommon for men to be removed from aspects of the childbirth process. Three men reported how they were sent home despite their partners being in labour; “they’ve got their rules and regulations. ...There’s nothing much you can do about it (F. 4). Men also described being asked to leave the labour room to allow examinations to take place (cf. Brown 1982):

They were coming and checking her every couple of hours and every time they asked me to leave. ...They’d say “Do you mind going out I’m going to check her”. ...At the time you don’t think. You do what you’re told. (F. 5)

As is clear in this quote, men did not appear to question procedures; “I don't think that's them making me feel uncomfortable ... just me in myself being uncomfortable asking them questions ... that's their main job” (F. 2). Equally, men did not appear to exert any real influence during the labour or birth. The man whose child was born by caesarean described how he was increasingly worried and concerned about his partner and unborn child but had not expressed this at the time. He felt the decision to perform the caesarean had taken longer than necessary, which he perceived was due to a lack of guidance given to his partner; “I wished ... they'd said to her ... just go for a caesarean”. However, he had not promoted the idea of a caesarean and later in the interview described himself as “blind to it all”, not knowing what to suggest for the best; “I just wanted it to be over with”:

You're worried, you're anxious, you're scared. ...You don't know what's going on. You want the end product like but obviously you don't want the end product to ... for anything to happen. ...I just wanted them to make the decision and get in there. (F. 1)

Across the three previous extracts, men's narratives appear a long way removed from demonstrations of hegemonic masculinity; usually displayed in terms of technical competence, hands-on ability, being in command and self-confidence (Courtenay 2000). Instead, these illustrate how men found themselves in marginalised positions; lacking confidence in their ability to act, easily and quickly removed from the scene, and excluded from the decision-making process. Thus, in negotiating the reality of childbirth men appeared to

relinquish notions of autonomy and action which rendered them acquiescent and in need of direction. That said, it is also important to observe that notions hegemonic masculinity continued to set the boundaries to what was considered appropriate behaviour during childbirth. Traditional representations of the controlled, stoic man appeared throughout the second interviews. As was the case with the man in the previous extract who sought to keep his feelings hidden; “I kept her calm. ...I couldn’t show I was worried” (F. 1). Thus, while these men were marginalised by hegemonic masculine ideals, they were still able to draw upon aspects of dominant masculinity to reaffirm their masculine identity.

Analysing men’s accounts, it appears that rather than being placed in a marginalised position by health-care professionals during childbirth, men positioned themselves as marginal within a particularly challenging domain. There was no evidence to suggest, for example, that men ‘blamed’ maternity staff for their position. Rather, men were full of praise for the ways in which staff sought to include them; “The midwives were absolutely fantastic. ...They didn’t just aim everything at [partner]. ...I didn’t expect that” (F. 2). Men tended to rationalise their marginal position; “I’m not the patient” (F. 3). Moreover, men perceived their status to be similar to other men; “People I know who are fathers, say more or less the same thing. ...Nothing can prepare you for [childbirth]. Everything ... happens around you. ...You just have to be there” (F. 2). In retrospect, ‘being there’, which emerged in every account, seemed to be what mattered most; “Just to be there ... right from the start, from the moment of birth” (F. 3). In short, men’s marginalised status was

not perceived as problematic by men; it generally appeared as the price men pay 'to be there':

When you go in [the labour room] there is a bed and a chair. ...Your expectation is that's your chair and you don't move. It's all lined up like that. ...There is a chair next to every bed at the head ... so like you know your place when you go in. ... But that wasn't the case. ...Every time they got me involved ...when they took me through it ... that was an extra for me. ...[Later in the interview] I didn't think they would get me involved as they did. ... [But] I don't think I would have walked away thinking, "Oh I wasn't involved". Because the emotion of seeing your daughter born ... *being there* to see it would cancel that out. ...I am grateful that they did get me involved, but I don't think it would have made the day any worse if they didn't. (F. 5)

In general, health-care professionals drew on an 'inclusion' discourse (cf. Early 2001) when discussing how men were positioned during childbirth; "Dad's are always welcome. ...We're much more open and inclusive" (HP. 4), which prevailed over more traditional maternity doctrine:

I think probably years ago men were seen as a bit of a pain if they turned up and certainly they weren't encouraged. ...But I think now that wouldn't be the case. I don't think there'd be any negative thoughts towards men being around. (HP. 1)

That said, one professional suggested they paid scant regard to the inclusion of men. As the following extract highlights, despite recognising the potential for the environment to be inhospitable, the onus was on men themselves to negotiate their inclusion:

I don't think men ... are excluded. I don't think we ... put on a specialist show or make a song and dance for them. But I think that they're certainly not excluded. What they make of it is partly how they ... interact. How they get the most out of it. ...I don't think there's a barrier [to inclusion]. We're probably not overly welcoming, but there's no barrier I don't think, no. (HP. 3)

In most cases, however, health-care professionals appeared welcoming and commonly facilitated men's inclusion via a variety of basic tasks designed to assist their partners. Importantly, professional constructions of masculine identity and appropriate male behaviour can be seen to underpin the nature of these tasks:

Certainly you'd give the dad a job to do. ...”Rub the bottom of her back there” or ...”Keep offering her drinks” or “Make sure you've got a wet flannel in your hand all the time to mop her brow”. ...Give him specific jobs to do. ...They like that ... because they can feel like a spare part sometimes (HP. 4).

Portrayed as a strategy for inclusion, this quote underlines men's marginal status from a professional perspective while also demonstrating how professionals seek to maintain control over space and territory. There was no sense that men themselves chose the tasks they performed or that men generally assumed responsibility for tasks without first receiving direction; "I think most dads need to be told what to do. ...Some look to you all the time. ...You can spend as much time looking after them as looking after the mum" (HP. 4). In constructing men's marginalised status, professionals highlighted a range of potential reasons for why men were "on the periphery" (HP. 1). This included men's sense of uncertainty and resultant lack of control; "They're quite nervous. They're quite uncomfortable. ...They don't quite know what their role is. They don't quite know why they're there" (HP. 5). Also evident were the apparent difficulties associated with health-care settings; "I think it's quite a hostile environment for them ... it's this hospital place isn't it" (HP. 1). Men also appeared to be marginalised by the often hectic and primarily women-centred context of childbirth:

Men like to feel that they're doing something. I think they feel very much in the way. ...So I think it's important to give them a little job to do. Make him feel as if he is useful. ...If you had all the time in the world you'd probably incorporate lots of different ideas. When you're busy ... involving the man for a lot of people would be just having him in the room. ...Saying to him, "This is the baby's heartbeat". ...Maybe asking occasionally, "Everything OK with you"? (HP. 2)

Importantly, men were perceived to have little in the way of prior anticipation regarding their role; “I think they expect nothing” (HP. 3), and, hence, men’s actual degree of involvement did not appear to be significant. For example, professionals described men as “grateful” and “absolutely bowled over” to be included in conversations and relatively modest interactions could have a positive effect:

She went off to the toilet and he was following her out and I put my hand on his arm ... and said, “She’ll be fine”. ...”You’ll be able to be in there with her”. And that’s literally all I said to him. Afterwards when I saw her on the ward she said to me, “Thanks for being so nice to [partner]. He really appreciated it”. And I’d literally said a line to him. He obviously didn’t expect me to say anything to him. ...They’re easily impressed aren’t they [laughs]. (HP. 1)

Underpinning this segment of professionals’ accounts was an understanding of the ways in which dominant constructions of masculine identity inhibited and restricted men’s actions during childbirth; “They just want the baby out safely” (HP. 2). Importantly, professionals appeared to harness these restrictions for their own benefit in terms of facilitating relatively minimal levels of inclusion, particularly when busy, seemingly without fear of rebuke. As a final illustration, the following extract aptly illustrates professionals’ appreciation of men’s marginalised position during labour and childbirth:

I strongly feel they're quite helpless in a situation where they don't have much control at all. ...They're pushed from pillar to post and told what to do. ...I think it's because they perhaps don't understand what's going to happen. ...I think it can be fear ...of not knowing what's expected of them. And perhaps feeling that they might make fools of themselves and feeling quite vulnerable really. (HP. 4)

### **Concluding comments**

This paper used Connell's theory of 'hegemonic masculinity' as a conceptual framework to explore how first-time-fathers construct masculine identities during pregnancy and childbirth. It highlights the ways in which men rationalised their position and negotiate a range of masculine identities within what appeared to be 'archetypal' sites of male anxiety and vulnerability. The paper illustrates how men's constructions of 'appropriate' practice during pregnancy and childbirth was in opposition to traditional masculine values, as men tended to concede power and control, which assigned them to marginalised positions. At the same time, men's practice was also informed by core masculine standards, particularly the notion of men as stoical and self-reliant in the face of adversity. Thus, while these men found themselves marginalised within the context of childbirth, they were still able to draw on identifiable markers of masculine practice which enabled them to enact a masculine form congruent with dominant masculinity. In short, their constructions of masculine identities did not represent a straightforward adherence to dominant ideals, but nonetheless occurred within the shade of hegemonic masculinity.



This paper has also shown how dominant constructions of masculinity informed health-care professionals' interactions with men within the context of pregnancy and childbirth. It highlights a rather restricted range of identifiable male practices among health-care professionals, who generally failed to incorporate a wider array of masculine identities into their accounts. The nature of the 'jobs' and the way in which men were 'positioned' were clearly guided by the notion that men *as men* prefer 'hands-on'/'technical' tasks and accept and/or favour their predominately marginal status. This was both understandable and reasonable given the woman-centred locale and the ways in which gender inhibited men and restricted their ability to act as they might otherwise; i.e. childbirth bore little resemblance to other aspects of men's lived experiences. These constructions provided health-care professionals with a framework which enabled them to predict how men would behave and allowed them to situate men in ways that involved minimum disruption to their own practice. Health-care professionals' accounts reiterate, therefore, how men's marginal status was embedded in the dynamics of the social structure, which produce and reproduce dominant masculine identities.

In summary, while limited in size and restricted to accounts from first-time fathers, this paper has begun the process of exploring how men construct masculine identities during pregnancy and childbirth. A considerable amount of empirical work remains to be done. Future research should pursue the experiences of men with more than one child, as well as the experiences of black and minority ethnic group men. Only by obtaining a greater variety of

accounts will a fuller understanding of the meanings and processes involved in constructing masculine identities within the context of childbirth become visible.

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