Donor insemination: exploring the experience of treatment and intention to tell

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Abstract This study explored the concerns and experience of men and women undergoing donor insemination (DI) treatment: levels of distress, mood, adjustment to infertility (Fertility Adjustment Scale: FAS), and intention to tell any potential child were examined. Two samples were included, a DI clinic in a London teaching hospital and the DI support group, the DC Network (the Donor Conception Network). Clinically significant levels of anxiety (HADS), high levels of distress and high scores on the FAS were reported by both men and women in the samples, suggesting that fertility problems and DI treatment are experienced as challenging. Achieving a pregnancy was the main concern expressed, but concerns about the donor and telling the child were also reported. Those who did not plan to tell their child reported higher levels of concern about telling, and higher levels of distress than those who planned to tell. Interest was expressed in accessing further counselling throughout treatment, and the difficulties in terms of the secrecy surrounding DI are discussed.

Introduction
For some time it has been acknowledged that fertility treatment can be stressful and can have a psychological impact on couples seeking help. For example, infertility has been referred to as a ‘life crisis’ and ‘stressful experience’ (Berger, 1980; Stanton & Dunkel-Schetter, 1991). Donor insemination (DI) is primarily offered to couples where there is a male factor fertility problem and while it has been practised for centuries the psychological impact of this treatment has received little attention. Daniels and Taylor (1993) suggest that DI carries with it a stigma and is often shrouded in secrecy; thus protecting the donor’s anonymity, the recipient couple and the medical professionals. Following the Human Fertilization and Embryology Act (HFEA) of 1990 all couples undergoing DI must be offered implications counselling which provides the opportunity to consider the implications of the treatment for themselves, their families and any potential child. Snowden and Snowden (1997) argue that implications counselling could help couples to see DI ‘from the child’s point of view’: ‘Whilst it may not appear important for a baby to know about it’s biological origins, the interest of a young adult in such knowledge is another matter’.

Received 11 August 1999. Accepted in revised form 25 January 2001.
Research by Golombok et al. (1995) and McWhinnie (1995) suggests that the majority of couples undergoing DI treatment do not intend to tell their child about their origins. Those who support non-disclosure point to studies that show there is no evidence to suggest that a child’s psychological adjustment is affected as a result of not being told of their DI origins (Golombok et al., 1995; Brewaeys et al., 1997). However, in recent years moves in Australia and New Zealand have been towards more open practices (Singer & Wells, 1993; Daniels et al., 1996). However, still little is known about those families who tell, the effect of telling or indeed the dilemmas for families who decide not to tell their child about his/her origins. Clamar (1980) and McWhinnie (1995) both point out that in circumstances where this information is revealed to the child inadvertently, the consequences are likely to be worse for the child than if they grow up in the knowledge of the information.

Snowden and Snowden (1997) suggest that with DI treatment, men and women face different dilemmas. For example, men may be concerned about their inability to make their partner pregnant, may feel anxious about the use of another man’s sperm for insemination or be wary about their ability to accept a child born as a result of DI. In contrast a woman may feel resentful towards the male partner, or feel the need to protect him from any outside awareness of his infertility. There may also be anxieties about being inseminated with the semen of another man. Monarch (1997) found that women, often with no fertility difficulties, carry much of the burden of investigations. Carmeli and Birenbaum-Carmeli (1994) suggest that men often feel marginalized by DI, where women become the focus of treatment.

Although new reproductive technologies continue to move forward in the pursuit of ever increasing ways of helping infertile men and women to conceive, the exploration of the psychological and emotional wellbeing of those who do so lags behind. Just as Sokoloff (1987) stated years ago, issues regarding information on the donor, counselling for parents, the burden of the family secret of DI and ultimately the wellbeing of the child have not been adequately addressed.

The current study aimed to explore levels of distress and psychological adjustment to infertility. In particular we aimed to:

1. clarify the concerns of men and women during the process of treatment;
2. examine the role of counselling with a view to providing recommendations for furthering psychological support for couples undergoing DI treatment; and
3. explore the views of couples about telling any potential child about his/her origins.

To do this the study we drew together and examined differences between two sample groups, one from the DI clinic in a London teaching hospital and the second from the members of a support group (the DC Network). In general the DC Network support a more ‘open’ approach for people intending to tell a child conceived by DI about his/her origins.

**Method**

**Participants**

1. DI clinic: this clinic was located within a large London teaching hospital.
2. DC Network: this network was set up in 1993 by Merricks and Montuschi and other parents of DI children to provide support to those who intend to tell DI children of
their origins. They have produced a book called My Story (1991) which couples can use to explain to their child about his/her origins. The network includes families with DI children, grown-up DI adults and single and lesbian women who have undergone DI, as well as couples and individuals currently undergoing DI treatment.

**Measures**

Three measures were used in this study were as follows.

*Experience/concerns questionnaire.* This questionnaire aimed to assess the extent to which DI patients were concerned about a variety of issues. It was drawn up after visits to the clinic, using our own clinical experience and after discussion with the research group at the DC Network. A first draft of the questionnaire was piloted with two members of the DC Network. There were 13 items asking about specific concerns which participants scored on a Likert scale anchored 1 (not at all concerned) to 10 (very concerned). Questions covered the following: medical procedure, the donor, effect on relationship with partner, telling the child or one’s family, risk of multiple births, achieving a pregnancy, feelings about a DI child, appearance of the child, child’s right to seek information at age 18, relationship between the DI child and non-DI children in the family (if applicable) and the match between donor and male partner. There was space for participants to list any other concerns they had about DI. Participants also rated their feelings and an estimate of their partner’s distress on scales from 1 = ‘not at all distressed’ to 10 = ‘very distressed’. A 1–10 scale also provided information on the extent to which the participant felt DI had interfered with their daily routine and lifestyle. Participants were asked whether they intended to tell the child by answering the following question: ‘If treatment is successful do you plan to tell the child about the DI procedure? Yes/No/Don’t know (please circle as necessary). What are your reasons for this?’

Space was provided on the questionnaire to gather comments on intention to tell, others told, and the experience of implications counselling. A list of all areas likely to be covered in an implications counselling session was included for participants to check whether this had been discussed or not.

*Mood.* The Hospital Anxiety and Depression Scale (HADS) (Zigmond & Snaith, 1983) was used to measure anxiety and depression. This 14-item questionnaire has been validated for use in hospital outpatient populations and has well demonstrated reliability and validity (Herrmann, 1997). Seven items relate to anxiety and seven relate to depression. Respondents are asked to rate how they have been feeling in the past few weeks, for example: ‘I feel cheerful . . . not at all, not often, sometimes, most of the time’. Each item is scored from 0 to 3 and scores are derived by summing individual scores, giving the minimum score of 0 and a maximum of 21. Zigmond and Snaith (1983) recommended scores between 8 and 10 be regarded as borderline cases with those scoring 11 or more having clinically significant levels of anxiety and depression.

*Fertility adjustment.* This was measured using the Fertility Adjustment Scale (FAS) (Glover et al., 1999). This is a recently developed scale, designed to assess adjustment to fertility problems and focuses on the extent to which the person has come to terms
cognitively, emotionally and behaviourally with the possibility of not having a child. Participants are asked to rate their agreement from 1 (strongly agree) to 6 (strongly disagree) with a number of statements such as: ‘I will continue with investigations/treatment until I succeed in having a child’ and ‘I seem to live my life from month to month’. When scoring the FAS the total score is found by adding each response to gain an overall adjustment score. A total high score is taken to represent earlier stages of adjustment; scores range between 12 and 72. The FAS has been used with men and women undergoing other fertility treatments (Intrauterine insemination or in vitro fertilization) and the mean score was found to be 39.1 (SD = 10.3) for men and for women 39.3 (SD = 13.0). This scale is still in the early stages of being piloted with different groups but has been shown to have good internal reliability and test–retest validity.

Procedure

The local research ethics committee granted ethical approval.

DI clinic sample. All couples attending the clinic for DI treatment were sent a recruitment letter by the clinic staff informing them of the study and inviting them to participate by sending a tear-off slip to the researchers. Those who returned slips were sent consent forms, information sheets and questionnaires. Stamped addressed envelopes were sent to all participants.

DC Network sample. The Network’s research steering group published a short piece about the study in their newsletter, inviting members to participate. A recruitment letter was included which invited members to return a tear-off slip to the researchers. Those who returned the slips were then sent information sheets, consent forms, questionnaires and stamped addressed envelopes.

Analysis

The quantitative results were analysed with SPSS for windows 7.01 (the Mann-Whitney and chi-square tests were used to analyse results from the Likert scales, the HADS and FAS). Responses given to the open questions were sorted into categories and content analysis carried out. These categories, and the quotes assigned to them were examined and checked by another psychologist.

Response rates

The DI clinic sample. All the couples attending a London teaching hospital DI clinic currently having DI treatment (70 couples) were invited to participate in the study. Twenty-five couples (36%) responded, stating they were willing to participate. However, only 12 couples (48% of those who responded or 18% of those approached) returned their questionnaires. Twelve couples and one woman, whose partner did not participate (13 women and 12 men), were included in the study.

The DC Network sample. All members from the DC Network (280 households) were approached for participation in the study. However, the majority of these were couples
that had completed treatment and have a child/children. Results from these participants are reported elsewhere (Hunter et al., 2000). It was not known how many were still in treatment. Nine couples, and two women whose partners did not participate, who were currently having DI treatment, were included in the study.

In total this study examined the experiences of 24 women and 21 men currently undergoing treatment.

**Results**

**Sample characteristics**

The mean age of the clinic group and the DC Network group was 33 (SD = 5.57) and 32 (SD = 5.09), respectively. The two groups did not differ significantly in terms of duration of treatment, with the clinic and Network group having received an average of 8 cycles (SD = 5.97) and 5.3 cycles (SD = 3.51), respectively. The mean length of time reported being in treatment was 25 months (SD = 17.72) for the clinic participants and 21 months (SD = 11.17) for the network participants. Whilst the clinic participants gave a mean level of distress as 7.26 (SD = 3.38) the network participants gave similar mean rating of 7.25 (SD = 2.46). The two groups also scored similarly on anxiety and depression (HADS) and total FAS scores (see ‘Distress and mood’ section for means). The groups did not differ significantly on the dimensions of age, ethnicity, duration of treatment or levels of distress.

The only significant difference was found to be age of leaving full-time education ($\chi^2(1) = 11.23, p < 0.01$). Thirteen (61%) of the clinic sample left full-time education at age 16, whilst eight (38%) continued on, this was compared to only two (10%) of the DC Network sample who left at age 16 whilst 18 (90%) continued beyond this age. Data were missing from four participants from the clinic on this subject.

Due to the low response rate and the similarities (apart from educational status) on socio-demographic variables, the two groups were combined. This provided a group large enough to examine some gender differences.

In the combined group there were 24 women and 21 men. All were currently in treatment and were in heterosexual relationships. There was a significant difference between the age of men and women in treatment (mean ages of men and women were 35 and 31 years, respectively; $U = 132, p < 0.05$). Forty-four (98%) out of the 45 participants reported their ethnic status as ‘white’, and one as ‘Mediterranean’.

**Distress and mood**

Women were more distressed than the men about the fertility problems, scoring 8.17 (SD = 2.60) compared to the men’s score of 6.20 (SD = 3.05) ($U = 126; p(0.05.)$). The men’s mean rating of their partner’s distress (8.30, SD = 2.34) was consistent with the women’s rating of themselves. However, on average the women rated their partners as more distressed (7.30, SD = 3.00) than the partners rated themselves. In terms of the FAS, the scores were above those found in the original studies’ sample of couples attending the same clinic with a range of fertility difficulties (mean scores in this study being: men: 49.10, SD = 6.70, women: 49.04, SD = 8.42). This suggests they may have difficulties coming to terms with the possibility of not having a child. Men’s and women’s mean scores were in the borderline range for anxiety on the HADS (men: 8.21, SD = 4.36, women: 9.54, SD = 4.66), and were within the non-depressed range for depression (men: 3.31, SD = 2.70/women: 4.50, SD = 3.86).
The experience of counselling

Ten percent of the men and 21% of the women reported that they would like to see a counsellor for sessions (supportive or therapeutic counselling). On recollection of their implications counselling sessions prior to treatment the following issues were raised (all participants had received implications counselling). Sixteen (80%) couples recalled having been given information about the donor; most (19 out of 20 couples, 95%) were given information about the medical procedure. Seven couples (35%) recalled discussing issues related to telling their families, and seven couples (35%) discussed the issue of how to tell their child about DI. Fourteen (70%) couples reported being given the chance to express their feelings about treatment and DI.

Concerns during treatment

Men and women in treatment rated DI treatment as interfering with their daily lives to a moderate extent. Women rated the level of interference into their lives as significantly higher than men (means for women and men were 7.65 and 5.60; respectively; $U = 142.5; p < 0.05$). Travel, taking time off work and feeling that the treatment dominated one’s mind were the reasons given most frequently.

Table 1 shows men and women’s ratings of concern regarding aspects of their treatment. Whilst both men and women were most concerned about achieving a pregnancy, there was a significant difference between how they rated their level of concern about getting pregnant, with women giving higher ratings. Other aspects felt to be important at this treatment stage were the donor’s characteristics and telling the child. There was also a concern that DI was having an impact on the relationship with their partner.

| Table 1. Men’s and women’s mean ratings of concern regarding aspects of DI treatment |
|---------------------------------|---------------------------------|---------------------------------|---------------------------------|
|                                 | Men                             | Women                          | U                              |
|                                 | M     | SD    | M     | SD    |                                 |
| Getting pregnant                | 7.25  | 3.41  | 8.73  | 2.68  | 166*                            |
| Donor characteristics           | 5.80  | 3.07  | 5.00  | 3.01  | 195                             |
| Telling the child               | 5.30  | 3.29  | 5.34  | 3.12  | 224                             |
| Effect of DI on relationship    | 5.15  | 3.39  | 5.52  | 3.48  | 214                             |
| Matching the donor              | 4.70  | 2.63  | 5.21  | 3.01  | 207                             |
| Child’s right to seek info      | 4.50  | 3.33  | 5.21  | 3.32  | 202                             |
| Telling the family              | 4.10  | 3.29  | 3.91  | 3.21  | 215                             |
| Appearance of child             | 4.05  | 3.06  | 4.00  | 2.87  | 227                             |
| Multiple births                 | 3.60  | 2.92  | 2.82  | 2.34  | 196                             |
| Medical procedure               | 3.25  | 1.99  | 3.39  | 2.40  | 228                             |

*p < 0.05.

Note. All variables were rated on a 10-point anchored scale ranging from 1 = not at all concerned to 10 = very concerned.
**Intention to tell**

The different nature of the samples used in this study enabled us to examine intent to tell a potential DI child. There was a clear difference between the hospital clinic sample and DC Network sample in their intentions. All the DC Network participants \( n = 20 \) planned to tell a future child; while only three (13%) of the clinic sample \( n = 25 \) planned to tell, data were missing on two clinic participants. This difference was statistically significant \( \chi^2(1) = 32.51; p < 0.001 \)

Participants in the clinic sample left full-time education at age 16 significantly more frequently than those in the DC Network sample. Findings from this study therefore suggest there is tentative evidence of a relationship between level of education and telling the child or not; however, this clearly requires further research. Level of education was not related to other factors such as distress or mood, but was only related to intent to tell a future child.

Those who were undecided about telling their child were also found to be significantly more distressed about their fertility difficulties than those who were planning to tell their child. On a scale of distress marked 1–10 (not at all distressed–very distressed) the mean score of those undecided was 8.2 (SD = 2.48) whilst those who planned to tell had a mean score of 6.43 (SD = 3.14). This was statistically significant \( U = 143; p (0.5) \). There was also a significant difference between those who were undecided or wished not to tell and those who intended to tell on the concern scales for telling your child and telling family. Those who were uncertain or wished not to tell scored 6.35 (SD = 3.51) for telling a future child and 5.45 (SD = 3.53) for telling family. Those participants who intended to tell scored 4.43 (SD = 2.59) regarding telling the child \( U = 153; p (0.5) \) and 2.73 (SD = 2.32) regarding telling family \( U = 129; p (0.5) \).

Many couples from the clinic had spoken to other people about their DI treatment. Out of those sampled from the clinic, four out of 13 (30%) women and four out of 12 (33%) men had not told anyone about their treatment. All others had told someone, and only one man and one woman reported a negative reaction. As may be expected, all those from the DC Network had told people about their DI treatment. The majority of those told had responded positively, only two men and one woman had reported a negative reaction.

**Content analysis of participant comments**

Content analysis was carried out on comments regarding the most difficult aspects of treatment (see Table 2).

The predominant issues for men and women were ‘secrecy and stigma’ of DI (women: 15%, men: 10%):

The general public should be better informed on the treatment so that there is less secrecy in telling children they are DI treatment children because of the stigma attached to it. (Man)

Men and women also commented on the ‘duration of treatment’ (women: 11%, men: 11%), mentioning the ongoing cycles, and failure. ‘Impersonal treatment’, feeling unsupported by staff and the process being too rushed were also of concern to both men and women (women: 11%, men: 10%).
Very stressful waiting time, then if your period starts and the treatment hasn’t worked you have tears, then start again. (Woman)

I felt like I was on a conveyor belt. (Woman)

The slightly impersonal touch to it all. The fact that after receiving a treatment they can’t get you out quick enough. They lose touch with the women’s emotions and stress. (Man)

Men and women differed on several areas, women commenting more on ‘medical issues’ such as worries about drugs, and medical management (9.5%). Men commented on male infertility issues (10%), and the impact of DI on their relationship (15%):

Infection, AIDS, if all sperm is screened, can it be missed? (Woman)

Coming to terms with the fact DI though costly, time consuming etc. has not solved my infertility but only offered a way around it. (Man)

Blaming each other and arguing. But we are strong now and it has been an experience. (Man)

Content analysis was carried out on the qualitative data gathered on counselling and three main themes arose: the need for counselling in the early stages of treatment; wanting more contact with others in treatment and feeling judged by the counsellor. These themes are illustrated below:

I am pleased that the HFEA have regulated treatments, but still have concerns that husbands state they have ‘accepted’ their inability to make their wife/partner
pregnant and clinics do not enforce counselling prior to commencing treatment. It is too late once a pregnancy from DI has been achieved! (Woman)

I think one way to improve services would be to offer more hands on support from people who have been through what you are going through. (Woman)

I felt as if my future was in the counsellor's hands. The doctor would use the counsellor's information in decision as to whether to treat me. So I felt everything I said was crucial although I didn’t really know what she wanted to hear. I did not like being judged as to my ability to be a good parent. (Woman)

Table 3 shows the reasons given for the decision made regarding whether or not to tell a future child. The following quotes illustrate some of these reasons.

Those who did not express a positive intent to tell a future child:

I am concerned the child will find real father and not love me. (Man)

My son does not need to know anything as there is nothing to know or find out, why upset a happy healthy child. (Man)

We have told nobody, I think it is best for the child they believe that the man that they have known as dad is their dad but if he did ask questions when older I might explain that he is special. (Woman)

Those who intended to tell a future child:

It makes everything easier in the longer term. Keeping secrets is very tiring and destructive. (Man)

I couldn’t cope with deceit over years. Much higher risk of rejection if child discovers origins as an adult. Whole family knows, wrong to keep from child itself. Possible medical reasons. (Woman)

I am reasonably confident about a good relationship between our children and my husband, but the DI aspect does sometimes concern me, mainly will the child love my husband as its father? (Woman)

<table>
<thead>
<tr>
<th>Reason</th>
<th>DI clinic</th>
<th>DC Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telling disrupts child's happiness</td>
<td>5 (21%)</td>
<td>0</td>
</tr>
<tr>
<td>Need further advice before decision</td>
<td>7 (30%)</td>
<td>0</td>
</tr>
<tr>
<td>Don’t believe in secrecy</td>
<td>1 (4%)</td>
<td>12 (60%)</td>
</tr>
<tr>
<td>Fear others might tell child</td>
<td>2 (8%)</td>
<td>4 (20%)</td>
</tr>
<tr>
<td>Fear child will want real father</td>
<td>1 (4%)</td>
<td>0</td>
</tr>
<tr>
<td>Child might not love father</td>
<td>1 (4%)</td>
<td>0</td>
</tr>
<tr>
<td>Unsure when to tell child</td>
<td>1 (4%)</td>
<td>0</td>
</tr>
<tr>
<td>Child will be mine, no need to tell them</td>
<td>3 (13%)</td>
<td>0</td>
</tr>
<tr>
<td>Important for child to know their origins</td>
<td>0</td>
<td>3 (15%)</td>
</tr>
</tbody>
</table>
Discussion

Distress and mood

This study found women’s rating of distress about fertility difficulties was higher than the men’s rating. Lasker and Borg (1989) suggest that men are more likely to keep DI a secret, and that secrecy in DI is bound up with protection of the male partner. In this study, women, and to a lesser extent men, were concerned about the level of secrecy and stigma surrounding DI. Interestingly, the majority of men and women had told someone about their difficulties with only a small minority experiencing a negative reaction. This suggests that the fear of an adverse reaction is not supported by experience although choice of who to tell may play a part in the response received.

The results of this study do not support those of Blaser et al. (1988), who found that DI did not pose a threat to men, and that infertile men were not a psychological risk group. In contrast, this research suggests that men experience high levels of anxiety and distress about their infertility. Men’s and women’s mean scores fell into the borderline range for anxiety (HADS). These anxiety levels could be seen as a reaction to the treatment, the monthly ‘ups and downs’, anxiety about the donor, and feelings about the fertility difficulties.

Both men’s and women’s scores on the FAS were above those quoted in the original study, suggesting that fertility problems may be difficult to process in this context of having DI treatment (Glover et al., 1999). Further research of this area might establish whether couples undergoing DI adjust more poorly to infertility difficulties than other groups with fertility difficulties. Raphael-Leff (1991) suggests that the lack of clear boundaries in infertility treatment, and not knowing when to accept failure, is one of the many factors linked to adjustment to infertility. This can be seen in the quote from one of the participants who stated, ‘you just become addicted to it, just one more cycle’. In addition, DI treatment is not a cure for male infertility but rather an alternative method of conceiving. Qualitative data from this study illustrates how some of the features of DI treatment such as concerns about the donor, the decision about telling and the insemination could compound aspects of infertility treatment which are already difficult. All of these aspects of treatment no doubt contribute to DI being experienced as challenging. This is illustrated by the following quotes that were in response to an open question about the most difficult aspect of DI treatment:

The emotional aspect of things, two failed attempts and one aborted attempt, both my wife and I cried bitter tears of helplessness and hopelessness. (Man)

I feel my life is empty, most of the time I dream of baby. (Woman)

Counselling needs

This study found that issues such as ‘telling your child’ or ‘families about DI’ were not always discussed in implications counselling sessions, whilst medical and donor issues were. This finding indicates the importance of systematic and consistent practice of implications counselling, perhaps with supportive psychological interventions at different stages during treatment. Couples expressed a concern about telling or not telling a future child about his/her origins, suggesting that the opportunity for an open discussion on this topic both prior to, and during treatment would be of benefit.
Acknowledgement of these issues in treatment settings might facilitate more sensitive discussions for couples who are undecided about telling, particularly as a significant number of men and women expressed an interest in further supportive or therapeutic counselling.

**Intention to tell**

Couples who belong to DC Network had actively sought out further support and information, addressing long-term concerns about DI treatment. Couples learn of the book *My Story*, serving perhaps as a ‘script’ with which to tell, unlike those couples from the clinic who do not seek such support. Those who were undecided, or wished not to tell their child were also found to be more distressed about their fertility difficulties. The direction of this relationship is unclear, and it is important to bear in mind that whilst this finding was significant the actual numbers are small and would clearly warrant further research. One explanation is that the ‘undecided’ group had difficulties coming to terms with the need for DI. Unresolved feelings about fertility problems might make it difficult to process thoughts and feelings about the specific aspects of DI such as the donor characteristics and telling the child. This may particularly be the case when the decision regarding telling is related to a ‘future’ situation, which at the treatment stage is by no means guaranteed. The couples’ main concerns at this stage were preoccupation with becoming pregnant. Another consideration is that the group who are undecided or plan not to tell often referred to the need for more information and advice on this area, and were not members of a support group. Thus, lack of support may increase the level of distress about fertility difficulties and DI treatment.

It is important to bear in mind that other research (Golombok *et al.*, 1995; McWhinnie, 1995) has found that the majority of couples choose not to tell. Yet there seems to be some ambivalence for those couples from the clinic who do not wish to tell their child, all but four of the couples have spoken to others about the treatment. There is then the risk that the child might find out inadvertently.

From the descriptions given in this study it is clear that the secrecy and stigma of DI can place a great strain on both the couple and on individual coping mechanisms. Even after having decided to talk with others about DI, telling is not necessarily an easy option, as shown by the reporting of some negative reactions by those who were told about DI treatment. Results suggest it is likely that the indecision about telling and concern about secrecy may be linked to higher levels of distress about fertility difficulties. So, whilst secrecy can help couples to think of their child’s conception as ‘normal’, it also ensures that male infertility remains a taboo issue.

A major problem inherent in research into DI is that there can be difficulties accessing clinical populations undertaking DI as the majority plan not to tell their child. In this study the two samples may differ in other respects which were uncontrolled in this study. Because there was not an even distribution of those intending to tell a child about DI across each sample we were unable to examine the effects of confounding variables, such as educational qualification, in detail. This low response rates points to the importance of recruitment methods in this field in order to be able to access those couples who are planning to keep their DI treatment a secret.

It is clear that further research into the complex area of whether, when or how to tell a DI child is called for. This study provides some tentative evidence that the issues surrounding telling and secrecy are far reaching, and that ‘total secrecy’ is difficult to maintain. There is also a need to move away from polarizing the two decisions regarding
telling a child or not as couples are helped to consider the `best’ decision for them and their families.

References


