A qualitative study of New Zealand fertility counsellors’ roles and practices regarding embryo donation

Sonja Goedeke 1,* and Deborah Payne 2

1 Department of Psychology, Division of Public Health and Psychosocial Studies, Faculty of Health and Environmental Sciences, AUT University, Private Bag 92006, Auckland 1142, New Zealand 2 Centre for Midwifery and Women’s Health Research, AUT University, Private Bag 92006, Auckland 1142, New Zealand

*Correspondence address. E-mail: sonja.goedeke@aut.ac.nz

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BACKGROUND: Embryo donation is a recently approved practice in New Zealand. Guidelines require disclosure of donor identity, openness, joint donor and recipient counselling and ethics approval on a case-by-case basis. This study explores the roles and practices of fertility counsellors in the context of New Zealand’s policies.

METHODS: Nine fertility counsellors were interviewed regarding their roles in the practice of embryo donation. Data were thematically analysed to identify counsellors’ key roles and concerns.

RESULTS: Counsellors supported the principles underlying the policy in New Zealand. They saw their role as, firstly, helping patients shift from a focus on their current situations to considering the longer term psychosocial implications of embryo donation. Secondly, counsellors facilitated donors’ and recipients’ exploration of the implications not only for themselves but also for existing and potential children resulting from the donation and the effects on the wider family network.

CONCLUSIONS: As determined by policy, counsellors play an integral role in facilitating embryo donation and regard their role as contributing to the long-term wellbeing of families created through and affected by embryo donation.

Key words: embryo donation / counsellors / qualitative analysis

Introduction

The anonymous versus non-anonymous use of donor gametes and embryos is a much debated issue. In recent years, there has been increasing awareness that for their long-term psychosocial wellbeing and identity development, donor-conceived people need to have access to information about their genetic heritage. Hence, there has been a move away from anonymous third-party donation (Hammarberg et al., 2008; Human Fertilisation and Embryology Authority, 2010).

Researchers have pointed to the need for counselling to help potential donors and recipients explore the issues and implications of gamete donation (Daniels, 1993, 2007; Boivin et al., 2001). With regards to embryo donation, some countries have few guidelines, while in New Zealand, the practice is highly regulated making counselling mandatory. In this paper, we explore the roles of counsellors from the main fertility clinics in New Zealand in relation to embryo donation. It is hoped that the paper offers useful insights into the role and contribution of counselling in successful embryo donation.

The Human Assisted Reproductive Technology Act (HART) 2004 in New Zealand provides for a procedural framework for ethical review and policy advice, enacted through two committees: The Advisory Committee on Assisted Reproductive Technology (ACART), which is responsible for developing policy and guidelines and advising the Minister of Health; and the Ethics Committee on Assisted Reproductive Technology (ECART), which implements ACART’s policies and recommendations and reviews applications for assisted reproductive technologies (ART’s) such as embryo donation (Daniels and Douglass, 2008).

Embryo donation (ED) is a relatively novel practice in New Zealand having been available as an option for couples accessing fertility treatments since 2005. At the time of writing, since 2006 all 24 ED applications had been approved by ECART, with reports of two births (ACART, 2008a,b; Mussen, 2009; ECART, 2010).

In New Zealand, ED is required to follow specific guidelines set out by ACART (2008a,b). Each case for ED must gain approval from ECART before it can proceed. Guidelines specify that embryos must have been created using donors’ own gametes and must be approved for donation by ACART. The guidelines require joint donor and recipient counselling and ethics approval on a case-by-case basis. This study explores the roles and practices of fertility counsellors in the context of New Zealand’s policies.
‘surplus’ to requirements. ED is limited to producing full genetic siblings in no more than two families. In other words, embryos may be donated to one family only. Recipients must have a diagnosis of medical infertility. They must prepare profiles for the donors, which provide descriptions of themselves, their reasons for and expectations of ED and police-vetting information. Independent legal advice for both parties is suggested.

The most significant recommendation, however, is that donor and recipient couples undergo counselling both separately and together. Counselling aims for understanding between the two parties and their agreement regarding the use, storage and disposal of embryos. It must cover topics such as: the rights and needs of resulting children, including their access to information about their genetic origins, and the two families’ wishes, expectations and plans regarding contact and information-sharing. Moreover, the counselling is to be appropriate to the culture(s) of the parties. Counsellors are expected to ensure that any of the donors’ or recipients’ children, as well as any family or whanau (the Maori term for extended family), have been given the opportunity to be included in counselling.

In this way, New Zealand unlike many other countries follows an open, and not anonymous, practice of ED and has been at the forefront in terms of addressing and supporting the sharing of information in third-party assisted reproduction (Daniels, 2004). ED policy has been shaped by New Zealand’s open adoption practices, research about long-term effects of open versus anonymous sperm donation and the Maori concept of whakapapa, ‘a conceptual framework for considerations of relatedness, personhood and reproduction’ (Glover and Rousseau, 2007, p. 119).

The process for ED involves potential donors and recipients separately approaching the clinic, where the counsellor will outline the process. For those who choose to pursue ED, counsellors assist the donors in outlining their criteria for suitable recipients, and the recipients in developing their profiles. Both parties undergo counselling sessions to explore their reasons for ED and its implications. The counsellor will then seek to identify possible recipients based on the donors’ wishes. Thereafter joint counselling sessions are arranged. If both parties still wish to proceed and the counsellors believe all issues have been addressed as per the guidelines, applications are then submitted to ECART. Although the policy for ED is presented as guidelines, in practice, ED is approved by ECART only if the recommendations are observed.

### Counselling in ART

Infertility and associated treatments are recognized as highly stressful (Wischmann, 2008) and counselling may play an important role in educating, assessing and supporting people experiencing infertility (Daniels, 1993, 2007; Wischmann, 2008). Counsellors are encouraged to have an holistic, psychosocial approach to their practice, and to consider issues beyond the individual client’s experiences, such as how the infertility and its treatment affects the couple’s networks and relationships, the implications for the child born as a result of treatment and for his or her siblings and wider family and also the impact on a societal level (Daniels, 1993; Boivin et al., 2001).

ED is a form of ‘third-party’ reproduction involving people and genetic material external to the couple in creating a child. Boivin et al. (2001) and Hammarberg et al. (2008) suggest that third-party reproduction raises more emotional, psychological, ethical and legal issues than other forms of ARTs not involving donation. Daniels highlights the particular role of counselling in third-party reproduction (in Boivin et al., 2001). Counselling may assess potential donors for their psychological suitability (such as the particular experiences that may make them seek to be donors), address issues of loss and realistic expectations, and ensure their non-coerced and informed consent and the ‘boundaries of their role’ (Baetens et al., 2000). ED is, however, also more complex than gamete donation, in that it involves the full genetic material of the donating couple rather than just the genetic material of one member of the couple (Goedeke and Payne, 2009).

The decision to undertake ED is difficult (Cattoli et al., 2004; Nachtigall et al., 2005; Hammarberg and Tinney, 2006). Issues identified as contributing to its complexity include the varying meanings the donors and recipients may give to the embryo (De Lacey, 2005; Nachtigall et al., 2005), donors’ feelings regarding a genetic child being raised within another family (De Lacey, 2005; McMahon and Saunders, 2007), disclosure concerns, legal aspects (Borrero, 2002) and participants’ beliefs regarding genetic relatedness and what constitutes a family (McMahon and Saunders, 2007).

Therefore, several authors recommend that counselling is offered specifically to couples considering ED (Borrero, 2002) and should entail detailed information and education provision (Hammarberg and Tinney, 2006), and assist donors in managing their ongoing feelings about potential offspring (McMahon and Saunders, 2007). Indeed, Kovacs et al. (2003) propose that such counselling may facilitate donation rather than discarding. In New Zealand, it is the fertility clinic counsellors (who may be social workers, registered counsellors or psychologists) who are primarily responsible for identifying and exploring these issues, and their implications, with potential donors and recipients (Daniels, 2007).

Although there has been a long-standing recommendation that people have access to ‘proper counselling’ in relation to ART (see, for example, the Warnock Committee Report, cited in Monach, 2003), research to date has only minimally reviewed its efficacy (Monach, 2003) and even less so in the case of ED (Applegarth, 2006). One study found that counselling for donation was useful, particularly for the donors (Hammarberg et al., 2008). In New Zealand, counselling for embryo donors and recipients is mandatory, and yet there has been no research investigating whether or not they find this helpful, or how counsellors experience their role. It is particularly relevant to explore New Zealand counsellors’ perspectives of their roles given that they are placed in a unique position through ACART’s guidelines and because they are expected to facilitate openness and information-sharing in the practice of ED.

This article reports on the findings of interviews with nine New Zealand fertility counsellors exploring their roles in working with donor and recipient couples either considering or undergoing ED.

### Materials and Methods

Ethical approval for this study was gained from the AUT University’s Ethics Committee. To ensure confidentiality, pseudonyms for participants were used. Invitations for counsellors to participate in the study and participant information forms were emailed to each of the six main fertility clinics operating throughout New Zealand at the time of the study. Subsequent to our study, another clinic has been opened.
Interested counsellors then contacted the first author. From a potential sample of 11, a purposive sample of 9 counsellors, representing 5 fertility clinics, participated in the study. At the time of recruitment, no counsellors were available at one of the clinics, as they had recently resigned from their positions and new staff had not yet been recruited.

With the consent of the participants, both researchers took part in all but one of the interviews. Two sets of two counsellors elected to be interviewed together and the remaining five participants were interviewed individually. One participant was interviewed via telephone; the rest face to face. The interviews took from 40 to 90 min. The interviews were semi-structured, and open-ended questions followed a list of topic areas to be addressed within each interview, such as the participants’ roles, their experience of ED, their views on the guidelines, issues addressed during counselling and the concerns arising from their counselling experiences.

Interviews were audiotaped and then transcribed verbatim. The transcripts were analysed thematically drawing on the process identified by Braun and Clarke (2006). Firstly, to become familiar with the data, the interview transcripts were read several times individually by the researchers. Secondly, working through the nine transcripts together, the researchers identified initial themes that best fitted the data. Thirdly, codes were assigned to the data and fourthly, the themes were worked into categories.

Although not all participants had worked with couples who had undergone or completed ED, all the participants had been involved with counselling couples who were exploring the option.

**Results**

Participants identified two main roles of counselling: firstly, to assist clients to move from an individualistic perspective to one that considers all parties involved in ED, and secondly, to assist clients to shift from a focus on the present to the future, of how ED could unfold for all parties (Table I).

**Roles in ED counselling**

When couples initially approached counsellors about ED, their focus was often on their immediate situation: potential donors had surplus embryos they wanted to see used and valued and potential recipients wanted to have children. Fertility treatments to a certain extent encouraged this individual perspective as medical treatment focuses solely on the individual couple and treating their infertility.

### Table 1  Counselling roles and practices.

<table>
<thead>
<tr>
<th></th>
<th>Donor</th>
<th>Recipient</th>
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<tbody>
<tr>
<td>Individual</td>
<td>Facilities exploration and agreement regarding:</td>
<td>Facilities exploration and agreement regarding:</td>
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<td></td>
<td>- decision that family is complete</td>
<td>- parenting a non-genetically related child</td>
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<td></td>
<td>- decision to donate</td>
<td>- emotions (including grief), thoughts and beliefs regarding raising a non-genetically related child</td>
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<td></td>
<td>- emotions (including grief), thoughts and beliefs regarding having a genetic child raised in another family</td>
<td>- child’s right to knowledge of whakapapa</td>
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<td></td>
<td>- child’s right to knowledge of whakapapa</td>
<td></td>
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<tr>
<td>Within couple unit</td>
<td>Facilities exploration and agreement regarding:</td>
<td>Facilities exploration and agreement regarding:</td>
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<td></td>
<td>- Proﬁle matching: similarity</td>
<td>- parenting a non-genetically related child</td>
</tr>
<tr>
<td></td>
<td>- Seeing each others’ perspectives</td>
<td>- emotions (including grief), thoughts and beliefs regarding raising a non-genetically related child</td>
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<tr>
<td></td>
<td>- Establishing a relationship</td>
<td>- child’s right to knowledge of whakapapa</td>
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<td></td>
<td>- Mediation during the entire ED process, including application, pregnancy, outcome</td>
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<td></td>
<td>- Exploration and negotiation of future issues such as: information-sharing, contact, nature of relationships</td>
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<tr>
<td>Between donor and recipient couples</td>
<td>Facilities:</td>
<td>Facilities:</td>
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<tr>
<td></td>
<td>- Information-sharing and disclosure</td>
<td>- Partnership for a non-genetically related child</td>
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<td></td>
<td>- Questions such as being ‘given away’ and impact on donor-conceived child and genetic siblings: dealing with emotional reactions</td>
<td>- Questions surrounding rights to knowledge (whakapapa)</td>
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<tr>
<td></td>
<td>- Contact between all parties: donor-conceived child and genetic parents, genetic siblings, recipient parents and donors’ child/ren</td>
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<tr>
<td>Families</td>
<td>Explore relationship between the two families, including the wider family (whanau), and consideration of issues such as:</td>
<td>Facilities:</td>
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<td>- Parenting decisions</td>
<td>- Death and disability</td>
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<td></td>
<td>- Questions from children and others(wider social network)</td>
<td>- Nature of relationships</td>
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<td>- Death and disability</td>
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<td>- Nature of relationships</td>
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<td>Wider societal level</td>
<td>Facilities:</td>
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<td></td>
<td>Explore relationship between the two families, including the wider family (whanau), and consideration of issues such as:</td>
<td>- Report written and submitted to the ethics committee for final assessment and approval.</td>
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<td>- Parenting decisions</td>
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Embryo donation counselling in New Zealand 2823
However, counsellors described their role as needing to extend donors’ and recipients’ perspective to consider the entire network of people involved.

Firstly, counsellors felt that they may need to work towards agreement within the couple unit, to ensure that as a couple they had addressed their feelings and thoughts around donating/receiving, and the implications of donating their genetic material or receiving an embryo that is genetically unrelated. This was not necessarily an easy process. For the donor couple, the issue of readiness to accept an embryo that is genetically unrelated. This was not necessarily addressed their feelings and thoughts around donating/receiving, and the implications of donating their genetic material or receiving.

Once couples have made the decision to pursue ED, the counsellors then attempt to match prospective donors with recipients. However, this is dependent on having sufficient donors. Usually donors are given recipients’ profiles to choose from, and then the donors’ profiles are shown to the recipients. Counsellors believe that matching is important in an attempt to ensure that the donors and recipients have enough common ground for a relationship to begin to develop.

Eleanor: So that when they meet...are they going to like each other. ...That’s an excellent key to it working well for the child. Obviously if it works for them it’s going to work better for the child.

In preparation for the joint counselling, counsellors aim to anticipate and explore the thoughts and feelings that the other party may have and help donors/recipients understand each others’ perspectives.

Sarah: I try and prepare them, the donors...that you really want to make this decision now, because, also for the sake of the recipients...Think if there is going to be a change of mind, what’s the impact for the recipients?

Once the two parties meet, counsellors saw their role as helping establish the relationship. As the donation proceeds, counsellors described their role as being mediators, working through and passing on information, for example, about the progress of the pregnancy.

Nancy: So all those different possibilities we’ve had to talk about like, if you miscarry, when do you want to tell people? Who do you want, how will you tell, what would you like to do?...It’s a big mediation role.

The HART Act’s guiding principle is that the child’s rights must be considered. Part of the counselling role is to ensure that the implications both for the child resulting from ED, and also for any pre-existing children, are identified in the hope that any contentious future issues can be managed in a way that maintains an ongoing and positive relationship in the interests of the child.

Dorothy: If the two sets of parents are in some conflict or disagreement, the child’s going to suffer. That network then is a vital first step in the whole process...It’s critical.

Counsellors believe that the donors should think about their responses to possible questions from children, such as about having been ‘given away’. Donors/recipients need to recognize that their children will be full genetic siblings, and to think through the implications for all the children involved. Hence, the counselling focus is not just on the parents and their desire to see embryos used or to have a child, but also the existing and future children.

Other issues needing to be addressed included are the following: the method and timing of disclosure, and the level and nature of contact and relationships. Thus, counsellors ensure that a long-term view is considered. This extends to thinking through scenarios when the ED child is an adult.

Dorothy: As soon as we talk about children we stand the risk of infantilizing them, always thinking of them as children who need to be looked after and decisions made for them, rather than seeing them as potential adults, who like us, want to make their own decisions.

Table 1 outlines the issues to be addressed by various parties in ED counselling.

Counsellors recognized the significance attached to genetic connectedness and saw their role as bringing to the fore the implications of this knowledge.

Thus, ED counselling consisted of bringing all the parties together in considering both present and future issues for all involved.

The process of fulfilling ED roles

The counsellors believed that fulfilling the above roles required certain skills and contexts.

Counsellors found that often individuals considering ED had encountered either a lack of knowledge or support from others, which hindered their ability to process the issues involved. Thus, it was important to provide clients with a safe space to explore the issues.

Rachel: Donors and recipients very often find it difficult to talk with the people around them...some of the couples have faced criticism from people around them and their own family about what they’re planning to do. So sometimes they do become a bit isolated, and there are not that many people that they can talk to about it.

Providing full information was also imperative to prepare clients for the complicated process of ED. One counsellor found that providing information about the implications of donation, particularly having their genetic child raised in another family, was an important factor in influencing the couple’s decision to proceed.

Elaine: I reckon 60 or 70% of people who approach me to donate their embryos withdraw after the first interview. When you front up and tell them...the implication of ED: this will be your fully genetically connected child...how will this be in the future...So I think the information session that I do with them, it’s a good filter.

When donors or recipients had made the decision to pursue ED, counsellors again saw their role as providing information and repeated opportunities to think through issues that may confront the families, such as current and future scenarios related to the donation process, successful or unsuccessful outcomes and future relationships. They asked clients to explore the ‘what ifs’.

Elaine: Yes it’s the whole preparation for that long-term implication of it. We talk about the complications, and all the time we talk about the implications—what happens tomorrow, what happens in a year, what happens in 5 years, what happens in 50 years?
Counsellors sometimes needed to actively confront clients with issues being avoided or not considered.

**Dorothy:** It forces people to actually front up to the issues that are involved in helping them make an informed decision about what they are going to do... The message I have is that people find the counselling a helpful experience, because it helped them to look at the issues that are involved in this. Some people are going to look at those issues and decide: this is not for us...

Although counselling may lengthen the ED process, which may be difficult for clients, this time was seen by counsellors as being valuable.

**Audrey:** I absolutely agree that ‘slow it down’ is important because it gives people time to think... It’s good because people can catch up with their own feelings. And it’s good for us because we can figure things to support them.

Whether or not the process of ED is actively pursued after counselling has occurred, or whether or not the eventual outcome is the desired one for the couples, the counselling process created an opportunity for working towards a sense of resolution.

**Sarah:** I say, ‘If this doesn’t work have you started thinking about what and when?’ You start exploring that because if you do it takes away the desperation of this having to work. ‘You know this is not the last resort and there are other things including being child free’. You are sowing the seed... for both sides. The donors have done what they needed to do with the embryos, and the recipients have explored other possibilities, and that may be enough for them to say, ‘That’s enough’.

In this way, counsellors portrayed the counselling process as a positive and empowering one.

**Dorothy:** This is something that enables the professionals to help move these people from a defeatist position, a failure position, into one of ‘I’m confident about making this choice because this is right for us’; making a proactive positive decision and a shared one.

**Factors affecting the counselling role**

A factor discussed was the function played by ECART’s assessment. ED guidelines stipulate that the potential donors and recipients should have separate counsellors, and that the two parties and their respective counsellors engage in joint counselling.

This ideal was sometimes difficult, especially when a clinic had only one counsellor or when a counsellor had had prior involvement with both parties, which meant that pre-existing counselling relationships could not be maintained.

**Rachel:** We’ve had to change tack part of the way through the process, which I think is hard on couples. One couple has said to me that they were a bit dismayed at the thought of having to meet a new counsellor when they already had a counsellor.

ECART requires the counsellors to assess the donors’/recipients’ suitability, which may create a potential role conflict in being both a counsellor and an assessor.

**Rachel:** It’s a dual role in a way that is not always easy. It would be much easier to focus on one or the other. It’s possible to combine them but it’s hard work. Sometimes it can feel that more of the balance gets skewed towards either the ethics committee application or exploring some of the issues in the preparation. So you just have to try and keep a balance between the two.

However, the rigour of ECART’s application process was seen by the counsellors as having potential benefits.

**Elaine:** It (The ECART application) is an issue for us... but then we do the counselling and the report evolves from the counselling. You wouldn’t have the depth of information to do the report if you hadn’t done the counselling.

For some counsellors the process of needing to work through an at times lengthy and complex application felt problematic.

**Jessica:** It actually just becomes a really difficult process for the counsellors and the clients. It sometimes actually detracts from just being able to give a good quality discussion about the issues, because you’re busy trying to make sure you’ve ticked all the boxes and covered everything adequately within the time frame.

In contrast, some counsellors also appreciated the need for the complexity of the process.

**Carol:** There’s a general, oh no, someone’s asking about embryo donation, because it’s so arduous and fraught. Yes, there’s a lot of resistance to it. I think we all have reservations about it. There isn’t the sort of confidence around it that there might be for other processes...

One counsellor further pointed out that the guidelines were intended to be principles to guide practice rather than prescriptive rules.

**Dorothy:** I think unfortunately the guidelines have become rules and that means that some counsellors and some of the participants are actually seeing it as a form filling and how to put my best foot forward and convince them that I’m all OK, rather than entering into the process and just letting it emerge.

Overall counsellors supported and approved the rationale and reasoning behind the policy. Given the novelty of ED, ACART’s guidelines were given more importance by the counsellors than possibly other areas of their practice. Owing to little research or follow-up on the long-term implications of ED, the counsellors gained reassurance and support for their practice from ECART’s guidelines. Particularly for those counsellors who had reservations about ED as a practice, it relieved them of having to make the final decision. Counsellors ensured as far as possible that the areas outlined in ACART guidelines (2008) were addressed, with the assessment for suitability and approval resting with ECART.

**Eleanor:** I certainly agree that it’s useful. It also makes it easier for clinics and staff if there are guidelines about ‘in these sets of circumstances you can do this’ or ‘if these circumstances aren’t met, you can’t’.

**Audrey:** The ultimate decision is the ethics committee which is different from me.

Counsellors spoke of their clients having a relatively high level of understanding of some of the issues that needed to be considered, such as the need for openness and access to information. This knowledge made their role easier and provided a basis from which to work.

**Carol:** I think generally people who come here to enquire about these processes are aware of adoption processes for example, and so they are aware of openness being of value and aren’t surprised when we talk about the HART Act and openness in other processes too.
With ED being a novel process however, counsellors felt uncertain and cautious.

**Eleanor**: I think we are fairly nervous about embryo donation... Simply because we don’t know what the outcomes will be and we certainly don’t want to be in a position of repeating history with adoption... And so, if you haven’t got any maps—and you haven’t got any evidence, you have to be cautious about how you proceed. I mean to some extent it’s experimental.

Some counsellors felt that ED could become less threatening as it continues to be taken up. In the interim however, ED was still regarded by counsellors as a last resort and not one that they would immediately recommend to clients.

At times, some of the counsellors felt that they occupied different positions from the consultants and other health professionals involved who might advocate for ED more strongly as a result of concerns about the cost of storing embryos or less awareness of the implications of the practice.

**Nancy**: I find there’s little bit of tension between us and the laboratory because the laboratory, they want to know what we’re doing about these couples who’ve indicated that they want to donate the embryos on a form. But I won’t chase.

The ACART policy, however, made the role and importance of counselling more visible and lent credence to the counsellors’ concerns.

**Limitations of the study**

The number of participants in this study is small and self-selected. However, the number represents the body of available counsellors working in the area in New Zealand, and they represent the fertility centres across the country. Participants are thus the key figures responsible for enacting policy and shaping practice in relation to ED.

**Discussion**

Counselling constitutes the central component of the ED process in New Zealand, and the guidelines make it explicit that ED cannot be undertaken without thorough individual and joint counselling. Although the policy requirements for ED are guidelines for recommended practice, they are prescriptive in the sense that, to obtain ECART approval, certain issues need to be addressed. The guidelines formalize and make visible the counsellors’ roles and responsibilities.

In this study, counsellors identified two main roles for themselves in ED counselling: to assist their clients to move from an individualistic perspective to considering all the parties involved in ED, and to facilitate a shift in focus from the present to how things could unfold for all parties in the future.

In doing so, counsellors draw upon approaches that include family systems approaches and transitional or loss/grief models.

Family systems theorists view the individual as existing as part of a wider ecological system that includes the genetic system, the nuclear family, the extended family and the social and environmental systems. Family relationships are assumed to be central to an individual’s functioning, and psychosocial problems can often best be understood in terms of the context of the family; the wellbeing of one family member influences the wellbeing of all (Bradbury and Marsh, 1988). Family systems theory has informed adoption counselling. Bradbury and Marsh (1988) propose that adoption, like other types of blended families, involves a broader view of family and includes the adoptive couple and their extended family, the biological parents and their extended family, and the adoptee. In pre-adoption counselling, all members of the biological and adoptive parents’ families are ideally invited in for counselling, and counselling addresses the impact of the adoption on all parties, both in the short and long-term.

According to Applegarth (2006), ED counselling draws substantially on the practice of adoption. In terms of the New Zealand guidelines, there are strong parallels between the practice of adoption and that of ED practice. However, it is important to acknowledge the differences in the two practices, most significantly, the differing motives of ED donors and the birth parents in adoption. Furthermore, in adoption there is already a child, whereas in ED a child has yet to be born (refer Goedeke and Payne, 2009).

We suggest the counsellors in this study draw on family systems theory and the practice of adoption to inform their exploration, with donors and recipients, of the possible implications of ED for all parties and make transparent the interdependency of relationships and outcomes. Parallels have been drawn between the practice of open adoption in New Zealand and the policy guidelines of ED in New Zealand (Goedeke and Payne, 2009) and may be influential in shaping counsellors’ practice.

Infertility counselling also draws on transition or loss/grief models, exploring the losses and transitions that infertility presents to the individual and couple, and the reconstruction of themselves in the context of loss. In this study, the counsellors clearly draw on theories of loss and transition, and they explore with both donors and recipients the losses that ED brings: for donors, loss of parenting their genetic child, loss of parental authority and decision-making and for recipients their loss of genetic ties. They further explore the potential losses that may be experienced by the donor-conceived child (loss of genetic ties to social parents, loss of connection to the genetic parent). In this way, the counselling is again similar to that frequently adopted in pre-adoption counselling (Janus, 1997). Applegarth (2006) recommends assisting individuals to work through their grief and integrate their losses into their experiences of infertility. Applegarth draws on social exchange theory to describe a process whereby donors and recipients, in their relationship with each other, seek to maintain a balance between maximizing rewards and minimizing losses. However, in this study, it was apparent that counsellors drew more heavily on the experience of loss rather than gain.

This exploration of losses and transitions can be likened to what Cramond (1998) describes as implications counselling: counselling that enables persons to understand the implications of treatment for themselves, for their family and for any children born as a result. Daniels (1993) suggests that implications counselling can become therapeutic counselling when couples are helped to work through their own emotional issues, fear, concerns and anxieties, and thus empowered to make a decision.

However, it must be noted that ED counselling is not necessarily value free and brings a distinct agenda. In this study and in relation to ED, counsellors clearly invest in two particular discourses that shape their practice, which are inherent in ACART’s guidelines and similarly inform other areas of practice such as in adoption counselling. The first is a human rights discourse that emphasizes that the needs of the child must at all time be considered (Michelle, 2006). In terms of the HART
Act and ED policy in New Zealand, the needs of the donor-conceived child are held to include information-sharing about donor origins and identity and openness. The second is a genetic essentialist discourse, which Michelle (2006) describes as a prioritizing of the significance of genetics on development and relationships. That the donor-conceived child and donors are genetically related has long-term consequences, which need to be addressed and made transparent in counselling.

However, with counsellors adopting these particular discourses, it is possible that donors and recipients may not feel free to therapeutically explore their fears with the concern that this could compromise their application. Further, counselling is mandatory in ED, and while this could go some way towards normalizing a need for counselling and reinforcing the value of counselling, it may also detract from people’s ability to fully engage with a process of therapeutic counselling. With reference to oocyte donation, Klock and Greenfeld (2004) have argued that counsellors need to be neutral about issues such as disclosure if they are to maintain an effective therapist—client relationship and allow couples to come to independent decision-making.

The counsellors did express some concern that their role in providing recommendations about candidates’ suitability to ECART could conflict with the counselling role. This tension needs to be recognized and considered given to the possibility that at times the counselling and report-writing roles may need to be separated out and undertaken by different counsellors. Given the small number of counsellors working in this area in New Zealand, this constitutes a very real dilemma.

However, counsellors felt like they were nonetheless able to offer the space to explore decision-making around ED and to manage ongoing relationships in ways that suited the families.

Counsellors expressed considerable anxieties regarding ED. There was a real concern about the possibility of ‘harm’ to future generations. Counsellors saw their role as having real moral and ethical implications for future children and their families. In bringing together donors, recipients and their families, and helping them to establish relationships, counsellors saw themselves as being creators and enablers of future family formations and relations. They recognized the potential for parents to be gatekeepers of knowledge of family building (Daniels and Thorn, 2001) and hence their role in developing positive relationships and processes between the donor and recipient families.

Family systems theory and grief theory further acknowledge the dynamic nature of families and of grief and that psychosocial processes involved are ongoing, having greater or less significance at various points across the lifespan, and are not discrete, time-limited events (Rosenblatt, 1996). It was thus important that all the potential long-term consequences be thoroughly explored in the counselling process. However, as is evident from follow-up studies, for example, that of MacCallum and Golombok (2007), information about the benefits of openness and disclosure do not necessarily translate into practice. It is thus uncertain if ED donors and recipients will disclose and maintain ongoing relationships as is envisaged by the counsellors.

In future research, it may be useful to explore how donors and recipients experience this counselling: as additional hurdles to be overcome in the ED process or as an empowering activity. It may further be useful to engage in long-term follow-up of donor and recipient families to explore if ongoing contact and relationships between the two families are being maintained.

The counsellors in this study belonged to Australian New Zealand Infertility Counselling Association (ANZICA), a network which, in addition to providing support for counsellors in the area of fertility counselling, develops position papers on policy and practice. Daniels (1993) has suggested that counsellors have a role to play in contributing towards social policy. The concerns of counsellors as regards the practice of ED are reflected in an ANZICA position paper in 2006. Given that ED has significant psychosocial consequences, it is particularly important that the concerns of counsellors be taken on board in future policy development.

From a medical perspective, ED is a relatively simple procedure. However, the responsibility for enabling the practice rests largely with the counsellors through the specification of counselling in the guidelines. The medical role focuses primarily on the achievement of pregnancy, whereas the counselling role takes into account current as well as long-term implications for the donors, recipients and children. In ensuring that donors and recipients and their families make fully informed decisions, counsellors bring to the fore the ethical and moral considerations associated with ED.

As emphasized by Daniels, counsellors have a role to play in educating and making visible the long-term psychosocial consequences of the practices of ARTs not just to the client but also to the rest of the team, and ensuring that services remain ‘client-centred and responsive’ (1993, p. 511). The role of counsellors in facilitating ED and the issues that they identify also need to be recognized, valued and supported by the team. In New Zealand, this role is explicit and embodied in policy. We suggest that the way in which counselling proceeds in New Zealand and the roles the counsellors fulfil can serve as a model and potentially inform practices and policies in other countries also, particularly given the more recent moves towards donor non-anonymity and the growing awareness of the importance of access to knowledge about genetic heritage.

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