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‘No longer invincible’: the Impact of Involuntary Childlessness on Older Men.

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Major findings: Findings countered the stereotype that men are not interested in reproduction. I argue that that involuntary childlessness should be considered as a significant factor in older men’s poor health and social capital.

Conclusions: This piece challenges the common narratives that the social, emotional, and relational aspects of involuntary childlessness do not affect men.

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Introduction:

In managing the range of clinical conditions and disorders that present for treatment, the physical therapist needs to be aware of the social determinants which impact upon their patients and the presenting conditions, 'health is something that starts in families, schools, communities and workplaces. It can be found in parks and in the air people breathe' [1: 18]. Factors like age, culture, gender, disability, ethnicity, reproduction, socio-economic status, and sexuality intersect and affect every individual's health differently. The aim of this paper is explore how one seldom-considered social determinant - male involuntary childlessness – affects older men's mental and physical health and well-being.

The global demographic trend of increase in longevity and declining fertility rates has been widely reported [2,3] including Australia [4,5], Canada [6], China [7], Europe [8], New Zealand [9-11], South Africa [12], and the United States of America [13,14]. Governments, health and care, and economic institutions are concerned how this demographic shift will affect pensions, the provision of health and social care, and the wellbeing of their populations [15,16]. For example, by 2033 the population of the United Kingdom (UK) is predicted to rise to 71.6 million with those aged 85 and over more than doubling to 3.3 million [17]. In the UK, those needing care are projected to grow by around 90% by 2041 with carer numbers predicted to only increase by approximately 27% [18]. Nonetheless, adult children typically undertake informal care

with an ‘oldest old’ relative while married older people primarily receive spousal care [19]. ‘Childless’ adults are often seen as ‘available to care’ [20] and 20 - 40% more likely to provide support [21]. In the UK, 58% of carers are female and 42% male [22] and it is estimated that by 2030 there will at least two million people aged 65 and over without an adult child to support them if needed [23,24].

The decline in fertility not only affects political-economic (structural) institutions –but also individuals who are childless. Statistics concerning the level of childlessness are ambiguous because they are almost exclusively based on the collection of a mother’s fertility history at birth registration [25]. However, there are probably more childless men than childless women: in Europe it is estimated that approximately 25% of men are life-time childless compared to 20% women [26]. Childlessness has affects across the life course in terms of how childless people perceive themselves, are viewed by others (social agency) and by institutions (structurally). For example, childless adults are often seen as ‘free’ from the burden of parenthood and available to care for ageing parents and/or to available to cover for colleagues with families [20,27]. Nevertheless, social scientists argue that the childless are ‘at risk for social isolation, loneliness, depression, ill health and increased mortality’ Dykstra [28: 1288].

This piece draws on my Auto/Biographical doctoral study based in the UK and uses data from that country and the Northern Hemisphere.

Childlessness:

Across all cultures a key adult status is achieved 'through the production of children' [29: 4]. However, childlessness has only relatively recently been recognised as a substantive research subject in the field of social science. Previously, many social scientists had focussed on childbearing age, fertility rates, family formation and practices, relationship dynamics, social networks, and marital status [30]. Ways of 'doing family' [31] and 'family practices' [32] have a significant impact on identity and relationships. Contemporary scholarship view familial forms and intimate social networks as fluid with familial forms now including, bio-legal, fictive, genetic, claimed families, chosen families, reconfigured, and personal communities [33-35].

Childlessness involves individuals negotiating two sets of embedded socio-cultural normatives [27,36]: pronatalism (idealisation and promotion of human reproduction); and heteronormativity (the unchallenged position that biological family forms and heterosexuality are the norm). The vast majority of cultures construct parenthood as natural, unconscious, and spontaneous. Consequently, there is an embedded unreflective acceptance of pronatalist ideals [37] that positions the childless as outsiders [27,38-40] . Childlessness therefore, involves navigating pronatalist socio-cultural institutional norms surrounding age, class, economics, ethnicity, faith, gender, identity, relationships, reproductive expectations, and sex/sexuality [41]. The experience of childlessness by lesbians, gay men, bi-sexual and trans-people (LGBT)

highlights issues that intersect with generational and socio-cultural inequalities [27]. For older people of this population, non-parenthood was a normal feature of their lives, "*I think from about like 15 years old I knew I was gay, so in my mind even then I knew I would never get married. You don't get married them days - you didn't have children"* [Raymond (70) in 42,43: 87].

'Childless' adults have been often viewed as a binary of 'voluntary' or 'involuntary' childlessness [44] . However, the childless are 'not a homogeneous group' [45] and many studies have not reflected the heterogeneity of the childless population. Kelly [46] highlighted the inconsistencies, discrepancies, and complexity in the use of terms such as 'infertility', 'voluntary' and 'involuntary' 'childlessness', 'childless' and 'childfree' [BJF/AWOC20,39,40]. Numerous studies have included a conflagration of the never married, expected-to-be-childless, childless-by-choice, childless-by-circumstance, those who have outlived children or whose children have left home [30,47]. Parents may become 'functionally childless' through geographical absence, bereavement, estrangement, miscarriage, and stillbirth [44,48]. Moreover, how individuals self-define their status may change over time and circumstance [49,50]. For example, an examination of longitudinal research found women reported higher childlessness in later waves data compared to earlier waves [47]. Allen and Wiles [44: 208] propose that 'Childlessness is a shifting identity within various storylines across time and circumstances.' A number of authors have argued that there is a 'continuum of

childlessness' with distinct groups at either end. The remainder locate themselves at different points at different times over the life course as personal circumstances change [40,51,52]. More recently, Albertini and Kohli [53: 354-5] suggest that childlessness and parenthood form one continuum 'we conceptualise parenthood and childlessness not as two fully separate conditions, but as a continuum of parental statuses.'

The vast majority of research into childlessness focuses on the 'involuntarily childless.' This term is generally used in a clinical context because it is typically applied to people who have ceased infertility treatment. However, the population of the 'involuntarily childless' also includes people who wish(ed) to become parents but did not seek treatment. Childless people who do not seek medical advice are not recorded and consequently, accurate figures for those who are 'involuntary childlessness' are difficult to calculate [54]. Moreover, this absence of non-treatment seekers has led to the criticism that much infertility research cannot be generalised to the wider population [54: 142-3]. Nevertheless, a diagnosis of actual or potential infertility has been shown to have considerable impact on mental and physical health, social stress, all forms of relationships, and wellbeing [55-58].

The discourses surrounding reproduction have historically centred on 'women's and maternal processes' [59: 248] with the vast bulk of significant socio-cultural material addressing women's experiences [60,61]. Lohan [62: 215] argued that men are absent from the literature 'on family planning, fertility, reproductive health and

midwifery.' Furthermore, Inhorn [63: 1] argues that men have become the 'second sex', in all areas of scholarship concerning reproduction. She reasons that many scholars are biased because of their 'widely held but largely untested assumption' [64: 6] that men are not interested and disengaged from reproductive intentions and outcomes. Throsby and Gill [65] argue that compared to the vast canon of material on motherhood, there is a paucity of works examining fatherhood. Moreover, most of those pieces take 'a strongly instrumental perspective' [65: 333]. Consequently, the meanings of male reproduction to men remain mostly unexplored [60,61,66].

The impact of childlessness on men is seldom studied yet the vast majority of society's prize virility, strength and vitality as normative ways-of-being-a-man. Nonetheless, men were found to experience greater existential stress over involuntary childlessness than women [67]. An international review of anthropological studies found male infertility had a significant effect on masculinity, 'Men who fail as virile patriarchs are deemed weak and ineffective' [68: 45]. Webb and Daniluk [69: 12] found on receiving a diagnosis of infertility, men felt 'grief, powerlessness, personal inadequacy, betrayal, isolation, threat and a desire to overcome, survive and positively reconstruct their lives'. Quantitative studies have found links between childlessness and poor health: a tri-country study reported links between older childless people and poor health behaviour [70]. Compared to partnered men, formerly married childless men's behaviour included increased levels of depression, excessive smoking, worse physical

health and sleeping difficulties. Weitoft et al [71] analysis of Swedish records identified lone childless men and lone non-custodial fathers having an increased risk of death through suicide, addiction, external violence, injury, poisoning, lung and heart disease. Moreover, unmarried and childless British men had greater risk of poor midlife physical function, even after adjustment for social class, education, and employment status confounders [72]. In a survey of men aged 40-59 years men in relationships were found to be better psychologically and socio-economically than childless single men [73].

Much of the language surrounding childlessness define it in terms of 'lack' compared parenthood [27]. For example, Letherby [40] explained how the term 'childfree' can be viewed as negating the experience of loss felt by those who self-define as involuntary childless (14). There is a similar complexity in gerontological research and wider practice. Terms such as 'old' 'older' 'elderly' and 'senior' carry both positive and negative connotations depending on context, location, and intent [74-76]. I acknowledge the complexity surrounding many of the terms related to childlessness and ageing. Therefore, I ask the reader to bear in mind that many terms used in this piece have contentious and/or multiple interpretations. A summary of helpful facts is provided in Table 3 at the end of the discussion section.

Background to the research:

Why research men and childlessness? Male involuntary childlessness was the subject for my dissertation in my Master of Arts in Counselling [77]. Personal experience was fundamental to the choice of dissertation subject: I had been particularly broody in my mid-30's. Moreover, a number of counselling clients had raised the issue during our sessions. Consequently, I decided to explore men's experience of wanting to be fathers. In that Grounded Theory qualitative study, I conducted semi-structured interviews with 10 men aged from 30 to 60+. Fatherhood was viewed as a re-connection, repayment, repeat, or replacement, of their childhood experience. All the men reported having experienced depression: eight of the men thought that childlessness was an element in their mental health. The men also talked about feeling bereaved and isolated. Furthermore, some linked their poor health behaviours to their childlessness. For example, excessive alcohol consumption, poor diet, and spending a disproportionate time spent at work. One striking finding was the paucity of material on men's experience of involuntary childlessness.

This absence of data spurred me on to self-fund a Master of Science in Research Methods [78] examining the levels of 'broodiness' (desire for parenthood) between men and women. This sequential quantitative-qualitative mixed-methods study deployed an on-line questionnaire to measure the influences, motivations, and reasons to parent. Of the completed replies (n=232), the quantitative data were analysed using descriptive, univariate, bivariate techniques [79] while the qualitative data were analysed using a

latent thematic technique [80]. Findings showed that 59% of men and 63% of women said they wanted children. This finding challenges the widely held belief that men are not interested in parenthood. In addition, the men reported higher levels of anger, depression, sadness, jealousy and isolation than equivalent women did. The main influences on men's wishes to have children were 'cultural and family expectations' with an underlying factor of 'biological urge' and 'personal desire.' The male biological urge to reproduce is often absent from academic and general media. I was then fortunate to secure a PhD studentship at Keele University (UK) exploring the impact of involuntary childlessness on older men [42].

My PhD was an auto/biographical qualitative study that used a pluralistic framework consisting of biographical, life course, gerontological, and feminist approaches [81]. The biographical approach provided a method of understanding the participants' experience in his social environment. Central to this aspect of the study was the use of Wengraf's [82] Biographic-Narrative Interpretive Method (BNIM). The BNIM approach highlights how individuals' experiences are set in relation to past, present and future contexts [83]. The life course perspective examines biographical experience in the framework of the key principles of human agency, historical time and place, the social contexts of transitions, timing, and linked or independent lives [84,85]. The feminist approach explores how social actors perceive the organisation of their social world and how this relates to their subjective experience [86]. Feminist scholars

highlight the intersection of power issues with myriad other social categories such as ethnicity, sexual orientation, and class [75,87]. To collect and understand the interactions between involuntarily childless men's life experience and their cultural, economic, political, and societal contexts [88] a qualitative approach using semi-structured biographical narrative interviews was selected. John Oliffe [89: 68] argues that qualitative research can disrupt the 'dominant discourses that espouse men as stoic and alexithymic by collecting and making available first-hand accounts.'

The aim of the study was to examine the lived experiences of self-defined involuntarily childless men aged 50 to 70 years. The criterion for inclusion was for men who did not have children but who currently or in the past, wanted to be a father. The age range was selected to reflect the increase in live births between World War 2 and the early 1960's [90]. The study is based on a small 'fortuitous sample' [91: 235]. The initial mode of recruitment was the 'snowball method.' However, difficulties in recruitment led to a loosening of the age criteria and an increasing the sources of recruitment. For example, both participants and third party recruiters reported great difficulty asking about others' fertility history. Recruitment methods were widened and included handing out 'business cards' with details of the study, dedicated website linked to Twitter, directly engaging personal and organisational networks, newspapers and magazine advertisements, and arranging an interview on local radio. A detailed account

of the recruitment process can be found in my chapter in the edited volume Studies of Ageing Masculinities: Still in Their Infancy [92].

The final sample was formed of 14 participants' whose ages ranged between 49 and 82 years (mean 63.5 years). The sample was not stratified by other criteria as these may have hampered recruitment. Thirteen of the participants were White-British and the other was Anglo-Celtic Australian. Two of the men self-identified as gay and the rest self-identified as heterosexual. Seven of the participants had partners and the remainder were single. One gay man and one heterosexual man were widowers. One man was resident in Thailand and the other participants' were located in the UK. Keele University Ethical Review Panel approved the study. To maintain participant confidentiality pseudonyms are used in this piece.

Data collection involved two semi-structured biographical interviews [82]. The first interview schedule consisted of five elements. First, 'Tell me a little about yourself?' Second, 'I would be grateful if you could just tell me about when you first became aware of being a father?' In order to understand the gerontological aspects of male childlessness three short questionnaires were then deployed: 'Quality of Life' 'Social Networks' and 'Ageing'. The relationship between three instruments has been well established [see 93 for a detailed explantion] and are examined in the following 'health' section. The participants' were sent a transcript of the first interview to read and assess if they had been accurately represented. The second interview focussed on their

response to that transcript. This allowed the correction and/or the development of the original narrative and the introduction of new material. Eleven of the interviews were face-to-face. Two participants requested to be interviewed via Skype and the other participant by email. One man declined the second interview but agreed to the material from his interview to be included in the study.

The qualitative data analysis software QSR Nvivo 9 [94] was used to manage the data analysis and for the management and storage of all materials. A latent thematic analysis was applied to the data [80]. The analysis was an iterative process that involved open coding that formed provisional, candidate, and main themes [80]. The open codes were then collated into meaningful groups - provisional codes. The analysis then moved on to analyse the codes into significant broader patterns of meaning to develop candidate themes. Four main themes evolved: Pathways to childlessness, Negotiating Fatherhood, Relationships and Social Networks, and Ageing Without Children. The focus in this piece is on the men's health: how they rated and defined their health status, how they accessed health care, and their 'Quality of Life' (QoL).

My age and involuntary childlessness makes this paper auto/biographical. I follow Wright Mills [88: 216] who encouraged social scientist to 'learn to use your life experience in your intellectual work: continually to examine it and interpret it. In this sense, craftsmanship [sic] is the centre of yourself and you are personally involved in every intellectual product upon which you […] work.' Liz Stanley [95] contended that

the ‘auto/biographical I’ demonstrates ‘the active inquiring presence of the sociologists in constructing, rather than discovering, knowledge.’ Consequently, the biographies of ‘the researcher and the participants as data and as an inextricable part of the research process’ [96]. Accordingly, the auto/biographical approach acknowledges and identifies the biases of the researcher and the dynamics of the research process [97].

Auto/biography is deeply connected to the feminist approach with its focus on reflexivity, relationships, positionality, and power [87]. Feminist scholars have been at the forefront of research that recognised the impact of infertility on men’s sense of identity. Scholars of masculinity have only examined fatherhood and have missed or avoided the subject of not being a father and/or infertility [98]. Consequently, feminisms and feminist scholars have heavily influenced all my academic work. Drawing on that background, and in common with the sociological concept of reflexivity, a brief autobiography is provided in Table 4.

Results:

Health:

The increase of smaller families also has had an impact on the provision of care for informal and formal health and care providers. While some cultures embed care of parents within traditional familial settings, others do not. In the latter many people do not realise the extent which formal health and care settings rely on ‘the family’

(typically adult children) to support older people [53] . In addition, biological ‘next of kin’ often provide an intermediary role between the cared-for and the care provider. Many also become the default advocate for their relative(s).

Later life has often been viewed in the context of a loss of agency across a range of environments including the economic, mental and physical health, identity, socio-cultural, and well-being [99: 91]. Biological ageing reflects the changes in physiological functioning and physical structures that leads to increased risk of mortality and disease and disability [99: 76]. The age range of the participants covered the ‘third age’ [100]: a period widely associated with competences before the ‘decline’ and ‘decrepitude’ associated with the fourth age [101]. Nevertheless, contemporary discourses surrounding ‘old age’ have moved from of one of loss and decline to one of ‘successful’ ageing measured by objective indicators [102,103]. However, older people with poor health have consistently rated themselves as having a good quality of life and ageing successfully [103,104]. Moreover, older people have reported that, in addition to their own health, and that of kith and kin, finance was an important element to their quality of life [105].

The participants’ responses indicated that both health and relationship were very important to their ‘QoL.’ All the men defined ‘QoL’ as good health and relationships. The partnered men, with the exception of John, all rated their own ‘QoL’ highly. The single men mostly rated their quality of life negatively. The men’s view of their quality

of life reflects the significance of people's subjective experience [104,106]. Table 1 shows how the participants rated and defined their QoL.

Table 1 near here

The perception of decline in function in later life was prevalent amongst the participants. However, these views could be ascribed to other people and not specifically associated with childlessness. Table 2 shows both how the participants rated and defined their health status, and how they accessed health care. This highlights the intersection between subjective agency and objective social norms in which the participants ways of 'doing health' was linked to their subjective experience of control and functionality.

Table 2 near here

The participants' concerns regarding health and ageing ranged from those that were not related to men, or involuntary childlessness, to those that were. Martin described the essential management of his heart condition juxtaposed against good health.

M**artin:** *"I've got a pacemaker. Had that for 20-odd years, doesn't do anything to me other than keep me alive. No, my health's pretty good, you know, for my age I suppose. I still dig gardens. […] I comfort myself by looking at the average statistics and saying well for, for my height, I'm about the right weight."*

Martin drew on the contemporary ‘successful ageing’ discourses that endorse health as a personal issue. The participants often expressed the effect of the decline in eyesight or hearing age as the introduction to their prediction that their health would worsen in the future.

Russell: *“I'm overdue for an eye test. I'm conscious that my eyesight is deteriorating. […] I've had the hernia for ten years. I'm sure a doctor would say to me, I should get it fixed - it'll get worse.”*

Russell’s statement highlights two issues concerning health and ageing. First, the physiological degeneration that applies to all with ageing. Second, an attitude towards personal health that is frequently associated with men. Men are typically seen to have an ambivalent attitude to health and to accessing health services [107-110]. Men’s health behaviours have often been linked to the hegemonic masculine ideal of stoicism and risk taking. The stereotypical constructions surrounding men and masculinity entail men being independent, virile, assertive, strong, emotionally restricted, and robust. Those traits are often associated with poor social and health behaviours, with older solo-living men reported as demonstrating similar ‘macho’ attitudes to health as young men [108]. However, older partnered men are advantaged by their health being monitored by their partner, compared to lone older men [111-113].

The participants' attitude to attending health services ranged from the stereotypical as espoused by Russell, to Edward and Michael who both self-defined as a hypochondriac (see table 2).

Edward: *"I am a bit of a hypochondriac, I will go and see him if, her, sorry, I should say, if something starts that worries me, or if I can't explain."*

The use of the term 'hypochondriac' by both men to describe their usage of health services draws attention to how men negotiate dominant socio-cultural 'virility' discourses surrounding men and masculinity. Contrary to the widespread association of men's avoidance of the health services, most of the men viewed attendance at the GPs as common sense. With the exception of John, those men with partners would often discuss any issue with their partner, and therefore confirmed the wellbeing support dynamic of a relationship (see Table 2). In John's relationship, his partner was avoidant.

John: *"I have to sort her doctor's and dental appointments. There have been times when I have taken her to the GP's and not told her that's where we're headed. Otherwise she wouldn't have gone! Ha! "*

John's experience confounded the common belief that men in heterosexual relationships benefit from a 'spousal dividend' where women have a major role in maintaining a 'health watch' [114: 128]. Current research points towards that it is the quality of the relationship that is a factor in any health 'dividend' [115]. Contemporary studies have started to reveal the complex relational dynamics between health and care institutions and the agency of individuals. Consequently, health and care settings are locations where the performance of hegemonic masculinities is embedded within the structure of the institution and in the agency of the individual [107,109]. Studies have shown that some staff in health care settings viewed male patients negatively for not conforming to

the expected traditional masculine ideal norms of invincibility and bravery [116,117]. For example, health care providers and clients in IVF clinics both demonstrated hegemonic masculinities [118]. Moreover, a systematic literature review of the fathers influence on infant feeding found that the fathers were excluded from accessing both infant feeding antenatal classes and professionals. In addition, there was a lack of 'father-specific' material [119]. For example, James found his embodied experience was not acknowledged before being diagnosed with a chronic heart complaint.

James: *"I had to keep on at the medical establishment before I could get the checks and tests that I needed, I felt I needed, you know. I was quite, I mean I didn't want to have it, but I was glad to be proved right."*

Interestingly, James also noted that not only did he have to negotiate the norms embedded within the social structure, but also the social norms he used that framed his being-in-the-world. The stoicism James displayed was associated with a cohort value and reflected the ethic of his working class background. However, that value position conflated with his needs and highlighted an internal conflict between conforming to the normative social narrative and individual agency.

James: *"I don't like to bother the doctor, you know, I'm still of that generation. But, also I think, "Well I've only got this one chance" you know? And bugger 'im if he doesn't, you know, he doesn't wanna see me again. He can't not see me again."*

Individuals and institutions have often referred to the male body in a mechanistic fashion. This reflects the Cartesian duality of body and mind and supports the masculine discourse surrounding how men and socio-cultural narratives view men's bodies as

controllable and controlled. Martin used the metaphor of a motor engine to describe the function of his pacemaker. In doing so, he drew on his background in engineering and interest in motorcycling, but also reflected a discourse that has been popular in the promotion of good health behaviour for men [120].

Martin: *"It's like putting an electric, electronic ignition on your engine."*

However, the body-as-machine conflicts with the knowledge of the decline of the body with age. Negotiating the transition from the 'body infallible' to the 'body fallible' challenged the perception of control and raised questions surrounding age and self. John summarised the effect his co-morbidities had on the reflexive gaze he now viewed himself in the context of his age.

John: *"So having the health stuff having gone a bit like this [points to leg], just makes you more vulnerable – because you're suddenly aware, you know, you're not, you're no longer invincible."*

Chronic ill health had challenged John's sense of his body's indomitability with a resultant difficulty in rationalising the change in the mind – body dynamic. Although few of the participants spoke of themselves as 'invincible' neither did they voice any narrative concerning the body as fallible. Colin noted how his experience of living with motor neurone disease (MND) changed his perspective of later life. As a young man, he was extremely athletic and he viewed old age as something to be avoided. However, since his diagnosis with MND in his early 50s, his view of his future life had changed: he now desired to live as long as possible.

Colin: *"Before I had MND I saw the doctor very, very, rarely. […] I wouldn't say invincible but I was a fast runner and super fit. When I was younger, I had no desire to live beyond 70. Now I do."*

All the participants associated health with QoL - frequently pointing out that an improvement in their health would improve their quality of life. Consequently, decline in mental and/or physical health was cited as a disadvantage of ageing. For Harry, a combination of personal bereavement, care issues, local environment, and loss of independence affected his view of later life. The recent death of his partner (Helen) of over 20 years had significantly affected Harry's world-view. At the time of the study, there had been widespread reports in the UK media of the abuse older people in public and private health and social care settings.

Harry: "*The one concern I have in life is longevity. I don't want to be old. […] Old people that are laying in hospital beds being beaten up by people that don't care for them. […] I don't want to be that man laying in that home, you know?*

Harry associated age with the potential loss of autonomy with the loss of physical capacity and well-being. Harry's opinions highlight the interaction between an individual's fears surrounding aging, and consequent loss of agency, in the context of the prevailing public discourse. A distinct theme in that discourse was the portrayal of the health and care structures as undignified, limiting and repressive [121-123]. All the participants expressed issues surrounding dignity in later life. Michael raised the concern regarding how a solo-living older person would access health and care services.

Michael: *"My Swiss, single, fatherless, gay friend said to me, "Who's gonna take us to the hospital? Who's gonna push us, when we fall on the floor, who's gonna pick us up?"*
Michael's experience highlights the agentic and structural issues to ageing without children or family. Many childless adults caring for older relatives reflect, "Who will do this for me when I need care when I am old?" [see 20]. This is particularly acute for singleton adult children who have no sibling to share the care of parents or care for each other in later life. Martin's narrative revealed a sub-text alluding to not repeating the experience of his parents, but also his own experience as the only child of increasingly ill parents. Therefore, one legacy he would not be passing onto any children was one of 'duty of carer.' Martin drew on his experience of caring for his mother and her dementia in her later years.

Martin: *"My mother's last five years were of no value to her at all. […] I think if you knew you were in that situation and you were still that mentally astute to plan it [suicide]. It's not something I would rule out, particularly if I was impacting other people's lives to the point that was unacceptable to me."*
This raises the question of who will advocate for those who have no one to mediate for them with the institution. Other participants also ventured that there was a point when the decline-dependency balance would lead to them to take control of their death.

Harry: *While I can get out and drive and get about and do stuff. […] Life as an invalid or in poor health – I don't want any of that. […] I don't mind going tomorrow. I'm not looking for it or desiring."*
The loss of control through diminishing health brought a number of scenarios from the participants regarding their fears and how these may be resolved. **George:** "*I do fear – a*

stroke or cancer, dementia, both my parents had dementia. […] I fear that if restrictions of those sort come along - that I will become self-centred, obsessed with myself, and all the things that are wrong or afraid because I can't cope. "

George related the notion that the age-related reduction in external performance and health resource capacity ideally would be countered by an inversely proportional spiritual growth. George's 'ideal' transformation counters the fears he expressed regarding ill health and becoming 'self-obsessed' in later life.

George: *"I would like to be able to age gracefully. […] In terms of my health or my ability to do things, I hope I will make the adjustments as they come along, to those, to that new space. And I can be as big, as large a person, even though my horizons might be coming in, there is a sense of which other things can open up. […] I hope as, and when those come, I can make the adjustments, gracefully, and find an inner freedom even though I haven't gotten an outer of freedom. Or have less of an outer freedom."*

Spirituality has been shown to have a positive effect in old age [124]. The mechanism of how faith influences subjective wellbeing is not fully understood. However, faith provides coherence and meaning through community, social and emotional support, shared beliefs, safety and structure through ritual. Three participants practiced a faith George, David, and Alan. They indicated that their faith would also deliver spiritual sustenance and a way-of-being. David highlighted how faith was central to his identity and his way-of-being-in-the-world. Consequently, he foresaw greater commitment to the spiritual aspect of his life as he aged.

David: *"I would like to improve my contribution to church and I would like to spend more time on my own spiritual growth ...That probably ought to be the number one*

focus, because that naturally feeds through into improving the quality of everything else."

For those with no partner or without a nominated power of attorney, there was an additional anxiety of loneliness in later life. Michael was emotionally and geographically distant from his family. Consequently, 'end of life' was an issue that was difficult to acknowledge. Accepting his solo-living status, Michael tacitly recognised the connection between the lack of close relationships, including childlessness, and isolation at the end of life.

Michael: *"I think it's a dilemma and I don't there's an immediately easy answer to it. […] And I'm sure a there's lot of people who don't need care but die alone. […] Yes, it's something I think we put to the back of our mind, those of us who are single."*

Similarly, Raymond had anxieties surrounding his capacity to care for himself if incapacitated through injury and as result, isolated. Although Raymond's strong relationship with his sister - she had power of attorney - he viewed residential care as preferable to being a burden to her. The drive to maintain an identity and autonomy was one of adaption and negotiation of self-in-the-world and being-in-the–world.

Raymond*: "I've accepted the fact that if I have to go into an old folks' 'ome, I'll go. 'S'nothing else 'cos I certainly won't gu and live wi' me sister or with anybody else 'cos, I don't think it's fair to put a burden like that on somebody else. […] The only thing I worry about now is if I fall or anything like that."*

The attitude the participants displayed to residential care in later life highlighted a difference between the heterosexual and non-heterosexual men. The former did not

express any anxieties regarding their sexuality in accessing any form of residential setting in later-life. However, both Alan and Raymond raised concerns regarding discrimination against non-heterosexuals in residential settings.

Raymond: *"Housing associations now are certainly having to train their staff and open their doors to taking in gay people. Not just men, women too. […] To be the only man sat in a room full of women is a bit daunting. […], I'd feel really at a loss then, I wouldn't know what to, how to join in. Where if I say, equally men and women, then it's not so bad, you know."*

Alan and Raymond's concerns reflect an ongoing debate on housing options for older LGBT people, with the fear that their sexual orientation will result in inadequate treatment, discrimination, or isolation [125,126]. Although not all the participants referred to their sexual activity, seven directly or indirectly associated ageing with a decline in their libido. Age and health affect sexual activity, with many studies highlighting the reduction in sexual behaviour in older age groups. A number of factors affect sexual activity: relationship satisfaction; physical and mental health; medication; self-image; diet; social network; social skills; moral values; and wellbeing [127,128]. Masculinities have often placed sexual performance as central to men's identity, and one challenge of ageing was the negotiation of reduced libido. The connection between health and sexual dysfunction was clearly demonstrated by John, whose circulatory, heart, and diabetic conditions all contributed to his erectile dysfunction (ED). Diabetes and hypertensive medication are a known cause of impairment in sexual function. John

attributed his alcohol abuse, suicidal ideation, poor diet and other poor health behaviours to his partner's sudden decision not to become a parent.

John: *"My neurophia damaged nerves in my extremities, with my feet and my hands, erectile dysfunction I've had for a number of years, a common diabetic problem. […] We ceased having sex, so, bloody hell, probably about 1988 or '89."*

The importance to older men of being in an intimate relationship to health, social health, social networks, and wellbeing has been well-established [93,108]. However, as John's narrative suggests, the dynamics within a relationship are not always positive or healthy (see tables 1 and 2). David, who had married Cathy, 23 years his junior, highlighted the nuances within a relationship. David initially labelled the decrease in his libido as a reduction in his health; an increased libido would have increased his quality of health. However, he also cited ageing and his maturing marriage relationship as affecting his libido. David had drawn on age and discourses drawn from the wider social network.

David: *"I don't think I'd quite have the level of libido that I used to when younger. I think my wife would be like to be jumped on more enthusiastically for longer [laughs]. […] So, that is an issue which, I assume, is to do with the mixture of ageing and marriage."*

The acceptance of a reduction in libido has usually been associated with older men, and as one of the elements in the transition of moving from the third age into the fourth age [129]. John's experience demonstrated the link between illnesses, cognitive processing and sexual functioning. Both David and John revealed the complex and changing

relational dynamics inherent within sexual relationships. Whereas Michael viewed the decline in his libido as a natural part of ageing.

Michael: *"My libido has reduced, yes, I'm aware of that. […] The hardness of one's erection does decrease, yeah, without feeling, interestingly, without feeling - it must be a natural flow because I don't wake up at night bitterly disappointed or do anything about it. Women apparently get very depressed about the menopause but men have a sliding and slow menopause."*

Michael had rationalised the change in his sexual identity; he also drew attention to the possible effect reduced sexual performance might have in a relationship. The nuances of later-life sexual identity involved the navigation between the physical, desire, individual preference and performance. Although Alan was 19 years older than David, he located his response to his reduced libido within a framework that emphasised both choice and control.

Alan: *"It doesn't disappear, no, no, no. I think you're more discerning in what you're looking for, you know. […] I wouldn't want a younger man sexually, not much younger, but, you know what I'm sayin' when I say younger: under, say, 40, no way. […] But that dun't mean that I can't appreciate the beauty of a younger man under the age of 40 and say, "Ooh 'e's a nice lad," you know? Eye candy! […] You can look at the menu but you don't 'ave to eat."*

The acknowledgement of the social clock as an element of identity performance was juxtaposed between the rationalisation of the lived self, duration, and embodied effect. Moreover, Alan located himself in relation to his peers as younger, and highlighted the complex relationship between social identity, age and performance.

Alan: *"The thing is I 'ave always thought of age as a state of mind. […] It's 'ow many years' experience you've got. It's not 'ow many years you've lived or 'ow many years your body's lived. […] I know an awful lot o' people are a lot younger than me, who be'ave like 80 year olds. I don't think I be'ave like an 80 year old."*

The narratives explored above show that the participants strongly associated their quality of life with health issues, often highlighting how an improvement in health would improve their quality of life. The effects of biological ageing, and related health issues, interacted with the participants' social and psychological identities. One consequence of an aged identity was the sense of liberation of not having to conform to social hierarchy and, possibly, accepting childlessness.

Stephen: *"Being more settled in terms of accepting life conditions as being, as being it. Rather than always feeling you've got to make change and fight, you know, resisting all the time. I think, as you get older, you tend to resist less. […] And that can be pleasurable somehow."*

Contrary to the widespread promotion of everything 'young', and denial of ageing, no participant indicated they wanted to return to their younger selves. Although liberation from the 'younger self' and social norms were acknowledged, there was a tension between the present and past selves.

George: "*I do fear – a stroke or cancer, dementia, both my parents had dementia. […] I fear that if restrictions of those sort come along - that I will become self-centred, obsessed with myself, and all the things that are wrong or afraid because I can't cope. "*

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spiritual growth. George's 'ideal' transformation counters the fears he expressed regarding ill health and becoming 'self-obsessed' in later life.

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Advantages of growing older were associated with contentment, freedom, maturity, and sagacity. The identities of 'wise man' and 'sage' are traditional patriarchal roles that have a strong connection to an 'ideal' form of masculinity [130]. The criteria the

participants used to formulate the ‘sage’ identity acknowledged their experience, knowledge, empathy, and fairness. All the participants associated later life with a decline in functionality, with the fear of loss of either physical or mental capacity evenly distributed among the sample. Studies that report on the health differences between parents and the ‘childless’ tend to be based on census, health, and mortality records and have highlighted of the poor health outcomes for the latter [70,71]. Only John fitted that ‘problem’ typology. The other participants’ concerns of ageing and involuntary childlessness were more nuanced.

Martin: *“I went to a 70th birthday party of a chap I went to school with. […] Physically, he’s, well, pretty well nearly crippled with back problems and knee problems. […] It was quite stark for me then to look at that - I’m physically very well. […] and he is opposite of that, but emotionally he’s very rich: it was evident how much he was loved by all these daughters and granddaughters. And that was a bit painful.”*

Martin reflected on the balance between the physical and emotional differences between himself and his long-time friend. Counterbalancing Martin’s greater health capital was the relational depth between the father and his adult children and grandchildren. The participants’ overall view of their future was a fear of the deterioration in physical and mental health. As such, their views were similar to ageing people generally. However, a worryingly significant difference was the little discourse concerning children or grandchildren in relation to health and care.

Discussion:

Childlessness is found in every society and cuts across all classifications. Childless people particularly women, report a range of reactions to their non-parental status from open hostility to sympathy. Many are accused of selfishness for having 'chosen' not to be parents [40]. However, there are many influences on why a person who wanted or expected to be a parent does not become one: bereavement, economics, education level, relationship issues, sexuality, and upbringing. The age of first sexual relationship, the longevity of the relationship and the timing of relationship formation and cessation are all circumstances that effect fertility outcomes. Involuntary childless men have to negotiate socio-cultural expectations of masculinity typically virility acknowledged via provider/protector roles. Unfortunately these often include emotional detachment, denial of emotions, fear of intimacy and emotional vulnerability [131], risk taking, aggressiveness, objectivity and control. [132]. However, Wong and Rochlen [133] argued that men have the same emotional experience as women but are socialized to perceive the expression of emotions as a weakness. In addition to having a lack of resources to express feelings, male emotional inexpressiveness has become an embedded ideal [98].

Conclusion:

Although older childless people have similar issues to any other older person, it is essential to acknowledge that they have additional concerns. Many feel 'outsiders' in

the social world for not fitting the pronatalist mandate with concomitant discrimination, exclusion, isolation and stigmatisation. Consequently, childlessness is treated as a deficit 'non-event' identity and considered a 'non-category' [30: 682]. Therefore, the childless are barely perceptible to policymakers, health and care providers and other institutions. The none-collection of men's fertility outcomes means that childless men are invisible to both institutions and individuals. Accordingly, the impact of male childlessness on men's social determinants and their mental and physical health and well-being across the life course are absent from policy and practice. Consequently, it is important for physical therapists to recognise and acknowledge the clinical implications of the additional vulnerabilities of male childlessness.

Table 3 near here

Table 4 near here

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Participant	Age (years)	Relationship status	How participant's rated their quality of life	How participant's defined quality of life
Colin	59	Partnered	"I have a great relationship with my partner and brothers."	"Being in a good, happy relationship and in good health."
John	59	Partnered	"There isn't one."	"Good health, good relationships."
David	60	Married	"A lot of good stuff: I have freedom and flexibility."	"Good relationships: some sense of community. Health is important."
Edward	60	Partnered	"Pretty happy and satisfied."	"Happiness and satisfaction. Health is important too"
George	60	Married	"Pretty good."	"Being able to afford to live and do things together."
James	65	Partnered	"Content: secure relationally and financially."	"It is health really."
Martin	70	Married	"Pretty well. A good partner and a good circle of friends."	"Basics to function: enough food, roof over your head, and health."
Stephen	49	Single	"Not that positive."	"Good work-life balance."
Russell	55	Single	"Measure of contentment."	"Wellbeing: 'No aggro'"
Frank	56	Single	"Not very good"	"Health, having enough to get by and good relationships."
Michael	63	Single	"I'm lucky but lack a social life."	"Friends and beauty."
Harry	64	Widower	"I take pleasure in my hobbies but nothing has the degree that it would have had, had she still been here."	"I don't have quality of life. You're dished out a hand of cards, this is what I got, I go with it."
Raymond	70	Widower	"Good if I can get out, poor if I can't"	"Health: I take each day as it comes."
Alan	82	Single	"Good. I have time to do things."	"If I could throw this walking stick away."

Table 1. Participants' self-rated and self-defined Quality of Life.

Participant	Health	Health status	Attitude to accessing health care
Colin	Terrible	Motor Neurone Disease	Self refers: MND treatment. Shares with family
John	Poor	Diabetes, neurophia, cardiomyopathy	Self refers: under treatment for all conditions.
David	Good	Reduced libido	Self refers: Christian Scientist, discusses with wife.
Edward	Pretty good	Gastric reflux, high cholesterol	Self refers: "I'm a bit of a hypochondriac"
George	Good	Decline in hearing & vision	Self refers: discusses with wife
James	Good	Angina	Self refers: informs partner. Rarely sees GP.
Martin	Pretty good	Pacemaker, decline in hearing & vision	Self refers: discusses with wife
Stephen	Okay	High cholesterol related to medication	Self refers: under treatment
Russell	Good	Hernia for 10 years, ocular decline	Self refers: rarely accesses GP services
Frank	Not good	ME, work related back injury	Self refers: struggled to get ME diagnosed
Michael	Healthy	Ocular hyper tension, loss of libido	Self refers: "The hypochondriac in me"
Harry	Not answered: focussed on health & death of partner		
Raymond	OK	Foot, back, & finger issues, loss of libido	Self refers: under treatment for foot ulcers
Alan	Not bad	Hearing loss, knee injury, loss of libido	Self refers: under treatment for knee injury

Table 2. The participants' self-rated health, health status and attitude to health care.

- The pathways to childlessness are influenced by a vast range of factors: class, economics, education, ethnicity, gender, race, relationships, sexual orientation, socio-cultural context etc.,
- The terms surrounding both aging and childlessness are culturally and personally sensitive.
- Childlessness is often seen as a binary between the Voluntary (chosen-childlessness) and Involuntarily (childless-by-circumstance). However, people's view of their childlessness changes over time and with circumstance.
- Childlessness fundamentally challenges the ideal status of parenthood leading to socio-cultural structurally embedded discrimination.
- Unwanted childlessness affects a person's behaviour, economics, mental and physical health, identity, relationships, and social status across the life course.
- In most countries, fathers' fertility history is not collected at birth registration. Therefore, there is a lack of accurate data on the level of male childlessness.
- Involuntary childlessness can have a significant negative impact on men's mental and physical health and well-being across the life course.
- The childless are a category absent from official policy and practice strategy, which rely on adult children to advocate and informally care for their parents.
- Compared to parents, older childless people are admitted to formal care earlier and discharged later. Childless older men are admitted into care earlier than childless women with similar a similar diagnosis.
- Older men tend to have smaller social networks than comparable women do do. Therefore, they have less informal support.
- Ageing and childlessness challenges traditional masculine ideals. Older men are seen as both lesser and a sexual threat.

Table 3. Key points.

Redacted for the review: authors ‘Auto/biographical’ profile.

Table 4. Auto/biographical context.

‘No longer invincible’: the Impact of Involuntary Childlessness on Older Men.

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Biographical note

Robin’s PhD (Keele, 2015) examined the experiences of involuntarily childless older men. His counselling and own experience of childlessness led him to self-fund his MA and MSc (University of Manchester, 2008; 2009) on respectively, the desire for fatherhood in childless men and the levels of desire for parenthood in non-parents and parents. He is a founder member of the campaign group Ageing Without Children. Recently he collaborated in research projects on: dementia technology; health monitoring technology; tracking technology for people-living-with-dementia, and the father’s influence on infant feeding. Previous careers include counsellor, scientific photographer, and kitchen assistant. Robin is a working class man from Old Trafford, Manchester, UK. He was born in 1960, the seventh of eight children.

‘No longer invincible’: the Impact of Involuntary Childlessness on Older Men.

Abstract:

Background: The global trend of declining fertility rates and an increasingly ageing population has led to increased scrutiny of parenthood. Although there are more childless men than childless women, there is very little research literature on the impact of male childlessness. The childless are absent from much social science literature, which has mainly focussed on family and women. Feminist studies into infertility and ageing have highlighted the absence of the male experience. Involuntary childlessness has been viewed as a complex bereavement formed by multiple losses. Distress levels in both men and women in this population have been found to be as high those with grave medical conditions.

Objectives: The aim of this study was to examine older men’s experience of involuntary childlessness.

Methods: This piece draws on my qualitative auto/biographical doctoral study that was framed by biographical, life course, gerontological, and feminist approaches. Data collection involved in-depth semi-structured biographical interviews with 14 self-defined involuntary childless men aged between 49 and 82 years from across the United Kingdom. A latent thematic analysis highlighted the complex intersections between agency, biology, childlessness, economics, mental and physical health, relationships, and socio-cultural structures.

Major findings: Findings countered the stereotype that men are not interested in reproduction. I argue that that involuntary childlessness should be considered as a significant factor in older men’s poor health and social capital.

Conclusions: This piece challenges the common narratives that the social, emotional, and relational aspects of involuntary childlessness do not affect men.

Keywords: aging; bereavement; childlessness; health; men; masculinities

Introduction:

In managing the range of clinical conditions and disorders that present for treatment, the physical therapist needs to be aware of the social determinants which impact upon their patients and the presenting conditions, 'health is something that starts in families, schools, communities and workplaces. It can be found in parks and in the air people breathe' [1: 18]. Factors like age, culture, gender, disability, ethnicity, reproduction, socio-economic status, and sexuality intersect and affect every individual's health differently. The aim of this paper is explore how one seldom-considered social determinant - male involuntary childlessness – affects older men's mental and physical health and well-being.

The global demographic trend of increase in longevity and declining fertility rates has been widely reported [2,3] including Australia [4,5], Canada [6], China [7], Europe [8], New Zealand [9-11], South Africa [12], and the United States of America [13,14]. Governments, health and care, and economic institutions are concerned how this demographic shift will affect pensions, the provision of health and social care, and the wellbeing of their populations [15,16]. For example, by 2033 the population of the United Kingdom (UK) is predicted to rise to 71.6 million with those aged 85 and over more than doubling to 3.3 million [17]. In the UK, those needing care are projected to grow by around 90% by 2041 with carer numbers predicted to only increase by approximately 27% [18]. Nonetheless, adult children typically undertake informal care

with an ‘oldest old’ relative while married older people primarily receive spousal care [19]. ‘Childless’ adults are often seen as ‘available to care’ [20] and 20 - 40% more likely to provide support [21]. In the UK, 58% of carers are female and 42% male [22] and it is estimated that by 2030 there will at least two million people aged 65 and over without an adult child to support them if needed [23,24].

The decline in fertility not only affects political-economic (structural) institutions –but also individuals who are childless. Statistics concerning the level of childlessness are ambiguous because they are almost exclusively based on the collection of a mother’s fertility history at birth registration [25]. However, there are probably more childless men than childless women: in Europe it is estimated that approximately 25% of men are life-time childless compared to 20% women [26]. Childlessness has affects across the life course in terms of how childless people perceive themselves, are viewed by others (social agency) and by institutions (structurally). For example, childless adults are often seen as ‘free’ from the burden of parenthood and available to care for ageing parents and/or to available to cover for colleagues with families [20,27]. Nevertheless, social scientists argue that the childless are ‘at risk for social isolation, loneliness, depression, ill health and increased mortality’ Dykstra [28: 1288].

This piece draws on my Auto/Biographical doctoral study based in the UK and uses data from that country and the Northern Hemisphere.

Childlessness:

Across all cultures a key adult status is achieved 'through the production of children' [29: 4]. However, childlessness has only relatively recently been recognised as a substantive research subject in the field of social science. Previously, many social scientists had focussed on childbearing age, fertility rates, family formation and practices, relationship dynamics, social networks, and marital status [30]. Ways of 'doing family' [31] and 'family practices' [32] have a significant impact on identity and relationships. Contemporary scholarship view familial forms and intimate social networks as fluid with familial forms now including, bio-legal, fictive, genetic, claimed families, chosen families, reconfigured, and personal communities [33-35].

Childlessness involves individuals negotiating two sets of embedded socio-cultural normatives [27,36]: pronatalism (idealisation and promotion of human reproduction); and heteronormativity (the unchallenged position that biological family forms and heterosexuality are the norm). The vast majority of cultures construct parenthood as natural, unconscious, and spontaneous. Consequently, there is an embedded unreflective acceptance of pronatalist ideals [37] that positions the childless as outsiders [27,38-40] . Childlessness therefore, involves navigating pronatalist socio-cultural institutional norms surrounding age, class, economics, ethnicity, faith, gender, identity, relationships, reproductive expectations, and sex/sexuality [41]. The experience of childlessness by lesbians, gay men, bi-sexual and trans-people (LGBT)

highlights issues that intersect with generational and socio-cultural inequalities [27]. For older people of this population, non-parenthood was a normal feature of their lives, "*I think from about like 15 years old I knew I was gay, so in my mind even then I knew I would never get married. You don't get married them days - you didn't have children"* [Raymond (70) in 42,43: 87].

'Childless' adults have been often viewed as a binary of 'voluntary' or 'involuntary' childlessness [44] . However, the childless are 'not a homogeneous group' [45] and many studies have not reflected the heterogeneity of the childless population. Kelly [46] highlighted the inconsistencies, discrepancies, and complexity in the use of terms such as 'infertility', 'voluntary' and 'involuntary' 'childlessness', 'childless' and 'childfree' [BJF/AWOC20,39,40]. Numerous studies have included a conflagration of the never married, expected-to-be-childless, childless-by-choice, childless-by-circumstance, those who have outlived children or whose children have left home [30,47]. Parents may become 'functionally childless' through geographical absence, bereavement, estrangement, miscarriage, and stillbirth [44,48]. Moreover, how individuals self-define their status may change over time and circumstance [49,50]. For example, an examination of longitudinal research found women reported higher childlessness in later waves data compared to earlier waves [47]. Allen and Wiles [44: 208] propose that 'Childlessness is a shifting identity within various storylines across time and circumstances.' A number of authors have argued that there is a 'continuum of

childlessness' with distinct groups at either end. The remainder locate themselves at different points at different times over the life course as personal circumstances change [40,51,52]. More recently, Albertini and Kohli [53: 354-5] suggest that childlessness and parenthood form one continuum 'we conceptualise parenthood and childlessness not as two fully separate conditions, but as a continuum of parental statuses.'

The vast majority of research into childlessness focuses on the 'involuntarily childless.' This term is generally used in a clinical context because it is typically applied to people who have ceased infertility treatment. However, the population of the 'involuntarily childless' also includes people who wish(ed) to become parents but did not seek treatment. Childless people who do not seek medical advice are not recorded and consequently, accurate figures for those who are 'involuntary childlessness' are difficult to calculate [54]. Moreover, this absence of non-treatment seekers has led to the criticism that much infertility research cannot be generalised to the wider population [54: 142-3]. Nevertheless, a diagnosis of actual or potential infertility has been shown to have considerable impact on mental and physical health, social stress, all forms of relationships, and wellbeing [55-58].

The discourses surrounding reproduction have historically centred on 'women's and maternal processes' [59: 248] with the vast bulk of significant socio-cultural material addressing women's experiences [60,61]. Lohan [62: 215] argued that men are absent from the literature 'on family planning, fertility, reproductive health and

midwifery.' Furthermore, Inhorn [63: 1] argues that men have become the 'second sex', in all areas of scholarship concerning reproduction. She reasons that many scholars are biased because of their 'widely held but largely untested assumption' [64: 6] that men are not interested and disengaged from reproductive intentions and outcomes. Throsby and Gill [65] argue that compared to the vast canon of material on motherhood, there is a paucity of works examining fatherhood. Moreover, most of those pieces take 'a strongly instrumental perspective' [65: 333]. Consequently, the meanings of male reproduction to men remain mostly unexplored [60,61,66].

The impact of childlessness on men is seldom studied yet the vast majority of society's prize virility, strength and vitality as normative ways-of-being-a-man. Nonetheless, men were found to experience greater existential stress over involuntary childlessness than women [67]. An international review of anthropological studies found male infertility had a significant effect on masculinity, 'Men who fail as virile patriarchs are deemed weak and ineffective' [68: 45]. Webb and Daniluk [69: 12] found on receiving a diagnosis of infertility, men felt 'grief, powerlessness, personal inadequacy, betrayal, isolation, threat and a desire to overcome, survive and positively reconstruct their lives'. Quantitative studies have found links between childlessness and poor health: a tri-country study reported links between older childless people and poor health behaviour [70]. Compared to partnered men, formerly married childless men's behaviour included increased levels of depression, excessive smoking, worse physical

health and sleeping difficulties. Weitoft et al [71] analysis of Swedish records identified lone childless men and lone non-custodial fathers having an increased risk of death through suicide, addiction, external violence, injury, poisoning, lung and heart disease. Moreover, unmarried and childless British men had greater risk of poor midlife physical function, even after adjustment for social class, education, and employment status confounders [72]. In a survey of men aged 40-59 years men in relationships were found to be better psychologically and socio-economically than childless single men [73].

Much of the language surrounding childlessness define it in terms of 'lack' compared parenthood [27]. For example, Letherby [40] explained how the term 'childfree' can be viewed as negating the experience of loss felt by those who self-define as involuntary childless (14). There is a similar complexity in gerontological research and wider practice. Terms such as 'old' 'older' 'elderly' and 'senior' carry both positive and negative connotations depending on context, location, and intent [74-76]. I acknowledge the complexity surrounding many of the terms related to childlessness and ageing. Therefore, I ask the reader to bear in mind that many terms used in this piece have contentious and/or multiple interpretations. A summary of helpful facts is provided in Table 3 at the end of the discussion section.

Background to the research:

Why research men and childlessness? Male involuntary childlessness was the subject for my dissertation in my Master of Arts in Counselling [77]. Personal experience was fundamental to the choice of dissertation subject: I had been particularly broody in my mid-30's. Moreover, a number of counselling clients had raised the issue during our sessions. Consequently, I decided to explore men's experience of wanting to be fathers. In that Grounded Theory qualitative study, I conducted semi-structured interviews with 10 men aged from 30 to 60+. Fatherhood was viewed as a re-connection, repayment, repeat, or replacement, of their childhood experience. All the men reported having experienced depression: eight of the men thought that childlessness was an element in their mental health. The men also talked about feeling bereaved and isolated. Furthermore, some linked their poor health behaviours to their childlessness. For example, excessive alcohol consumption, poor diet, and spending a disproportionate time spent at work. One striking finding was the paucity of material on men's experience of involuntary childlessness.

This absence of data spurred me on to self-fund a Master of Science in Research Methods [78] examining the levels of 'broodiness' (desire for parenthood) between men and women. This sequential quantitative-qualitative mixed-methods study deployed an on-line questionnaire to measure the influences, motivations, and reasons to parent. Of the completed replies (n=232), the quantitative data were analysed using descriptive, univariate, bivariate techniques [79] while the qualitative data were analysed using a

latent thematic technique [80]. Findings showed that 59% of men and 63% of women said they wanted children. This finding challenges the widely held belief that men are not interested in parenthood. In addition, the men reported higher levels of anger, depression, sadness, jealousy and isolation than equivalent women did. The main influences on men's wishes to have children were 'cultural and family expectations' with an underlying factor of 'biological urge' and 'personal desire.' The male biological urge to reproduce is often absent from academic and general media. I was then fortunate to secure a PhD studentship at Keele University (UK) exploring the impact of involuntary childlessness on older men [42].

My PhD was an auto/biographical qualitative study that used a pluralistic framework consisting of biographical, life course, gerontological, and feminist approaches [81]. The biographical approach provided a method of understanding the participants' experience in his social environment. Central to this aspect of the study was the use of Wengraf's [82] Biographic-Narrative Interpretive Method (BNIM). The BNIM approach highlights how individuals' experiences are set in relation to past, present and future contexts [83]. The life course perspective examines biographical experience in the framework of the key principles of human agency, historical time and place, the social contexts of transitions, timing, and linked or independent lives [84,85]. The feminist approach explores how social actors perceive the organisation of their social world and how this relates to their subjective experience [86]. Feminist scholars

highlight the intersection of power issues with myriad other social categories such as ethnicity, sexual orientation, and class [75,87]. To collect and understand the interactions between involuntarily childless men's life experience and their cultural, economic, political, and societal contexts [88] a qualitative approach using semi-structured biographical narrative interviews was selected. John Oliffe [89: 68] argues that qualitative research can disrupt the 'dominant discourses that espouse men as stoic and alexithymic by collecting and making available first-hand accounts.'

The aim of the study was to examine the lived experiences of self-defined involuntarily childless men aged 50 to 70 years. The criterion for inclusion was for men who did not have children but who currently or in the past, wanted to be a father. The age range was selected to reflect the increase in live births between World War 2 and the early 1960's [90]. The study is based on a small 'fortuitous sample' [91: 235]. The initial mode of recruitment was the 'snowball method.' However, difficulties in recruitment led to a loosening of the age criteria and an increasing the sources of recruitment. For example, both participants and third party recruiters reported great difficulty asking about others' fertility history. Recruitment methods were widened and included handing out 'business cards' with details of the study, dedicated website linked to Twitter, directly engaging personal and organisational networks, newspapers and magazine advertisements, and arranging an interview on local radio. A detailed account

of the recruitment process can be found in my chapter in the edited volume Studies of Ageing Masculinities: Still in Their Infancy [92].

The final sample was formed of 14 participants' whose ages ranged between 49 and 82 years (mean 63.5 years). The sample was not stratified by other criteria as these may have hampered recruitment. Thirteen of the participants were White-British and the other was Anglo-Celtic Australian. Two of the men self-identified as gay and the rest self-identified as heterosexual. Seven of the participants had partners and the remainder were single. One gay man and one heterosexual man were widowers. One man was resident in Thailand and the other participants' were located in the UK. Keele University Ethical Review Panel approved the study. To maintain participant confidentiality pseudonyms are used in this piece.

Data collection involved two semi-structured biographical interviews [82]. The first interview schedule consisted of five elements. First, 'Tell me a little about yourself?' Second, 'I would be grateful if you could just tell me about when you first became aware of being a father?' In order to understand the gerontological aspects of male childlessness three short questionnaires were then deployed: 'Quality of Life' 'Social Networks' and 'Ageing'. The relationship between three instruments has been well established [see 93 for a detailed explantion] and are examined in the following 'health' section. The participants' were sent a transcript of the first interview to read and assess if they had been accurately represented. The second interview focussed on their

response to that transcript. This allowed the correction and/or the development of the original narrative and the introduction of new material. Eleven of the interviews were face-to-face. Two participants requested to be interviewed via Skype and the other participant by email. One man declined the second interview but agreed to the material from his interview to be included in the study.

The qualitative data analysis software QSR Nvivo 9 [94] was used to manage the data analysis and for the management and storage of all materials. A latent thematic analysis was applied to the data [80]. The analysis was an iterative process that involved open coding that formed provisional, candidate, and main themes [80]. The open codes were then collated into meaningful groups - provisional codes. The analysis then moved on to analyse the codes into significant broader patterns of meaning to develop candidate themes. Four main themes evolved: Pathways to childlessness, Negotiating Fatherhood, Relationships and Social Networks, and Ageing Without Children. The focus in this piece is on the men's health: how they rated and defined their health status, how they accessed health care, and their 'Quality of Life' (QoL).

My age and involuntary childlessness makes this paper auto/biographical. I follow Wright Mills [88: 216] who encouraged social scientist to 'learn to use your life experience in your intellectual work: continually to examine it and interpret it. In this sense, craftsmanship [sic] is the centre of yourself and you are personally involved in every intellectual product upon which you […] work.' Liz Stanley [95] contended that

the ‘auto/biographical I’ demonstrates ‘the active inquiring presence of the sociologists in constructing, rather than discovering, knowledge.’ Consequently, the biographies of ‘the researcher and the participants as data and as an inextricable part of the research process’ [96]. Accordingly, the auto/biographical approach acknowledges and identifies the biases of the researcher and the dynamics of the research process [97].

Auto/biography is deeply connected to the feminist approach with its focus on reflexivity, relationships, positionality, and power [87]. Feminist scholars have been at the forefront of research that recognised the impact of infertility on men’s sense of identity. Scholars of masculinity have only examined fatherhood and have missed or avoided the subject of not being a father and/or infertility [98]. Consequently, feminisms and feminist scholars have heavily influenced all my academic work. Drawing on that background, and in common with the sociological concept of reflexivity, a brief autobiography is provided in Table 4.

Results:

Health:

The increase of smaller families also has had an impact on the provision of care for informal and formal health and care providers. While some cultures embed care of parents within traditional familial settings, others do not. In the latter many people do not realise the extent which formal health and care settings rely on ‘the family’

(typically adult children) to support older people [53] . In addition, biological ‘next of kin’ often provide an intermediary role between the cared-for and the care provider. Many also become the default advocate for their relative(s).

Later life has often been viewed in the context of a loss of agency across a range of environments including the economic, mental and physical health, identity, socio-cultural, and well-being [99: 91]. Biological ageing reflects the changes in physiological functioning and physical structures that leads to increased risk of mortality and disease and disability [99: 76]. The age range of the participants covered the ‘third age’ [100]: a period widely associated with competences before the ‘decline’ and ‘decrepitude’ associated with the fourth age [101]. Nevertheless, contemporary discourses surrounding ‘old age’ have moved from of one of loss and decline to one of ‘successful’ ageing measured by objective indicators [102,103]. However, older people with poor health have consistently rated themselves as having a good quality of life and ageing successfully [103,104]. Moreover, older people have reported that, in addition to their own health, and that of kith and kin, finance was an important element to their quality of life [105].

The participants’ responses indicated that both health and relationship were very important to their ‘QoL.’ All the men defined ‘QoL’ as good health and relationships. The partnered men, with the exception of John, all rated their own ‘QoL’ highly. The single men mostly rated their quality of life negatively. The men’s view of their quality

of life reflects the significance of people's subjective experience [104,106]. Table 1 shows how the participants rated and defined their QoL.

Table 1 near here

The perception of decline in function in later life was prevalent amongst the participants. However, these views could be ascribed to other people and not specifically associated with childlessness. Table 2 shows both how the participants rated and defined their health status, and how they accessed health care. This highlights the intersection between subjective agency and objective social norms in which the participants ways of 'doing health' was linked to their subjective experience of control and functionality.

Table 2 near here

The participants' concerns regarding health and ageing ranged from those that were not related to men, or involuntary childlessness, to those that were. Martin described the essential management of his heart condition juxtaposed against good health.

M**artin:** *"I've got a pacemaker. Had that for 20-odd years, doesn't do anything to me other than keep me alive. No, my health's pretty good, you know, for my age I suppose. I still dig gardens. […] I comfort myself by looking at the average statistics and saying well for, for my height, I'm about the right weight."*

Martin drew on the contemporary ‘successful ageing’ discourses that endorse health as a personal issue. The participants often expressed the effect of the decline in eyesight or hearing age as the introduction to their prediction that their health would worsen in the future.

Russell: *“I'm overdue for an eye test. I'm conscious that my eyesight is deteriorating. […] I've had the hernia for ten years. I'm sure a doctor would say to me, I should get it fixed - it'll get worse.”*

Russell’s statement highlights two issues concerning health and ageing. First, the physiological degeneration that applies to all with ageing. Second, an attitude towards personal health that is frequently associated with men. Men are typically seen to have an ambivalent attitude to health and to accessing health services [107-110]. Men’s health behaviours have often been linked to the hegemonic masculine ideal of stoicism and risk taking. The stereotypical constructions surrounding men and masculinity entail men being independent, virile, assertive, strong, emotionally restricted, and robust. Those traits are often associated with poor social and health behaviours, with older solo-living men reported as demonstrating similar ‘macho’ attitudes to health as young men [108]. However, older partnered men are advantaged by their health being monitored by their partner, compared to lone older men [111-113].

The participants' attitude to attending health services ranged from the stereotypical as espoused by Russell, to Edward and Michael who both self-defined as a hypochondriac (see table 2).

Edward: *"I am a bit of a hypochondriac, I will go and see him if, her, sorry, I should say, if something starts that worries me, or if I can't explain."*

The use of the term 'hypochondriac' by both men to describe their usage of health services draws attention to how men negotiate dominant socio-cultural 'virility' discourses surrounding men and masculinity. Contrary to the widespread association of men's avoidance of the health services, most of the men viewed attendance at the GPs as common sense. With the exception of John, those men with partners would often discuss any issue with their partner, and therefore confirmed the wellbeing support dynamic of a relationship (see Table 2). In John's relationship, his partner was avoidant.

John: *"I have to sort her doctor's and dental appointments. There have been times when I have taken her to the GP's and not told her that's where we're headed. Otherwise she wouldn't have gone! Ha! "*

John's experience confounded the common belief that men in heterosexual relationships benefit from a 'spousal dividend' where women have a major role in maintaining a 'health watch' [114: 128]. Current research points towards that it is the quality of the relationship that is a factor in any health 'dividend' [115]. Contemporary studies have started to reveal the complex relational dynamics between health and care institutions and the agency of individuals. Consequently, health and care settings are locations where the performance of hegemonic masculinities is embedded within the structure of the institution and in the agency of the individual [107,109]. Studies have shown that some staff in health care settings viewed male patients negatively for not conforming to

the expected traditional masculine ideal norms of invincibility and bravery [116,117]. For example, health care providers and clients in IVF clinics both demonstrated hegemonic masculinities [118]. Moreover, a systematic literature review of the fathers influence on infant feeding found that the fathers were excluded from accessing both infant feeding antenatal classes and professionals. In addition, there was a lack of 'father-specific' material [119]. For example, James found his embodied experience was not acknowledged before being diagnosed with a chronic heart complaint.

James: *"I had to keep on at the medical establishment before I could get the checks and tests that I needed, I felt I needed, you know. I was quite, I mean I didn't want to have it, but I was glad to be proved right."*

Interestingly, James also noted that not only did he have to negotiate the norms embedded within the social structure, but also the social norms he used that framed his being-in-the-world. The stoicism James displayed was associated with a cohort value and reflected the ethic of his working class background. However, that value position conflated with his needs and highlighted an internal conflict between conforming to the normative social narrative and individual agency.

James: *"I don't like to bother the doctor, you know, I'm still of that generation. But, also I think, "Well I've only got this one chance" you know? And bugger 'im if he doesn't, you know, he doesn't wanna see me again. He can't not see me again."*

Individuals and institutions have often referred to the male body in a mechanistic fashion. This reflects the Cartesian duality of body and mind and supports the masculine discourse surrounding how men and socio-cultural narratives view men's bodies as

controllable and controlled. Martin used the metaphor of a motor engine to describe the function of his pacemaker. In doing so, he drew on his background in engineering and interest in motorcycling, but also reflected a discourse that has been popular in the promotion of good health behaviour for men [120].

Martin: *"It's like putting an electric, electronic ignition on your engine."*

However, the body-as-machine conflicts with the knowledge of the decline of the body with age. Negotiating the transition from the 'body infallible' to the 'body fallible' challenged the perception of control and raised questions surrounding age and self. John summarised the effect his co-morbidities had on the reflexive gaze he now viewed himself in the context of his age.

John: *"So having the health stuff having gone a bit like this [points to leg], just makes you more vulnerable – because you're suddenly aware, you know, you're not, you're no longer invincible."*

Chronic ill health had challenged John's sense of his body's indomitability with a resultant difficulty in rationalising the change in the mind – body dynamic. Although few of the participants spoke of themselves as 'invincible' neither did they voice any narrative concerning the body as fallible. Colin noted how his experience of living with motor neurone disease (MND) changed his perspective of later life. As a young man, he was extremely athletic and he viewed old age as something to be avoided. However, since his diagnosis with MND in his early 50s, his view of his future life had changed: he now desired to live as long as possible.

Colin: *"Before I had MND I saw the doctor very, very, rarely. […] I wouldn't say invincible but I was a fast runner and super fit. When I was younger, I had no desire to live beyond 70. Now I do."*

All the participants associated health with QoL - frequently pointing out that an improvement in their health would improve their quality of life. Consequently, decline in mental and/or physical health was cited as a disadvantage of ageing. For Harry, a combination of personal bereavement, care issues, local environment, and loss of independence affected his view of later life. The recent death of his partner (Helen) of over 20 years had significantly affected Harry's world-view. At the time of the study, there had been widespread reports in the UK media of the abuse older people in public and private health and social care settings.

Harry: "*The one concern I have in life is longevity. I don't want to be old. […] Old people that are laying in hospital beds being beaten up by people that don't care for them. […] I don't want to be that man laying in that home, you know?*

Harry associated age with the potential loss of autonomy with the loss of physical capacity and well-being. Harry's opinions highlight the interaction between an individual's fears surrounding aging, and consequent loss of agency, in the context of the prevailing public discourse. A distinct theme in that discourse was the portrayal of the health and care structures as undignified, limiting and repressive [121-123]. All the participants expressed issues surrounding dignity in later life. Michael raised the concern regarding how a solo-living older person would access health and care services.

Michael: *"My Swiss, single, fatherless, gay friend said to me, "Who's gonna take us to the hospital? Who's gonna push us, when we fall on the floor, who's gonna pick us up?"*
Michael's experience highlights the agentic and structural issues to ageing without children or family. Many childless adults caring for older relatives reflect, "Who will do this for me when I need care when I am old?" [see 20]. This is particularly acute for singleton adult children who have no sibling to share the care of parents or care for each other in later life. Martin's narrative revealed a sub-text alluding to not repeating the experience of his parents, but also his own experience as the only child of increasingly ill parents. Therefore, one legacy he would not be passing onto any children was one of 'duty of carer.' Martin drew on his experience of caring for his mother and her dementia in her later years.

Martin: *"My mother's last five years were of no value to her at all. […] I think if you knew you were in that situation and you were still that mentally astute to plan it [suicide]. It's not something I would rule out, particularly if I was impacting other people's lives to the point that was unacceptable to me."*
This raises the question of who will advocate for those who have no one to mediate for them with the institution. Other participants also ventured that there was a point when the decline-dependency balance would lead to them to take control of their death.

Harry: *While I can get out and drive and get about and do stuff. […] Life as an invalid or in poor health – I don't want any of that. […] I don't mind going tomorrow. I'm not looking for it or desiring."*
The loss of control through diminishing health brought a number of scenarios from the participants regarding their fears and how these may be resolved. **George:** "*I do fear – a*

stroke or cancer, dementia, both my parents had dementia. […] I fear that if restrictions of those sort come along - that I will become self-centred, obsessed with myself, and all the things that are wrong or afraid because I can't cope. "

George related the notion that the age-related reduction in external performance and health resource capacity ideally would be countered by an inversely proportional spiritual growth. George's 'ideal' transformation counters the fears he expressed regarding ill health and becoming 'self-obsessed' in later life.

George: *"I would like to be able to age gracefully. […] In terms of my health or my ability to do things, I hope I will make the adjustments as they come along, to those, to that new space. And I can be as big, as large a person, even though my horizons might be coming in, there is a sense of which other things can open up. […] I hope as, and when those come, I can make the adjustments, gracefully, and find an inner freedom even though I haven't gotten an outer of freedom. Or have less of an outer freedom."*

Spirituality has been shown to have a positive effect in old age [124]. The mechanism of how faith influences subjective wellbeing is not fully understood. However, faith provides coherence and meaning through community, social and emotional support, shared beliefs, safety and structure through ritual. Three participants practiced a faith George, David, and Alan. They indicated that their faith would also deliver spiritual sustenance and a way-of-being. David highlighted how faith was central to his identity and his way-of-being-in-the-world. Consequently, he foresaw greater commitment to the spiritual aspect of his life as he aged.

David: *"I would like to improve my contribution to church and I would like to spend more time on my own spiritual growth ...That probably ought to be the number one*

focus, because that naturally feeds through into improving the quality of everything else."

For those with no partner or without a nominated power of attorney, there was an additional anxiety of loneliness in later life. Michael was emotionally and geographically distant from his family. Consequently, 'end of life' was an issue that was difficult to acknowledge. Accepting his solo-living status, Michael tacitly recognised the connection between the lack of close relationships, including childlessness, and isolation at the end of life.

Michael: *"I think it's a dilemma and I don't there's an immediately easy answer to it. […] And I'm sure a there's lot of people who don't need care but die alone. […] Yes, it's something I think we put to the back of our mind, those of us who are single."*

Similarly, Raymond had anxieties surrounding his capacity to care for himself if incapacitated through injury and as result, isolated. Although Raymond's strong relationship with his sister - she had power of attorney - he viewed residential care as preferable to being a burden to her. The drive to maintain an identity and autonomy was one of adaption and negotiation of self-in-the-world and being-in-the–world.

Raymond*:* *"I've accepted the fact that if I have to go into an old folks' 'ome, I'll go. 'S'nothing else 'cos I certainly won't gu and live wi' me sister or with anybody else 'cos, I don't think it's fair to put a burden like that on somebody else. […] The only thing I worry about now is if I fall or anything like that."*

The attitude the participants displayed to residential care in later life highlighted a difference between the heterosexual and non-heterosexual men. The former did not

express any anxieties regarding their sexuality in accessing any form of residential setting in later-life. However, both Alan and Raymond raised concerns regarding discrimination against non-heterosexuals in residential settings.

Raymond: *"Housing associations now are certainly having to train their staff and open their doors to taking in gay people. Not just men, women too. […] To be the only man sat in a room full of women is a bit daunting. […], I'd feel really at a loss then, I wouldn't know what to, how to join in. Where if I say, equally men and women, then it's not so bad, you know."*

Alan and Raymond's concerns reflect an ongoing debate on housing options for older LGBT people, with the fear that their sexual orientation will result in inadequate treatment, discrimination, or isolation [125,126]. Although not all the participants referred to their sexual activity, seven directly or indirectly associated ageing with a decline in their libido. Age and health affect sexual activity, with many studies highlighting the reduction in sexual behaviour in older age groups. A number of factors affect sexual activity: relationship satisfaction; physical and mental health; medication; self-image; diet; social network; social skills; moral values; and wellbeing [127,128]. Masculinities have often placed sexual performance as central to men's identity, and one challenge of ageing was the negotiation of reduced libido. The connection between health and sexual dysfunction was clearly demonstrated by John, whose circulatory, heart, and diabetic conditions all contributed to his erectile dysfunction (ED). Diabetes and hypertensive medication are a known cause of impairment in sexual function. John

attributed his alcohol abuse, suicidal ideation, poor diet and other poor health behaviours to his partner's sudden decision not to become a parent.

John: *"My neurophia damaged nerves in my extremities, with my feet and my hands, erectile dysfunction I've had for a number of years, a common diabetic problem. […] We ceased having sex, so, bloody hell, probably about 1988 or '89."*

The importance to older men of being in an intimate relationship to health, social health, social networks, and wellbeing has been well-established [93,108]. However, as John's narrative suggests, the dynamics within a relationship are not always positive or healthy (see tables 1 and 2). David, who had married Cathy, 23 years his junior, highlighted the nuances within a relationship. David initially labelled the decrease in his libido as a reduction in his health; an increased libido would have increased his quality of health. However, he also cited ageing and his maturing marriage relationship as affecting his libido. David had drawn on age and discourses drawn from the wider social network.

David: *"I don't think I'd quite have the level of libido that I used to when younger. I think my wife would be like to be jumped on more enthusiastically for longer [laughs]. […] So, that is an issue which, I assume, is to do with the mixture of ageing and marriage."*

The acceptance of a reduction in libido has usually been associated with older men, and as one of the elements in the transition of moving from the third age into the fourth age [129]. John's experience demonstrated the link between illnesses, cognitive processing and sexual functioning. Both David and John revealed the complex and changing

relational dynamics inherent within sexual relationships. Whereas Michael viewed the decline in his libido as a natural part of ageing.

Michael: *"My libido has reduced, yes, I'm aware of that. […] The hardness of one's erection does decrease, yeah, without feeling, interestingly, without feeling - it must be a natural flow because I don't wake up at night bitterly disappointed or do anything about it. Women apparently get very depressed about the menopause but men have a sliding and slow menopause."*

Michael had rationalised the change in his sexual identity; he also drew attention to the possible effect reduced sexual performance might have in a relationship. The nuances of later-life sexual identity involved the navigation between the physical, desire, individual preference and performance. Although Alan was 19 years older than David, he located his response to his reduced libido within a framework that emphasised both choice and control.

Alan: *"It doesn't disappear, no, no, no. I think you're more discerning in what you're looking for, you know. […] I wouldn't want a younger man sexually, not much younger, but, you know what I'm sayin' when I say younger: under, say, 40, no way. […] But that dun't mean that I can't appreciate the beauty of a younger man under the age of 40 and say, "Ooh 'e's a nice lad," you know? Eye candy! […] You can look at the menu but you don't 'ave to eat."*

The acknowledgement of the social clock as an element of identity performance was juxtaposed between the rationalisation of the lived self, duration, and embodied effect. Moreover, Alan located himself in relation to his peers as younger, and highlighted the complex relationship between social identity, age and performance.

Alan: *"The thing is I 'ave always thought of age as a state of mind. […] It's 'ow many years' experience you've got. It's not 'ow many years you've lived or 'ow many years your body's lived. […] I know an awful lot o' people are a lot younger than me, who be'ave like 80 year olds. I don't think I be'ave like an 80 year old."*

The narratives explored above show that the participants strongly associated their quality of life with health issues, often highlighting how an improvement in health would improve their quality of life. The effects of biological ageing, and related health issues, interacted with the participants' social and psychological identities. One consequence of an aged identity was the sense of liberation of not having to conform to social hierarchy and, possibly, accepting childlessness.

Stephen: *"Being more settled in terms of accepting life conditions as being, as being it. Rather than always feeling you've got to make change and fight, you know, resisting all the time. I think, as you get older, you tend to resist less. […] And that can be pleasurable somehow."*

Contrary to the widespread promotion of everything 'young', and denial of ageing, no participant indicated they wanted to return to their younger selves. Although liberation from the 'younger self' and social norms were acknowledged, there was a tension between the present and past selves.

George: "*I do fear – a stroke or cancer, dementia, both my parents had dementia. […] I fear that if restrictions of those sort come along - that I will become self-centred, obsessed with myself, and all the things that are wrong or afraid because I can't cope. "*

George related the notion that the age-related reduction in external performance and health resource capacity ideally would be countered by an inversely proportional

spiritual growth. George's 'ideal' transformation counters the fears he expressed regarding ill health and becoming 'self-obsessed' in later life.

George: *"I would like to be able to age gracefully. […] In terms of my health or my ability to do things, I hope I will make the adjustments as they come along, to those, to that new space. And I can be as big, as large a person, even though my horizons might be coming in, there is a sense of which other things can open up. […] I hope as, and when those come, I can make the adjustments, gracefully, and find an inner freedom even though I haven't gotten an outer of freedom. Or have less of an outer freedom."*

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David: *"I would like to improve my contribution to church and I would like to spend more time on my own spiritual growth ...That probably ought to be the number one focus, because that naturally feeds through into improving the quality of everything else."*

Advantages of growing older were associated with contentment, freedom, maturity, and sagacity. The identities of 'wise man' and 'sage' are traditional patriarchal roles that have a strong connection to an 'ideal' form of masculinity [130]. The criteria the

participants used to formulate the ‘sage’ identity acknowledged their experience, knowledge, empathy, and fairness. All the participants associated later life with a decline in functionality, with the fear of loss of either physical or mental capacity evenly distributed among the sample. Studies that report on the health differences between parents and the ‘childless’ tend to be based on census, health, and mortality records and have highlighted of the poor health outcomes for the latter [70,71]. Only John fitted that ‘problem’ typology. The other participants’ concerns of ageing and involuntary childlessness were more nuanced.

Martin: *“I went to a 70th birthday party of a chap I went to school with. […] Physically, he’s, well, pretty well nearly crippled with back problems and knee problems. […] It was quite stark for me then to look at that - I’m physically very well. […] and he is opposite of that, but emotionally he’s very rich: it was evident how much he was loved by all these daughters and granddaughters. And that was a bit painful.”*

Martin reflected on the balance between the physical and emotional differences between himself and his long-time friend. Counterbalancing Martin’s greater health capital was the relational depth between the father and his adult children and grandchildren. The participants’ overall view of their future was a fear of the deterioration in physical and mental health. As such, their views were similar to ageing people generally. However, a worryingly significant difference was the little discourse concerning children or grandchildren in relation to health and care.

Discussion:

Childlessness is found in every society and cuts across all classifications. Childless people particularly women, report a range of reactions to their non-parental status from open hostility to sympathy. Many are accused of selfishness for having 'chosen' not to be parents [40]. However, there are many influences on why a person who wanted or expected to be a parent does not become one: bereavement, economics, education level, relationship issues, sexuality, and upbringing. The age of first sexual relationship, the longevity of the relationship and the timing of relationship formation and cessation are all circumstances that effect fertility outcomes. Involuntary childless men have to negotiate socio-cultural expectations of masculinity typically virility acknowledged via provider/protector roles. Unfortunately these often include emotional detachment, denial of emotions, fear of intimacy and emotional vulnerability [131], risk taking, aggressiveness, objectivity and control. [132]. However, Wong and Rochlen [133] argued that men have the same emotional experience as women but are socialized to perceive the expression of emotions as a weakness. In addition to having a lack of resources to express feelings, male emotional inexpressiveness has become an embedded ideal [98].

Conclusion:

Although older childless people have similar issues to any other older person, it is essential to acknowledge that they have additional concerns. Many feel 'outsiders' in

the social world for not fitting the pronatalist mandate with concomitant discrimination, exclusion, isolation and stigmatisation. Consequently, childlessness is treated as a deficit 'non-event' identity and considered a 'non-category' [30: 682]. Therefore, the childless are barely perceptible to policymakers, health and care providers and other institutions. The none-collection of men's fertility outcomes means that childless men are invisible to both institutions and individuals. Accordingly, the impact of male childlessness on men's social determinants and their mental and physical health and well-being across the life course are absent from policy and practice. Consequently, it is important for physical therapists to recognise and acknowledge the clinical implications of the additional vulnerabilities of male childlessness.

Table 3 near here

Table 4 near here

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Participant	Age (years)	Relationship status	How participant's rated their quality of life	How participant's defined quality of life
Colin	59	Partnered	"I have a great relationship with my partner and brothers."	"Being in a good, happy relationship and in good health."
John	59	Partnered	"There isn't one."	"Good health, good relationships."
David	60	Married	"A lot of good stuff: I have freedom and flexibility."	"Good relationships: some sense of community. Health is important."
Edward	60	Partnered	"Pretty happy and satisfied."	"Happiness and satisfaction. Health is important too"
George	60	Married	"Pretty good."	"Being able to afford to live and do things together."
James	65	Partnered	"Content: secure relationally and financially."	"It is health really."
Martin	70	Married	"Pretty well. A good partner and a good circle of friends."	"Basics to function: enough food, roof over your head, and health."
Stephen	49	Single	"Not that positive."	"Good work-life balance."
Russell	55	Single	"Measure of contentment."	"Wellbeing: 'No aggro'"
Frank	56	Single	"Not very good"	"Health, having enough to get by and good relationships."
Michael	63	Single	"I'm lucky but lack a social life."	"Friends and beauty."
Harry	64	Widower	"I take pleasure in my hobbies but nothing has the degree that it would have had, had she still been here."	"I don't have quality of life. You're dished out a hand of cards, this is what I got, I go with it."
Raymond	70	Widower	"Good if I can get out, poor if I can't"	"Health: I take each day as it comes."
Alan	82	Single	"Good. I have time to do things."	"If I could throw this walking stick away."

Table 1. Participants' self-rated and self-defined Quality of Life.

Participant	Health	Health status	Attitude to accessing health care
Colin	Terrible	Motor Neurone Disease	Self refers: MND treatment. Shares with family
John	Poor	Diabetes, neurophia, cardiomyopathy	Self refers: under treatment for all conditions.
David	Good	Reduced libido	Self refers: Christian Scientist, discusses with wife.
Edward	Pretty good	Gastric reflux, high cholesterol	Self refers: "I'm a bit of a hypochondriac"
George	Good	Decline in hearing & vision	Self refers: discusses with wife
James	Good	Angina	Self refers: informs partner. Rarely sees GP.
Martin	Pretty good	Pacemaker, decline in hearing & vision	Self refers: discusses with wife
Stephen	Okay	High cholesterol related to medication	Self refers: under treatment
Russell	Good	Hernia for 10 years, ocular decline	Self refers: rarely accesses GP services
Frank	Not good	ME, work related back injury	Self refers: struggled to get ME diagnosed
Michael	Healthy	Ocular hyper tension, loss of libido	Self refers: "The hypochondriac in me"
Harry	Not answered: focussed on health & death of partner		
Raymond	OK	Foot, back, & finger issues, loss of libido	Self refers: under treatment for foot ulcers
Alan	Not bad	Hearing loss, knee injury, loss of libido	Self refers: under treatment for knee injury

Table 2. The participants' self-rated health, health status and attitude to health care.

- The pathways to childlessness are influenced by a vast range of factors: class, economics, education, ethnicity, gender, race, relationships, sexual orientation, socio-cultural context etc.,
- The terms surrounding both aging and childlessness are culturally and personally sensitive.
- Childlessness is often seen as a binary between the Voluntary (chosen-childlessness) and Involuntarily (childless-by-circumstance). However, people's view of their childlessness changes over time and with circumstance.
- Childlessness fundamentally challenges the ideal status of parenthood leading to socio-cultural structurally embedded discrimination.
- Unwanted childlessness affects a person's behaviour, economics, mental and physical health, identity, relationships, and social status across the life course.
- In most countries, fathers' fertility history is not collected at birth registration. Therefore, there is a lack of accurate data on the level of male childlessness.
- Involuntary childlessness can have a significant negative impact on men's mental and physical health and well-being across the life course.
- The childless are a category absent from official policy and practice strategy, which rely on adult children to advocate and informally care for their parents.
- Compared to parents, older childless people are admitted to formal care earlier and discharged later. Childless older men are admitted into care earlier than childless women with similar a similar diagnosis.
- Older men tend to have smaller social networks than comparable women do do. Therefore, they have less informal support.
- Ageing and childlessness challenges traditional masculine ideals. Older men are seen as both lesser and a sexual threat.

Table 3. Key points.

I am a childless man who has been desperately affected by the desire to be a biological father. I am a British-white, heterosexual male, 59 years old, divorced and re- married, with a non-genetic life-long hearing impairment. I was born, raised, and educated in Old Trafford, a working class area of Manchester, United Kingdom. I am the seventh of eight children and I always expected to be a dad. My reactions to my 'broodiness' have included; anger, depression, elation, guilt, isolation, jealousy, relief, sadness, yearning, and withdrawal. I worked for 31 years as scientific and technical photographer before training, and qualifying, as a counsellor. Searching for a reflexive subject for my counselling dissertation, I recalled I had been particularly broody in my mid-30's; I wondered if other men had similar feelings. My academic background follows my multi-modal counselling style in that it draws on the knowledge, experience, myths, and legends, of different tribes.

Table 4. Auto/biographical context.