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Donor Conception Disclosure: Directive or Non-Directive Counselling?

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Abstract It is widely agreed among health professionals that couples using donor insemination should be offered counselling on the topic of donor conception disclosure. However, it is clear from the literature that there has long been a lack of agreement about which counselling approach should be used in this case: a directive or a non-directive approach. In this paper we investigate which approach is ethically justifiable by balancing the two underlying principles of autonomy (non-directive approach) and beneficence (directive approach). To overrule one principle in favour of another, six conditions should be fulfilled. We analyse the arguments in favour of the beneficence principle, and consequently, a directive approach. This analysis shows that two conditions are not met; the principle of autonomy should not be overridden. Therefore, at this moment, a directive counselling approach on donor conception disclosure cannot be ethically justified.

Keywords Counselling · Ethics · Donor conception · Secrecy · Disclosure

Introduction

It is widely agreed among health professionals, as well as medical and governmental organizations and associations, that couples using Assisted Reproductive Techniques (ART) should be offered counselling (Boivin 2003; Human Fertilisation and Embryology Association [HFEA] 2012). It differs from country to country whether this counselling is mandatory or not. The European Society for Human Reproduction and Embryology and the American Society for Reproductive Medicine guidelines (the two largest professional societies) prescribe that counselling should be offered at all stages of ART treatment (Strauss and Boivin 2001; Boivin et al. 2001; American Society for Reproductive Medicine [ASRM] 2013). Counselling can be seen as a process which takes place between a counsellor and a patient “in a private and confidential setting to explore any difficulty, distress or dissatisfaction with life that the client may be experiencing. Counselling can increase a client’s ability to make choices and change aspects of their situation” (British Infertility Counselling Association 2013, ¶1.1). Counselling in the context of infertility treatment covers many specific tasks such as information giving, implications and decision-making counselling, support counselling, and therapeutic counselling (Strauss and Boivin 2001). In this article, the focus is on the approach that should be used during implications and decision-making counselling: Should the counsellor assist the patient in making decisions according to the patient’s own values (the non-directive counselling approach), or should the counsellor direct the
patient to a decision that is seen as the most appropriate, even if this decision does not correspond with the patient’s own values (the directive counselling approach)?

Here, we will focus specifically on the much debated topic of donor conception (DC) disclosure. For a long time, a directive approach advocating secrecy was used in counselling sessions (Nachttagal 1993; Allan 2012). Patients were advised not to tell their child(ren), and others in their environment, about the use of donor material. Nowadays, both a directive and a non-directive approach are defended, with the directive approach now favouring disclosure, preferably at an early age (HFEA 2012; Australian and New Zealand Infertility Counsellors Association 2012; Peterson et al. 2012; Hertz, Nelson, and Kramer 2013; Klock 2013). The defence of the directive approach in this counselling context is rather remarkable for two reasons. First, psychosocial counselling is generally considered to be non-directive: In the psychosocial field it is agreed that parents should not be directed towards a certain behaviour. Counselling otherwise is seen as manipulative and unprofessional (British Association for Counselling and Psychotherapy 2013). Second, both in law and ethics it is considered that parents should be able—in most cases—to make decisions concerning the well-being of their child free from external intervention (McHaffie et al. 2001). This parental responsibility—which includes both rights and duties—towards a child is based on the supposition that parents will act in the best interests of their child. In a medical setting this can be translated for instance into the right to an informed consent on the child’s behalf (British Medical Association 2008).

A directive counselling approach promoting openness interferes with the privacy and autonomy of the parents, hereby challenging this general belief in the parental autonomy. In the following, we will discuss whether this exception to the non-directivity rule is ethically justifiable for the specific topic of DC disclosure.

Defining the Two Approaches

First, it should be clarified what is meant by “non-directive” and “directive” counselling. While there is no single accepted definition of these two approaches, an agreement exists on how to differentiate both approaches and what they generally stand for (Oduncu 2002; Xafis et al. 2014). Non-directive counselling is seen as an approach by which the counsellor takes a neutral position in order to facilitate the weighing of pros and cons of an action by the patient(s) (Klock 1997, 2013; Sachs and Hammer Burns 2006). Patients are provided with information in order to make a decision in accordance with their own personal views and beliefs; they are not influenced by the opinion of the person communicating that information (Hayden 2005; Kirklin 2007; Xafis et al. 2014). Non-directive counselling “may include the offer of information but does not involve giving advice or directing a client to take a particular course of action” (British Infertility Counselling Association 2013, ¶1.1). Directive counselling can, consequently, be defined as the opposite. In this approach, the counsellor directs the patients towards a goal that does not originate in them and that may not correspond with their own beliefs. The counsellor has a clear goal in mind and tries to convince the patients to comply with his or her advice (Kessler 1997; Bernhardt 1997). Such advice can be convincing for patients who regard their counsellor as an “expert” or an “authority,” someone who knows “what is best.” A counsellor can be directive in many ways. An option can be favoured overtly, or it can be communicated in a more subtle way by putting an unbalanced focus on only one position (Xafis et al. 2014). For instance, a counsellor who were to say, “It is best you do this” or “If I were you, I would do that,” would be using a directive approach because the position he or she favours is openly promoted. An example of more subtle directive counselling in the context we wish to discuss here would be a counsellor who only explains the risks of non-disclosure and withholds mentioning risks of informing the child about the donor conception (or vice versa). An extreme version of directivity is when a certain decision is said to be a condition for access to treatment. The approach can thus be seen as a continuum with on the one end counsellors giving one-sided/biased advice or guidance regarding a certain decision and on the other end threatening not to offer treatment if the patient does not agree with certain conditions.

In this article we hold a strict dichotomy between non-directive and directive counselling for the sake of the argument. In practice, this distinction is often not so clear. However, the practice is not the focus of this article. We take the normative position that is presented in the guidelines as a basis for our analysis.

ART Counselling and the Disclosure Decision:
Guidelines and Opinions

As already mentioned, the guidelines and recommendations of several associations and organizations in the ART
field differ in terms of how counsellors should approach couples seeking ART with regard to the decision whether or not to disclose the conception method to the child.

Counsellors’ Positions

Non-Directive Counselling

With regard to directive counselling in general, it is argued that recommending certain behaviour (in this case, disclosure) is detrimental because it shuts the door to future counselling when the patients do not follow the counsellor’s opinion (Klock 2013). A neutral position is also deemed important because the counselling session should be an opportunity for the couple to freely discuss their thoughts and feelings without feeling judged (Sachs and Hammer Burns 2006). If the counsellor imposes his or her view, patients may feel uncomfortable and sense a conflict with their own opinion (Klock 1997, 2013). Another consideration in favour of this neutral position has to do with the effectiveness of directive counselling (Klock 2013). We do not know whether couples actually follow the recommendations the counsellor gives regarding, for instance, the disclosure decision. It is possible that the patients will say they agree just to avoid problems or further questions. Patients might feel constrained to discuss their difficulties regarding the disclosure decision and could be driven to hold back their own opinion and intentions.

With regard to counselling on the topic of DC disclosure, Kainz (2001) said that “the therapist should remain neutral and help the couple come to their own decision regarding disclosure” because “at this point, there is no evidence in the literature that there is a “best” option for all couples” (Kainz 2001, 484). The Counselling Special Interest Group of the Canadian Fertility and Andrology Society recommends counselling concerning “the implications of privacy/secrecy and openness and the level of disclosure recipients are comfortable with” (Canadian Fertility and Andrology Society Counselling Special Interest Group 2009, 31). In this case, it is not clear whether the counsellor should provide specific advice, particularly because the starting point of the guideline is that disclosure is the better option (they argue that enough evidence is available to support this).

Directive Counselling

The second position is represented by a group of mental health professionals who support the idea of promoting openness. Their arguments question the moral value of privacy and they warn for the possible harms to the psychological well-being of both the parents (the burden of a secret) and the child (the awareness that something is not right) (Daniels, Grace, and Gillet 2011). A secret can create a barrier to open communication in the family and there is always the risk of accidental discovery at a later unsuspected and possibly inappropriate time, which could be particularly damaging for the child (Turner and Coyle 2000). In contrast, disclosure, and specifically disclosure at an early age, is said to be best for the development of the child’s self-concept and identity (Kirkman 2003; Landau 1998; McGee, Brakman, and Gurmankin 2001). Informing children about their conception is thought to render them capable of forming a “correct” identity based on all the information available regarding their own life (Horowitz, Galst, and Elster 2010). This view is for instance supported by the Australian and New Zealand Infertility Counsellors Association (ANZICA). According to ANZICA, the recipient parents “need to tell the offspring themselves about circumstances of their conception” (ANZICA 2012, ¶6). Peterson et al. (2012) also state in this regard that “counselors can assist couples in understanding the importance of disclosing the nature of the conception to the child” (246).

Guidelines and Legislation in the Field of ART

Several guidelines from numerous instances have been developed on the topic of DC disclosure, but only a few pieces of legislation concern this topic. Focusing on the guidelines first, in a report on the ethical aspects of information sharing after DC, the Nuffield Council on Bioethics (2013) argues that openness is not intrinsically valuable. The council takes the view that openness towards donor-conceived children is important as long as it contributes to the quality of family relationships. According to the council, the decision whether or not to disclose should be made by the parents because it depends on their social context whether openness is valuable or not. If parents believe that non-disclosure is the better option for their particular situation, this should be respected and supported by the counsellor (Nuffield Council on Bioethics 2013). Nonetheless, the council also adds that it will “usually be better for children to be told, by their parents and at any early age” (Nuffield Council on Bioethics 2013, 102). Thereby, a directive stance is taken with regard to what should be considered
by the parents. Along the same lines, the German guidelines on psychosocial counselling take an ambiguous position on what approach should be used during counselling. On the one hand, they underline the parents’ autonomy in the disclosure decision. On the other hand, early disclosure is recommended to avoid family secrets (Thorn and Wischmann 2009). The American Society of Reproductive Medicine (ASRM) is also ambiguous about the counselling approach that should be used. For instance, the Ethics Committee of the ASRM states that “it is the recipient parents’ choice whether to disclose the fact of donor conception to their offspring” (Ethics Committee of ASRM 2013, 4). However, the committee also states that although whether to reveal the fact of donor conception to offspring has long been the subject of debate, more recently a strong trend in favor of encouraging disclosure has emerged. The Ethics Committee finds that disclosure to the child of the fact of donor conception […] may serve the best interests of offspring (Ethics Committee of ASRM 2004, 2013, 1).

Along with organizations, legislators have also decided upon the issue. For instance, in the United Kingdom, it is now mandatory to offer pretreatment counselling that includes the advice that children conceived via donor insemination should be told about their donor origin (Blyth 2012). In the HFEA’s Code of Practice, the authority states that “the centre should tell people who seek treatment with donated gametes or embryos that it is best for any resulting child to be told about their origin early in childhood” (HFEA 2012, guidance note 20.7). Our question regarding the justification indirectly also affects the evaluation of the legislation on this topic: if directive counselling cannot be justified, then legislation obliging counsellors to provide directive counselling is also unjustified.

Balancing Two Ethical Principles

The discussion about non-directive and directive counselling can be seen as a balancing of two ethical principles: the principle of autonomy versus the principle of beneficence (Oduncu 2002; De Wert, Dondorp, and Knoppers 2012). Advocates of the principle of autonomy refer to respect for an individual’s right to self-determination and the need to provide all the relevant information available in an unbiased way so that the patient can make an informed and free decision. In the genetic context, the support for this principle and consequently, the non-directive approach, developed in part as a reaction to the coercive policies used in for instance Nazi Germany and the accompanying fear of eugenics (Oduncu 2002). In the psychosocial context, it was Carl Rogers (1942) who first used the term to define his patient-centred therapy, characterized by the idea that counsellors can only assist the patient during their decision-making process, but cannot influence the outcome. Rogers specifically used this term to show his rejection of the medical model, which was based on the beneficence principle. This principle states that the well-being of a person should be protected at all times and that active steps should be taken towards achieving it. The beneficence principle is nowadays still often adhered to by healthcare providers who consider a certain behaviour as beneficial for their patients (and their future child). For instance, most healthcare providers take a directive stance about taking folic acid when a woman is trying to get pregnant (Oduncu 2002; Bonte, Pennings, and Sterckx 2014).

When two principles conflict, a balance must be made in order to decide which principle should be preferred (Beauchamp and Childress 2013). Beauchamp and Childress proposed six ethical conditions to guide such balancing, which are sound and practical rules to weigh the principles at stake here:

1. Better reasons exist to act according to the overriding principle rather than to the overridden principle.
2. The goal of breaching one principle in favour of another must have a reasonable chance of success.
3. The breach must be the smallest breach possible and its proportion must be in line with the goal.
4. No alternatives for a breach must be available.
5. The consequences of the breach must be as small as possible.
6. All parties affected by the breach must be treated impartially.

Analysis of the Conditions

Condition 1: Better Reasons for the Overriding Principle

Advocates of the directive approach have to show that the child’s well-being is promoted when it is informed at
an early age about his or her donor conception and that it is harmed when not informed or only informed late in life. If this is the case, better reasons exist for following the beneficence principle and consequently overruling the parents’ autonomy. In the following, an analysis is made of the arguments given by advocates of the directive approach. First, we discuss the health risk when a child is not informed or only informed late in life. Then, we zoom in on different aspects with regard to psychological harm done to children when the information is not disclosed, or not in a timely fashion.

**Health Risk**

Children can be medically harmed when the DC is not disclosed or only disclosed at a later time (for instance, after the child has reproduced). Uninformed donor conceived offspring make wrong assumptions about their genetic heritage because they believe their social father is also their genetic father. When a genetic predisposition is overlooked because of the lack of correct genetic information, the consequences can be severe. An inaccurate diagnosis can be followed by inappropriate treatment. Disclosure about the donor conception can be necessary for a better diagnosis of emerging conditions, for preventive actions, and for making informed decisions about one’s reproduction (Ravitsky 2012).

It is impossible to know how many children are medically harmed by not being informed (in a timely manner) about their DC. Proper genetic screening of the donor is prescribed by guidelines for reproductive centres (ASRM 2013; Association of Biomedical Andrologists 2008; Dondorp et al. 2014). Of course, the hope to thereby avoid harm presupposes that donors are properly screened for the most common genetic disorders and that they provide truthful and extensive information about their family medical history. In the United States, screening differs significantly among centres (Sims et al. 2010). Daar and Brzyski (2009) argue that a substantial number of centres do not follow the guidelines. Also, even if screening is done properly, a rare genetic condition may be overlooked, a genetic condition may manifest only years after donation, or donors may not be entirely honest or complete when the anamnesis is investigated. The occasional cases where a genetic disease was found despite genetic screening illustrate this (Maron et al. 2009). Nonetheless, we can assume that the probability of such risk of medical harm caused by secrecy is low given that donors are screened for the most common genetic disorders and asked to provide extensive information about their family medical history. Moreover, openness about the donor conception is not going to improve this situation much. Apart from the fact that the child knows that it should not look at the father for genetic information, no useful information comes from being informed about the donor conception.

Another important aspect is the possibility of consanguineous relations when donor conceived children are not informed (Landau 1998). One could argue that disclosing the DC intercepts incestuous relationships between donor-conceived persons. However, the first question that needs to be addressed is the probability of such relations. Serre et al. (2014) investigated the probability of consanguineous events in France where a maximum of ten children per donor is allowed (comparable to other countries using an anonymous system). They showed that even when both the current number of pregnancies and the current number of donor descendants were ten times higher, the risk of such relations would still be lower than the risk associated with rare first-cousin relationships. Promoting openness about the donor conception out of fear for consanguinity is not grounded since the probability is too low. Moreover, as in the case of the medical risk, it is unclear how openness would prevent such relationships. Being informed about one’s donor conception does not mean that one is informed about the donor’s file number or identifying information in order to be able to compare donors. In addition, parents should not solve the problem of possible at-risk relationships; this should be done by restricting the number of children per donor. At this moment, the number of offspring is set in an arbitrary manner; however, norms should be decided on the basis of, among other elements, realistic consanguinity risk estimates (Janssens, Nap, and Bancsi 2011).

**Psychological Risk: Knowledge About the Conception**

**The Case of Non-Disclosure** Some papers claim that a certain degree of psychological harm is done to the child when the DC is never revealed. For instance, the child could suffer psychologically if he or she is aware that something is not right or that something is kept secret from him or her (Daniels, Grace, and Gillet 2011). It is argued that family secrets, such as the use of donor material, may have a negative impact on family dynamics in general. There is an unequal distribution of power
with the person aware of the secret having more power than the person for whom the secret is concealed. Also, with the two parents being aware of something the child does not know, the child is excluded from the coalition between his or her parents, which can deteriorate relationships (Slepian et al. 2012; Turner and Coyle 2000; Baran and Pannor 1993a, b). First of all, parents always have more power than their children until a certain age. The unequal distribution of power is a given in a parent-child relationship. Second, not all family secrets are harmful. Many people and families conceal a secret—it is inherent to human interaction (Vangelisti and Caughlin 1997; Imber-Black 1993). Recent research has shown that whether or not a secret is harmful depends on the motivation for keeping the secret. Caughlin and Afifi (2004) found for instance that when the motivation for avoiding a topic was the protection of the relationships, a diminishment in negative association between avoidance and dissatisfaction appeared. Third, the probability of this harm cannot be measured since such effects can only be reported by those who have found out. However, several studies have shown that children who are not informed have positive relationships with their parents and develop normally, which shows that this specific family secret does not always have an impact on the child’s life (Golombok et al. 2002a, b; Brewaeyts et al. 1997; MacCallum, Golombok, and Brinsden 2007; Lycett et al. 2004; Nachtigall et al. 1997; Shenfield and Steele 1997). We should be careful in generalizing all secrets as harmful (Shenfield and Steele 1997). In this regard, a distinction should be made between never revealed secrets and secrets that are disclosed at a later and possibly inappropriate time, or by inappropriate people. Secrets such as the use of donor material may indeed be harmful when they are revealed in anger (Snowden and Snowden 1993). In that case, not the secret itself (the use of donor material), but rather the fact that the parents “betrayed” their child can be damaging for the child. This is often accompanied with feelings of frustration when they are not able to receive information on their donor (McWhinnie 2001; Kirkman 2004).

It is often argued that the adoption context illustrates the harm caused by non-disclosure (Feast 2003). However, in that context, the shift in legislation (the move towards open adoption) was immediately linked to the provision of identifying information about the birth parents (Feast 2003; Haimes 1988). It was the lack of such information that was claimed to be damaging for the adopted child, causing a so-called “genealogical bewilderment” and identity problems, and not the secrecy itself (McWhinnie 1984; Baran and Pannor 1993a, b). A distinction should be made between the “secrecy or openness” discussion and the “anonymous or identifiable donor” discussion. If lessons can be learned from the adoption context, it may only be about providing information about the donor and not about possible harm caused by secrecy. Moreover, it is under discussion whether both contexts are similar and we should be careful to generalize possibly problematic consequences (Horowitz et al. 2010). As Shenfield (1999) already pointed out, “children born of gamete donation have been wanted long before their conception by their psychosocial parents. An adopted child, by contrast, was first abandoned by two biological parents before adoption by the psychological parents” (Shenfield 1999, 8). Both adopted and donor conceived children need to deal with their genetic origins. On top of that, adopted children need to deal with their social origins while donor conceived children do not, meaning that the context and background adopted children need to deal with (being abandoned) differs a great deal from the context and background of a donor-conceived child.

The Case of Disclosure While gamete donation seems to be a widely accepted method of reproduction in Western society, openness about the conception method is not unproblematic for every single person. Western society still highly values genetic ties, and genes are seen as the primary basis for kinship (Edwards 2009). This means that families using sperm or egg donation are still potentially subject to stigmatization. There are some indications that stigmatization is slowly decreasing in Western countries. The number of people who disclose or at least have the intention to disclose is rising compared to, for instance, thirty years ago. The attitude towards gamete donation is also changing. At the same time, however, the number of disclosers is still low, which might indicate that people still fear stigmatization. Data on this point are hard to gather; it is not clear at all whether or not social stigmatization has disappeared within Western society. Outside the Western world, there are many communities where donor conception is not accepted (Nuffield Council on Bioethics 2013). This is, for instance, the case in Muslim communities where the “lineage,” as traced through the paternal line, is considered highly important. In British South Asian communities it is for this reason feared that the
family and social environment will reject donor conceived children as soon as the DC is known. In addition, in these families, infertility raises questions about manhood and masculinity (Culley and Hudson 2007). Consequently, non-disclosure can serve as an important protection for the child and the family against the stigma surrounding infertility and other detrimental effects of openness about the DC (Nuffield Council Bioethics 2013). The broader social environment is clearly an important factor in deciding whether or not it is best to disclose. This concern regarding stigmatization is frequently raised by parents as a justification for non-disclosure and should not be dismissed without argument (Thorn 2006; Horowitz, Galst, and Elster 2010).

Psychological Risk: Timing

The Case of Late Disclosure Several studies show that, in cases of late disclosure (intentional or unintentional), some children develop psychological problems due to the feeling of “betrayal.” This revelation may lead to long and frustrating searches for the donor or for donor information (Lalos, Gottlieb, and Lalos 2007). The impact of late disclosure may be severe. However, we have no idea what proportion of donor-conceived children is at risk, since we do not know how many donor-conceived offspring find out about their conception method at a late age. It is possible that many more people find out about their DC at a later age but do not have a problem with it. We should keep in mind that the current research on the donor-conceived persons’ attitudes towards their DC disclosure only involves biased samples. Individuals who are aware of their DC but do not have a problem with it and did not have a problem with the method or timing of disclosure will probably remain under the radar. Donor-conceived people who are angry or discontent are more likely to contribute to websites, networks, or internet forums and participate in studies. Moreover, revealing the donor conception, even at a later time, can also have positive effects on the family relationships. In a few cases of accidental discovery of non-paternity in a medical context, it was found that the (unintended) disclosure was appreciated by the parties involved and did not disrupt family relationships (Ravelingien and Pennings 2013).

The Case of Early Disclosure Defenders of directive counselling for DC disclosure assume that early disclosure will be beneficial or will at least prevent possible future harm to the child. Recent studies do indeed show that, in case of early disclosure (prior to adolescence), the children appear to accept the information, integrate it into their life story, and have positive reactions to the disclosure decision (Hewitt 2002; Jadva et al. 2009). Nonetheless, possibly negative effects of early disclosure on the child and his or her family should not be overlooked. In Jadva et al. (2009), for instance, some adults who were told during childhood reported that they felt confused, frustrated, or upset about being a donor-conceived child. We should be careful in considering early disclosure as beneficial by definition.

Condition 2: Reaching the Goal

Another condition for allowing a breach of the autonomy principle is that the goal of this breach has to have a reasonable chance of success. Advising the parents to disclose the information, does not mean they will actually disclose (Klock 2013). It is possible that parents feel uncomfortable with disclosure and say that they will disclose to please the counsellor, but never have the intention to actually disclose. The counselling approach is only rarely mentioned in research papers about disclosure decisions of the parents. Visser et al. (2012) reviewed papers that reported on counselling in gamete donation. The review showed that only five studies specified the use of a directive counselling approach advocating (early) openness by the counsellor. This was, for instance, the case in a study by Rumball and Adair (1999), where early openness was advised by the counsellor. In this study, 181 of 308 participants completed a questionnaire on disclosure attitudes. Of these 181 participants, 127 had not told their child (minimum one-year-old) about the donor conception but 98 participants declared an intention to disclose in the future. In another study by Hammarberg et al. (2008) where a directive approach was used with regard to the disclosure decision, 41 per cent of the parents stated that the counselling had some impact on their disclosure decision, with 26 per cent reporting no impact at all.

Although little is known about the counselling approach, most studies show that the majority of heterosexual parents do not plan to disclose the DC to their child with study outcomes ranging from 54 per cent to 81 per cent (Nachtingal et al. 1998; Golombok et al. 2002a; b; Owen and Golombok 2009). In addition, the intention to disclose is not necessarily the same as actual disclosure. During pre-treatment counselling, a couple
might be convinced of disclosure, but the actual decision to disclose might be postponed and eventually abandoned during the life of the child because barriers such as discomfort and anxiety rise (Gottlieb, Lalos, and Lindblad 2000; Nordqvist and Smart 2014; Klock 2013; Cook et al. 1995; Daniels, Gillet, and Grace 2009). Most of the heterosexual couples who intend to disclose, do not do so (Gottlieb, Lalos, and Lindblad 2009). Most of the heterosexual couples who intend to disclose, do not do so (Gottlieb, Lalos, and Lindblad 2000; Lindblad, Gottlieb, and Lalos 2000; Lalos, Gottlieb, and Lalos 2007). The combination of the empirical evidence on actual disclosure and the uncertain effect of promoting openness raises doubts about the reasonable chance of success of a directive approach.

Condition 3, 4, and 5: Proportionality, Necessity, and Consequences

The following three conditions are treated together because they all aim at minimizing the breach. In this regard, the following question should be answered: Is advising parents to disclose the information among the smallest breaches possible to achieve the goal of informing children about their donor conception? One smaller breach to reach this goal would be to raise awareness by sensitization actions, for instance via advertisements, posters, and brochures. The “Time to Tell” campaign held in 2006 in Victoria, Australia, is an example of such a sensitization action with the goal of spreading information about the benefits of disclosure and about the donor-linking service. Electronic and print-media information was spread, and community education activities were organized (Johnson, Bourne, and Hammarberg 2012). This promotion of the donor registers resulted in an increase of applicants for the registers and an increase in uptake of resources concerning how to disclose from the website.

Both sensitization campaigns and directive counselling are directive, albeit on a different scale. Nonetheless, there is a difference between both actions with regard to their nature, with sensitization actions being impersonal and indirect. Parents are not personally addressed and large-scale campaigns can more easily be ignored, thus resulting in a smaller breach of their autonomy. However, due to this impersonal and large scale nature, there is no room, for instance, for personal advice about how to tell. DC disclosure can be a delicate subject to discuss, and when openness is promoted, personal advice adjusted to each particular family would be preferable. In addition, the effects of the campaign are unknown in the sense that it is impossible to measure whether more parents disclosed the donor conception to their children after the campaign. The only conclusion that can be drawn is that, given for instance the increase in uptake of resources from the website, there was a need for information. Sensitization actions could be proportional even if fewer children were informed about their DC than in case of directive counselling because they also involve a smaller breach of the parental autonomy. However, they still assume that good is done to the children, and this, as we argued above, is uncertain.

Another option to inform children about their donor conception would be adding the information to their birth certificate (Blyth et al. 2009). This interventionist approach would ascertain that children are informed because the disclosure would not depend on actions of the parents. In this case, the parents’ autonomy is breached more severely than in the directive approach. To justify this, it should be demonstrated—in line with the severity of the breach—that a high risk of serious harm to the child exists when it is not informed. From the analysis above, it is clear that no sufficient evidence so far is available for even a lesser degree of risk to the child. This means that, a fortiori, a more severe breach of the parents’ autonomy cannot be justified.

Following the above, one could argue that sensitization campaigns are preferable to directive counselling since they imply a smaller breach of parental autonomy, but they also are less likely to convince parents to disclose. However, the decisive element in the balance will remain the demonstration of the positive effects of disclosure on the child.

Condition 6: Impartial Treatment of All Parties

The last condition prescribes a consistent policy regarding the breach of a principle. The advocates of a directive approach propose a breach of the autonomy of the parents. To fulfil the sixth condition, all parents who have valuable information about the child’s conception should be treated equally. Not only parents using donor insemination should be affected, also adoptive parents should be included. In the adoption context, an open policy is already implemented. Parents are stimulated to tell their child about his or her adoption. Another large group of parents that should be included are the mothers (and fathers, if informed by the mother) in misattributed paternity cases (Ravelingien and Pennings 2013). Also, in this context at least one of the parents possesses, in
most cases, valuable information about the child’s conception. Therefore, it could be argued that, in this context, a directive approach favouring openness should be applied.

**Conclusion**

The aim of this paper was to investigate whether or not a directive counselling approach is ethically justified in the context of DC disclosure. Although, in general a non-directive approach is adopted within the context of medically assisted reproduction, some counsellors favour a directive approach in favour of early openness when it comes to the specific topic of donor conception. To decide whether or not the DC disclosure context can indeed be an exception to the rule, the two underlying principles of autonomy and beneficence should be balanced. To allow a breach of the autonomy principle, several conditions should be satisfied. Following this analysis, two conditions are not fulfilled. With regard to the first condition, the evidence available in favour of promoting openness is insufficient. The risk of non-disclosure should not be overestimated, and the risk of disclosure should not simply be put aside. At this moment there are no better reasons for advising openness than for respecting the parents’ own beliefs and wishes. Moreover, studies about the intention to disclose show that the desired effect of a directive counselling approach may not have a reasonable chance of success, thus failing the second condition.

Following this analysis, at this moment, directive counselling—whether in favour of disclosure or secrecy—is ethically unjustified. In practice this means that counsellors should aim to counsel “as neutrally as possible,” paying equal attention to the possible (psychological and medical) harms of secrecy as well as of disclosure. Counsellors should point out the possible dangers of keeping a secret on the one hand and disclosing personal information on the other hand, as well as the possible consequences of timing.

**References**


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