Donor insemination disclosure in social networks: heterosexual couples' experiences

Mauro Kerckhof, Hanna Van Parys, Guido Pennings, Petra De Sutter, Ann Buysse & Veerle Provoost

Published online: 01 Apr 2019.

Submit your article to this journal ⍉

View Crossmark data ⍉

Taylor & Francis
Taylor & Francis Group

Check for updates

Donor insemination disclosure in social networks: heterosexual couples' experiences

Mauro Kerckhof[a] (iD), Hanna Van Parys[a] (iD), Guido Pennings[b] (iD), Petra De Sutter[c] (iD), Ann Buysse[a] (iD) and Veerle Provoost[b] (iD)

[a]Faculty of Psychology and Educational Sciences, Ghent University, Ghent, Belgium; [b]Bioethics Institute Ghent, Ghent University, Ghent, Belgium; [c]Department of Reproductive Medicine, Ghent University Hospital, Ghent, Belgium

ABSTRACT

The way in which heterosexual couples manage information about infertility and donor insemination within their social networks has not yet been explored in-depth. This study focuses on how parents and aspiring parents manage information about infertility and donor insemination within their social networks. Fifteen Belgian couples were interviewed as part of a parenthood research project. Thematic analysis resulted in the identification of four themes. The first of these reveals how the social context can best be understood as a continuous confrontation with social expectations. A second theme highlights the diverse ways in which couples manage personal information in this confronting context. The third theme stresses how couples manage information about donor insemination so as to be treated as a 'normal' family. The final theme shows how emotional regulation within the context of the extended family plays a role in couples' decisions about how to manage information with relatives. Results are analysed using the concept of 'systemic emotion management' and the importance of being seen by others as a 'normal' family. Study findings signal the importance of managing information within social networks and are of relevance to a range of practitioners.

Introduction

Heterosexual couples' experiences of fertility problems take place in a social context that can colour their experience in either a positive or a negative way. A supportive social network can have a beneficial impact on infertility-related stress (Martins et al. 2013; Steuber and High 2015), although this is not always the case. For instance, there can be a mismatch between the type of support offered to, and the type of support desired by, infertile women (High and Steuber 2014). Furthermore, negative reactions from other people seem to have a greater emotional impact on the experience of infertile women than more supportive responses (Steuber and Solomon 2011). The

experience of infertility also influences the broader social context of the couple. For example, as a result of this experience, existing relationships can change in a positive (e.g. becoming more close) or a negative (e.g. becoming hostile) way (Steuber and Solomon 2011).

Qualitative studies have demonstrated the complexity of engaging with the wider social network in the case of infertility and have shown that couples often have to balance the need for social support with the need for privacy (Steuber and Solomon 2011). Steuber and Solomon (2011) stress the importance of managing information; in their study, women regulated infertility information by sharing information, concealing information or giving misleading information to others. This 'ongoing process' may fluctuate based on how the treatment goes, and it can be influenced by previous experiences with disclosing information (Bute and Vik 2010). For instance, couples may become less open about their fertility problems after experiencing unsupportive reactions from others (Bute and Vik 2010).

The importance of managing information within the social network for infertile couples stands in contrast to the low number of studies about this process for couples using donor insemination in particular. Since donor insemination is still considered a social taboo and remains shrouded in secrecy in Belgium, and more generally in Europe (Brewaeys et al. 2005; Indekeu et al. 2012), it is a more sensitive and challenging issue to manage than fertility treatment using one's own genetic material. For example, in Provoost et al.'s (2018) study, the way in which children and couples used words to refer to the donor so as to safeguard the role of the social parent illustrates how communicating about the donor can be challenging within families. Moreover, managing information within the social network has not often been studied specifically in couples using donor insemination.

Quantitative research has remained largely limited to enquiries such as 'Did you disclose it to others?' as part of a questionnaire (e.g. Indekeu et al. 2012; Salevaara, Suikkari and Soderstrom-Anttila 2013). Based on these kind of questions, it is known that parents often discuss donor insemination with people outside the nuclear family (e.g. Indekeu et al. 2012; Rosholm et al. 2010; Salevaara, Suikkari and Soderstrom-Anttila 2013). It has also been shown that parents who are open with the child about the donor insemination are more likely to be open with their social network. Interestingly, a considerable group of parents who disclose this information to others do not intend to inform their child. Several researchers consider this discrepancy to be a precarious situation (Rosholm et al. 2010). However, no quantitative study to date has explored the process of managing information within the wider social network.

Some of the qualitative studies that have focused on disclosure to the child have touched on the difficulties in managing the donor insemination within the individual's or couple's social network. Lycett et al. (2005), for instance, have shown that some parents decide to be open with their child about the donor insemination because they had the fear of accidental disclosure by others (e.g. friends and family) who were aware of the donor insemination. Parents who did not tell others did so because they were afraid of being rejected and wanted to protect their family from the stigma related to donor insemination (Hargreaves and Daniels 2007). Several studies have shown that sharing information about donor insemination within the extended family

can be especially challenging (Hargreaves and Daniels 2007; Nordqvist and Smart 2014). Nordqvist and Smart (2014) interviewed couples and the grandparents of the donor children. They found that families carefully negotiated the meaning of donor insemination and that this process was influenced by the existing family relationships.

Against this background, in this paper we explore how heterosexual couples who use donor-assisted reproduction manage information about the donation within their social network, not limited to the extended family. The study is part of a larger inter-disciplinary research project about the meanings of parenthood for families using medically assisted reproduction. All the couples used an anonymous sperm donor. The candidate recipients were allowed only to state a preference for basic phenotypic traits (i.e. hair colour, eye colour, height and weight) but were not given any further information about the donor. In Belgium, although known sperm donation (family, friends) is allowed, it is rarely used. Belgian law imposes anonymity of the donor both before and after donation (Pennings 2007). However, political debates about the law on donor anonymity have grown in recent years. Some political parties (e.g. the Christian Democratic Party) advocate for an exclusively open-identity policy, while others argue for a plurality of donor tracks, with both anonymous and identifiable donors.

Methods

Participants

Two groups of heterosexual couples ($n = 15$) were recruited at the Department of Reproductive Medicine of Ghent University Hospital. All couples attended an obligatory counselling session before starting donor insemination as part of the general treatment protocol. Potential participants were invited by the psychologist within the department. Contact with researchers was only established after the participants had been informed about the study and had given their consent for such contact orally or by e-mail. The inclusion criteria for candidates were: having Belgian nationality and being Dutch-speaking. The Ethics Committee of Ghent University Hospital approved the study.

The first group consisted of couples who were on the waiting list for anonymous donor insemination, who were in the process of donor insemination or who had just gone through this treatment. They are referred to as the 'aspiring parents'. These couples underwent at least one treatment cycle with own gametes, and they did not have any children in their current relationship. The departmental psychologist contacted 12 couples and was able to include five for the study. Four couples voluntarily provided their reasons for not participating: they preferred to keep the matter private (2), the male partner objected (1), or they found it difficult to talk about the topic of this study while not being pregnant yet (1). At the time of the data collection, three couples were pregnant and two couples were planning a subsequent treatment cycle.

The second group were parents who had child(ren) between the ages of 7 and 10 conceived through anonymous donor insemination at the department between 2002 and 2005; they are here referred to as the 'parents'. The recruitment of parents ended when 10 couples were willing to participate. Twelve of the couples approached did

Table 1. Information about the aspiring parents.

Mother	Father	Treatment*	Status
Gabrielle	Fritz	DI	Pregnant
Megan	Brian	DI	In treatment
Kirsten	John	DI	Pregnant
Denise	Carl	DI	Pregnant
Lilith	Scott	TESE	Waiting to start first DI cycle

*DI = Donor Insemination, TESE = Testicular Sperm Extraction.
Pseudonyms were used to refer to the couples.

not participate because they wanted to keep the method of conception a secret (7), because it was a sensitive topic for the male partner (3) or for both (1) or because they perceived the donor conception as a closed chapter (1). One parent was interviewed without her partner because he did not want to participate. None of the couples who refused participation wanted to tell their child(ren) about the donor insemination.

These two groups were both interviewed as part of the parenthood research project at different moments in their donor insemination treatment. We noticed that experience with their social network spontaneously shared by parents was similar to the experience of aspiring parents, even though in the case of the former group the treatment had been undertaken long ago. In our analysis, we therefore combined the two groups but sought to take this difference in time frame into account. The heterogeneity of our sample (combining aspiring parents and parents) is secondary to the central issue of interest, namely the shared experience of treatment (Holloway and Wheeler 2010).

Tables 1 and 2 give an overview of the participating couples, using pseudonyms to protect their privacy.

Interviews

Semi-structured interviews were conducted by two clinical psychologists within the parenthood research team, between May and October 2013. Couples were interviewed jointly at the location they preferred: either at home or in the department. Written informed consent was given at the time of the interview. Interviews lasted between 90 and 120 minutes and were audio-taped and transcribed verbatim using pseudonyms. To protect the participants' privacy, we also removed all references to places, dates or other information that could lead, directly as well as indirectly, to the identification of the participant. Transcripts were checked for accuracy by a researcher from the team and by the interviewer. As the interviews formed a part of the broader parenthood research project, the interview guide consisted of multiple open-ended questions and covered a variety of topics (e.g. thoughts about the treatment, reasoning about the donor). Two questions in the interview guide considered the social network: 'Did you tell people in your environment that you are being treated at the clinic, or not?' and 'How did the people in your environment react to this?' As the interviews were semi-structured, topics could also be brought up spontaneously by couples during the interviews.

Table 2. Information about the parents.

Mother	Father	Children	Treatment*
Maya	Joseph	1	DI
Brooke	Theo	2	DI
			DI
Jessica	Samuel	2	DI
			DI
Amelia	Matt	2	IVF, DI
			DI, ICSI-D
Candice	Patrick	2	IUI, DI
			DI
Jacqueline	Harry	1	DI
Cynthia	Oliver	1	DI, ICSI-D
Charlotte	Luke	2	DI, ICSI-D
			DI
Jillian	Oscar	2	DI
			DI
Rebecca	/	2	ICSI-D
			ICSI-D

*DI = Donor Insemination, IVF = *In Vitro* Fertilisation, IUI = Intra-Uterine Insemination, ICSI-D = Intracytoplasmic Sperm Injection with Donor semen.
Pseudonyms were used to refer to the couples and children.

Analysis

Qualitative data analysis was conducted using the step-by-step inductive thematic analysis advocated by Clarke, Braun and Hayfield (2015) supported by the QSR International's NVivo 11 data analysis software. We included all the data in which couples referred to their social network (e.g. friends and family) or the broader society. The transcripts were read multiple times while writing memos before initial codes were generated with our research question in mind. The first and last author performed these two steps separately and independently from each other. The last author challenged the initial codes and interpretations of the first author. This multiple coding was done to encourage thoroughness of analysis.

In the next step, the codes were structured into themes and subthemes. The organisation and delineation of the themes were revised multiple times after auditor discussions with all the co-authors. Coding summary reports were sent to the auditors (VP, HVP and GP) in advance of the meetings. Based on these reports the auditors challenged the themes and subthemes constructed by the first author. This process of revision (based on feedback from the auditors) was repeated until further exploration did not result in any new insights and consensus was reached. The different rounds of discussing the results enhanced the depth of analysis and improved the trustworthiness and validity of our study.

Results

Throughout the analysis, four themes were identified. The first theme describes how the broader social context in which the interactions took place was experienced by the couples. The second theme illustrates the diversity of ways in which couples managed disclosure to others. The third theme relates to managing information with the importance of being seen as a 'normal' family. The last theme shows how regulating emotions within the family played a role in the management of information.

Continuous confrontation

Several couples talked about how they experienced continuous confrontations with others about their inability to fulfil the social norm of having children. Family members in particular communicated their clear expectations about future parenthood to the couples. Carl and Denise (aspiring parents) were told at every family occasion: 'So now it is your turn, right'. Comments by people who were ignorant of the couple's fertility problems were hard to endure. Brian and Megan (aspiring parents) even thought about moving away from their neighbourhood because of these comments. The couple was asked nearly every month by their neighbours: 'Are you not going to start [a family]?' Those questions were very confronting as the couple wanted children but they were uncertain whether the treatment would result in a successful pregnancy.

> Brian: … 'How are things with you guys?' […] 'Do you not feel the itch [to have children]?' …

> Megan: … the itch, ooh! (Brian laughs). Then you would rather live somewhere in the countryside, really, just in the fields or in a busy city where they would just leave you alone but …

Not only the meddling of others but also the mere image of children and pregnancies was confronting to the couples and could provoke strong feelings of injustice. Megan said about the unexpected pregnancy of her sister: 'That is a lot of injustice. So, it keeps playing a role in the whole process, eh'. The couples saw babies and pregnant women 'everywhere': in the waiting room of the hospital, in the streets and often in their immediate social network, for example, pregnant relatives or friends. The latter were the most difficult to bear as Jillian (parent) explained:

> Then they come, like: 'Hi, I am pregnant!' Those moments where they come and play happy but for you, it is a punch in the face. And then you have to keep strong and say: 'Congratulations', while, in fact, you feel like saying, 'I want that too'. (Jillian, parent)

The combination of others actively reminding them of the social norm of procreation and seeing others who were pregnant 'everywhere' made the social context difficult to deal with, especially at times of uncertainty about the success of the couples' fertility treatment.

Diversity of disclosure practices

In the interviews, couples reflected on whether or not they would disclose personal information about their fertility problems and the donor treatment to others. Each couple managed this information differently: one couple did not tell anyone about their fertility problems and the donor insemination, some couples shared their fertility problems without mentioning the donor insemination and yet other couples were open about the donor insemination and fertility problems to some people.

The information about the donor insemination and the fertility problems were managed in different ways. All the couples but one shared their fertility problems with people close to them: family members, friends and/or colleagues. Four couples shared the fertility treatment with others, while they did not discuss the use of donor sperm

with anyone. Two of those couples (parents) kept the donation a secret for their child, and two other couples (parents and aspiring parents) were still in doubt about whether they should tell their (future) child.

The couples who disclosed the donor insemination did so to a limited number of people: close friends, family and/or colleagues. Some drew a distinction in their social network between those they told only about the fertility problems and those they also told about the donor insemination. Denise, for example, had told her parents and two colleagues about the donor insemination, but told other colleagues that she was having an *in vitro* fertilisation treatment. Participants often disclosed the fertility treatment to justify absences at work necessary for the hospital appointments. One exception to this limited disclosure was Megan (aspiring parent) who wrote a book about her donor insemination experience: 'because I am really open for it to announce that [donor insemination treatment] to the world somehow'.

The nine couples who were open with at least some people about the donor insemination described managing this information as a careful process. They characterised the people they opened up to as trustworthy, meaning that they would keep the information to themselves. Jillian and Oscar were careful to avoid unintended disclosure. They shared the information with some relatives and friends but did not want to tell their child:

> With us, naturally, it is altogether something different again [compared to families who have disclosed to their children]. You do have to consider who you will be talking to. (Oscar, parent)

The same carefulness was present in the couples who were or who planned to be open with their child. For instance, Theo (parent), whose two children knew about the DI, said, 'No, well, you should not go and shout about it from the rooftops' with regard to sharing the information with people. Several couples clarified why they did *not* tell specific close relatives or friends about the donor insemination while being open with others. They selectively excluded them from disclosure based on particular characteristics: being old, conservative or not trustworthy. For example, Fritz and Gabrielle (aspiring parents) disclosed to Gabrielle's parents about the donor insemination, but not to Fritz's parents. His parents had reacted negatively when Fritz told them he would need fertility treatment to have children. The couple therefore concluded that the donor insemination was 'definitely not something to mention' to them. Sometimes the couples' parents were also involved in carefully managing the information. For example, Joseph explained why he would not tell his godmother about the donor insemination: 'She is already eighty-nine, my mum has decided that she [the godmother] should not know about it'.

Being treated as a normal family

Several couples thought that telling others about the use of donor sperm would mean that people would not see them as a 'normal' family any more. Couples feared that this knowledge would cause people to behave differently towards their family compared to how they would to 'normal' families. Three couples (who did not disclose

to their children) mentioned this as an important reason for not informing their parents about the donor insemination. Charlotte (parent) explained things as follows:

> … I also think, about my in-laws, that it is not straightforward. They are their grandchildren. And otherwise, I would always wonder 'are they not acting differently towards them?' The fact that they know that, biologically speaking, they are not their grandchildren. I would find that much more difficult to deal with. I want my children to have just the same rights as any other … as when they come from a normal family. (Charlotte, parent)

When Jillian and Oscar, who were open about the donor insemination to family and friends, explained why they did not tell their child, they mentioned similar worries about being seen differently by others:

> Mm yes, of course, if you tell those children they might talk about it at school. Those children will tell their parents and those parents know you. How will they see you and … It's all a vicious circle. That really goes round and round from here to there and I think that these things are why you would keep it at a distance. Because for the outside world you do want to be just a family. Not like: 'Look, those children are not theirs'. I mean, people can be crude in these things. (Jillian, parent)

It was not only couples who did not tell their child(ren) about the donor insemination who were concerned about how others would view their family. John and Kirsten (aspiring parents) who planned to tell their child about the donor insemination and had disclosed the same to some relatives and friends were also concerned about the image others would have of their family. This came up when the couple explained why they found matching physical characteristics between the donor and the father important. John said it was not that his child '*per se* had to resemble me', but because he and Kirsten agreed that 'the outside world should not immediately say "hmmm, that is not right"'.

Couples who were already parents found it important that others should make comments about their resemblances. For example, the main reason for Samuel and Jessica (parents) not to share news of the donor insemination with their parents was to ensure that their parents would simply comment on their resemblances as if there was a genetic link. Not telling them about the donor insemination was seen as a way of ensuring that the grandparents would act 'normally'. Cynthia repeatedly stressed that June was 'their child', and she related this experience of 'being their child' with her decision not to share the donor insemination with their social network, because: 'If the environment would have known [about the donor insemination], they would not have said that [comments about resemblances]. Maybe. That's why, you see. Perception, it is a weird thing, yeah'. Thus, being treated as a 'normal' family (e.g. by receiving typical comments) could in turn further enhance the couples' feelings of being a 'normal family' and having their 'own child'. For Oscar, his observation that the people who knew about the donor insemination did not mention it any more proved to him that 'I am doing a good job as a dad'.

One couple (aspiring parents), however, had a different and more activist approach in their attempt to be treated as a 'normal' family. Megan wanted to publish a book about her donor insemination experience, and she undertook other actions such as debating with adult donor children who shared their stories on internet fora. Megan's

actions formed a part of her fight against the taboo on donor families. Brian and she felt that their choice to use donor sperm was not well understood by others. Megan concluded: 'We are "all alone"'. Furthermore, Megan felt threatened by the renewed importance attached to genetics in society (e.g. the possible change in the law to identify donors). Megan's openness about the donor insemination and her activism (in trying to reduce the taboo on donor families) seemed to serve the same purpose as the relative silence of the other couples: being seen and treated as just a 'normal' family by others.

Regulating emotions

Couples were aware that their fertility problems and their choice for donor insemination could also affect the extended family. As Scott (aspiring parent) pointed out, 'Yes, it is not pleasant for anyone. In fact, it is not pleasant for anyone in the family'. The emotional involvement of the family influenced how the couples managed information within the extended family. Couples' parents especially were emotionally involved in the process because they were often looking forward to having grandchildren.

Some couples modified the initial disclosure of their fertility problems after being confronted with the emotional distress this information caused to their relatives. The distress caused by sharing the fertility problems made couples reflect on the emotional capacity of relatives to cope with the donor insemination. For instance, Candice and Patrick (parents) did not tell Patrick's parents about the donor insemination because, when his mother learned about their fertility problems, she 'by this time was crying, uh, instead of us [laughs] … '. Carl and Denise (aspiring parents) had told Carl's mother that they would make a choice between adoption and donation. Later, after they already decided in favour of donor insemination, they did not tell his mother about it until the pregnancy was successful, 'because she [Carl's mother] was frightened all the time'.

Adapting their initial openness to their parents could also be an indirect way for couples to regulate their own emotional distress which cannot be viewed as independent from that of their parents. For example, Scott and Lilith (aspiring parents) explained that they did not tell their parents about the use of donor sperm because the couple did not want to cause them distress. At the same time, not sharing mention of donor insemination with their parents could prevent additional distress for the couple. Lilith felt that the emotional reaction of her mother-in-law to the news of the Scott's infertility was an extra burden on her shoulders:

> You felt that for her, it was, uh, very difficult, a difficult thing to know. She then said to me 'if only you knew how many tears I've shed'. She does not say that to Scott, so this ends up with me like 'yes, if only you knew how much "I" [emphasis] have cried, and that it is difficult for me'. (Lilith, aspiring parent)

Some attempts by couples' parents to support them were unintentionally experienced as distressing. John and Kirsten (aspiring parents) believed that Kirsten's parents did not understand the process they were going through when they received the diagnosis of infertility. The couple perceived the proposal of her parents 'to go for

adoption or donation' as a failure to acknowledge the couple's distress. Kirsten explained that dealing with the 'cold' reaction of her parents caused even more distress than the donor insemination itself. The couple tried to change the reaction of Kirsten's parents by using their family doctor as a secret mediator. They asked the doctor to explain tactfully to her parents the severity of having fertility problems. This indirect way of influencing the reaction of her parents can be seen as an attempt of the couple to decrease the emotional distress that was intensified by the parents' reaction.

The previous examples could give the false impression that the involvement of the family was always negative. The process in which the couples managed information in order to regulate the level of distress of their parents was most clear when the couples' parents shared their distress with the couple. Other couples may not have experienced the need to regulate the level of distress of family members, either because relatives did not know about the fertility problems or because they reacted in a way that was perceived as supportive by the couples. For instance, Gabrielle's mother said to her: 'Yes, it is your choice, but, you know, we accept what you will choose, like adoption or donor or whatever'. Since Gabrielle's mother was very supportive, this helped her cope with her own distress.

Discussion

This study explored the process of how couples manage information about the donor insemination within their social networks. The couples felt they were continuously and ubiquitously confronted by questions, comments and mere images related to their desire of having a child. As documented in other studies, some couples tried to avoid those confrontations, for example by limiting contact with pregnant family members or friends (Steuber and Solomon 2011). This strategy of avoidance seemed to fail since several couples perceived those confrontations as impossible to (entirely) escape from.

Couples' testimonies about this confronting context demonstrated how their perceived deviation from the 'social clock' caused a great deal of their infertility-related distress. The concept of the social clock here refers to the age norms that are agreed upon in a certain cultural context and have a prescriptive character, e.g. at a certain age you should have children (Neugarten, Moore and Lowe 1965). Furthermore, life is also anticipated to be 'normal', e.g. having a straightforward pregnancy and a 'natural' birth (Earle and Letherby 2007). Donor insemination on the other hand challenges this normative life-course trajectory (Earle 2014). The inability to conform and the feeling of being challenged by others about this defined the couples' experience within their social context more than the medical condition of infertility.

The 'others' to whom the couples disclosed information about the donor insemination varied from close friends to family members and colleagues. The diverse ways in which the couples disclosed information to those others was characterised by selectivity (e.g. not sharing all information with all people close to the participants) and carefulness (e.g. sharing information only with people whom they considered trustworthy). Participants' carefulness and selectivity in disclosing supports the idea that parents are conscious about and try to avoid unwanted disclosure to the child (by knowledgeable

members of the social network). Furthermore, none of the couples explicitly mentioned regretting their decision of telling someone about the donor insemination, nor was this found indirectly in their stories. Still, as the parents were triggered to reflect on their past decisions during the interview, it is possible that the decision to disclose information was made more intuitively at the time and was rationalised afterwards. Future research should consider this issue and should also ask couples directly whether they had ever regretted disclosing the donor insemination to someone.

The couples' parents were the most popular 'others' with whom they shared the information and also the most discussed 'others' in the interviews. In line with previous research, we found that the couples' parents could be an important source of support (Nordqvist and Smart 2014). However, the involvement of aspiring grandparents could also turn into an additional burden. Some couples applied a strategy of distancing themselves from the emotional distress of their parents, e.g. by adjusting their disclosure approach. Similarly, couples who had experienced perinatal loss distanced themselves from the grief of the grandparents because they could or would not carry this additional burden (Nehari, Grebler and Toren 2007). The emphasis on the supportive role of the couples' parents in the study of Nordqvist and Smart (2014), in contrast to our findings, may be explained by their selection criteria. They only interviewed grandparents who knew about the donor insemination, while couples who did not expect support from their parents often did not tell them about the donor insemination.

The way couples manage information did not seem limited to creating an emotional distance for coping with their own emotions. Couples in this study used selective disclosure to manage the impact of what they disclosed to their parents. This 'systemic emotion management' when talking about a sensitive issue functions as a way of regulating the private emotionality of each family member, including the one who is disclosing the information (Rober and Rosenblatt 2013). Another example of this can be seen in the restricted way in which lesbian parents and their children talked about the donor insemination so as to 'manage the emotionality within the family' (Van Parys et al. 2016). Future research about fertility problems and donor insemination should, therefore, consider these intergenerational family dynamics more clearly.

Fear of rejection by other family members and the desire for normalcy were reasons given by parents for not disclosing information about the donor insemination to their social network, which is a similar reason parents gave for not disclosing this to their child (Hargreaves and Daniels 2007; Lycett et al. 2005). The expectation that people would not treat them and their children as a 'normal' family any more may have prevented couples from sharing information with others. For example, one reason not to disclose the donor insemination to relatives was to still receive the typical comments about similarities often made within families. The similarities and interactions between disclosing to the child and the social network, including the child's perspective, should be further investigated. Likewise, children who know about the donor insemination will likely have to manage this information within their own social networks.

The importance of being treated as 'a normal family' may underlie the way couples dealt with resemblance talks. Becker, Butler and Nachtigall (2005) called it an 'unexpected finding' that families that were open or planned to be open with their child about the donor insemination had a similar protective way of responding to resemblance talks as the non-disclosing families. The majority of the disclosing couples in their study would not share the donor insemination freely with others. We can understand this 'unexpected finding' by acknowledging that all families find it important to be treated as 'normal families'. Similarly, we found that almost all parents in our study acted cautiously when disclosing this information to others. For couples coping with infertility, normalisation would help them maintain their quality of life despite being different (Benyamini, Gozlan and Weissman 2017).

The desire to be 'treated as a normal family by others' is a circular process. Nordqvist and Smart (2014) commented that it was important for parents that *others* recognised the resemblance between parents and children, even across non-genetic relationships, in order to feel connected with the donor child. We suggest that recognition by others that 'you are a family' not only influences the feeling of being bonded as a family but also makes it possible to act like a normal family, which in turn influences how others see you as a family. The idea of circularity as applied to the extended family can also be expanded to society more generally. Based on this idea of circularity, it may be difficult for donor families to 'act' as a normal family when others do not see them as a 'normal' family.

Strengths and limitations

A strength of our study lies in the bottom-up approach of studying what emerged as important concerns for the couples in the raw data. Only two questions in the interview guide considered the social network; most of the information was shared spontaneously by the couples while talking about their more general experiences. This was made possible by the semi-structured approach to interviewing. Furthermore, multiple auditor discussions contributed to a rigorous and trustworthy analysis of the interviews.

Our research approach carries some limitations. As is the case for all qualitative studies, our findings cannot be generalised to other contexts, such as countries with an open-identity policy. In Belgium, counsellors do not advocate telling the child about the donor insemination but hold a neutral position. The practice of anonymous donor insemination in Belgium, where there is no counselling directed towards openness, could be associated with parents being potentially less open within their social networks.

Secondly, the topic of managing information within the social network was not the main focus during the interviews. Although we demonstrated the importance of this topic, a study with a specific focus on how disclosure about donor insemination to the social network evolves may go into this topic more in-depth. Since couples were not systematically invited to talk about their disclosure to others, we could also not provide an overview of the couples' motives for disclosure to others, but we focused

instead on the broader process of how couples managed information within their social network.

Thirdly, our results are mainly based on the experiences of couples who leaned more towards openness than towards secrecy about the donor insemination. Most reasons for not participating in the study were related to keeping the donor insemination private; however, the couples who did participate showed great variability in how they dealt with disclosure. Amongst them were also couples who had kept the donor insemination private.

Lastly, our study was limited by the cross-sectional design. The disclosure practices of aspiring parents and parents may evolve over time, as reported for disclosure to the children. For this, a longitudinal study design would be more appropriate. Furthermore, potential differences between aspiring parents and parents may not have been observed in our study.

Clinical implications and suggestions for future research

An important challenge for several couples, especially before the treatment's success, lies in dealing with questions, comments and images in their social context related to pregnancy and family planning. Counsellors should prepare couples to cope with a possible confronting context that one cannot entirely escape from. In addition, counsellors should be attentive to the complexities of managing information within the couple's social network (e.g. sharing information with relatives in order to receive support can become an unexpected burden). Those complexities make it impossible to provide general guidelines for infertile couples about disclosure to their social network. While for some couples disclosure to their parents can increase social support, for others it may be helpful not to tell their parents (temporarily). For them, the support given by friends or colleagues may be very valuable when these people are less emotionally involved in the couple's family planning.

Future research should take research questions relating to the social networks of couples undergoing donor insemination treatment beyond the margin of studies that focus on other research concerns. Addressing social networks more directly will enable us to obtain richer data and allow us to further explore the process of managing information within these networks and the difficulties that couples are faced with when undergoing fertility treatment.

Conclusion

A focus on how couples using donor insemination manage information about infertility and the donor insemination within their social network helps to enlarge our understanding of the complexities and dynamics involved in information management. In this study, there was great diversity in the ways in which the couples managed personal information. The process of managing information was often challenging as couples found it important to be treated as 'a normal family' by others and since it involved regulating emotions within the family. Attention needs to be given to the confronting context in which couples experience their fertility problems and the way

couples manage relevant information within their social networks. This is an important theme that should be addressed both in counselling and in future research.

ORCID

Mauro Kerckhof http://orcid.org/0000-0002-7517-9573
Hanna Van Parys http://orcid.org/0000-0001-9049-3934
Guido Pennings http://orcid.org/0000-0003-0754-8055
Petra De Sutter http://orcid.org/0000-0002-8792-3814
Ann Buysse http://orcid.org/0000-0001-5047-3293
Veerle Provoost http://orcid.org/0000-0003-4451-3425

References

Becker, G., A. Butler, and R. D. Nachtigall. 2005. "Resemblance Talk: A Challenge for Parents Whose Children Were Conceived with Donor Gametes in the US." *Social Science & Medicine* 61 (6): 1300–1309. doi:10.1016/j.socscimed.2005.01.018

Benyamini, Y., M. Gozlan, and A. Weissman. 2017. "Normalization as a Strategy for Maintaining Quality of Life While Coping with Infertility in a Pronatalist Culture." *International Journal of Behavioral Medicine* 24 (6): 871–879. doi:10.1007/s12529-017-9656-1

Brewaeys, A., J. K. De Bruyn, L. A. Louwe, and F. M. Helmerhorst. 2005. "Anonymous or Identity-Registered Sperm Donors? a Study of Dutch Recipients' Choices." *Human Reproduction* 20 (3): 820–824. doi:10.1093/humrep/deh708

Bute, J. J., and T. A. Vik. 2010. "Privacy Management as Unfinished Business: Shifting Boundaries in the Context of Infertility." *Communication Studies* 61 (1): 1–20. doi:10.1080/10510970903405997

Clarke, V., V. Braun, and N. Hayfield. 2015. "Thematic Analysis." In *Qualitative Psychology. A Practical Guide to Research Methods.*, edited by J. Smith, 222–248. London: SAGE.

Earle, S. 2014. "A Life-Course Approach to Human Reproduction." *Human Fertility* (Cambridge, England) 17 (3): 151–153. doi:10.3109/14647273.2014.940230

Earle, S., and G. Letherby. 2007. "Conceiving Time? Women Who Do or Do Not Conceive." *Sociology of Health & Illness* 29 (2): 233–250. doi:10.1111/j.1467-9566.2007.00546.x

Hargreaves, K., and K. Daniels. 2007. "Parents Dilemmas in Sharing Donor Insemination Conception Stories with Their Children." *Children & Society* 21 (6): 420–431. doi:10.1111/j.1099-0860.2006.00079.x

High, A. C., and K. R. Steuber. 2014. "An Examination of Support (in)Adequacy: Types, Sources, and Consequences of Social Support among Infertile Women." *Communication Monographs* 81 (2): 157–178. doi:10.1080/03637751.2013.878868

Holloway, I., and S. Wheeler. 2010. *Qualitative Research in Nursing and Healthcare.* Oxford: Blackwell Publishing.

Indekeu, A., T. D'Hooghe, P. De Sutter, K. Demyttenaere, D. Vanderschueren, B. Vanderschot, M. Welkenhuysen, P. Rober, and H. Colpin. 2012. "Parenthood Motives, Well-Being and Disclosure among Men from Couples Ready to Start Treatment with Intrauterine Insemination Using Their Own Sperm or Donor Sperm." *Human Reproduction* 27 (1): 159–166.

Lycett, E., K. Daniels, R. Curson, and S. Golombok. 2005. "School-Aged Children of Donor Insemination: A Study of Parents' Disclosure Patterns." *Human Reproduction* 20 (3): 810–819. doi:10.1093/humrep/deh703

Martins, M. V., B. D. Peterson, P. Costa, M. E. Costa, R. Lund, and L. Schmidt. 2013. "Interactive Effects of Social Support and Disclosure on Fertility-Related Stress." *Journal of Social and Personal Relationships* 30 (4): 371–388. doi:10.1177/0265407512456672

Nehari, M., D. Grebler, and A. Toren. 2007. "A Voice Unheard: Grandparents' Grief over Children Who Died of Cancer." *Mortality* 12 (1): 66–78. doi:10.1080/13576270601088475

Neugarten, B. L., J. W. Moore, and J. C. Lowe. 1965. "Age Norms, Age Constraints, and Adult Socialization." *American Journal of Sociology* 70 (6): 710–717.

Nordqvist, P., and C. Smart. 2014. *Relative Strangers. Family Life, Genes and Donor Conception*. London: Palgrave Macmillan.

Pennings, G. 2007. "Belgian Law on Medically Assisted Reproduction and the Disposition of Supernumerary Embryos and Gametes." *European Journal of Health Law* 14 (3): 251–260. doi:10.1163/092902707X232971

Provoost, V., J. Bernaerdt, H. Van Parys, A. Buysse, P. De Sutter, and G. Pennings. 2018. "No Daddy','a Kind of Daddy': Words Used by Donor Conceived Children and (Aspiring) Parents to Refer to the Sperm Donor." *Culture, Health & Sexuality* 20 (4): 381–396. doi:10.1080/13691058.2017.1349180

Rober, P., and P. C. Rosenblatt. 2013. "Selective Disclosure in a First Conversation about a Family Death in James Agee's Novel a Death in the Family." *Death Studies* 37 (2): 172–194. doi:10.1080/07481187.2011.628555

Rosholm, R., R. Lund, D. Molbo, and L. Schmidt. 2010. "Disclosure Patterns of Mode of Conception among Mothers and Fathers 5 Year Follow-Up of the Copenhagen Multi-Centre Psychosocial Infertility (COMPI) Cohort." *Human Reproduction* 25 (8): 2006–2017. doi:10.1093/humrep/deq153

Salevaara, M., A. M. Suikkari, and V. Soderstrom-Anttila. 2013. "Attitudes and Disclosure Decisions of Finnish Parents with Children Conceived Using Donor Sperm." *Human Reproduction* 28 (10): 2746–2754. doi:10.1093/humrep/det313

Steuber, K. R., and A. High. 2015. "Disclosure Strategies, Social Support, and Quality of Life in Infertile Women." *Human Reproduction* 30 (7): 1635–1642. doi:10.1093/humrep/dev093

Steuber, K. R., and D. H. Solomon. 2011. ""So, When Are You Two Having a Baby?" Managing Information about Infertility within Social Networks." In *Family Communication, Connections, and Health Transitions*., edited by M. A. Miller-Day, 297–322. New York: Peter Lang.

Van Parys, H., E. Wyverkens, V. Provoost, P. De Sutter, G. Pennings, and A. Buysse. 2016. "Family Communication about Donor Conception: A Qualitative Study with Lesbian Parents." *Family Process* 55 (1): 139–154. doi:10.1111/famp.12112