PSYCHOSOCIAL COUNSELLING

German guidelines for psychosocial counselling in the area of gamete donation

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Abstract
Building a family using donated gametes (semen, oocytes or embryos) is associated with specific issues which differ from building a family with gametes from both intended parents, the resulting family comprising separated biological and social parenthood. To respect the welfare of all parties involved, the ‘Beratungsnetzwerk Kinderwunsch Deutschland e.V.’ (Infertility Counselling Network Germany) has developed guidelines for psychosocial counselling in this area. The following article summarizes international developments and introduces the German guidelines.

Keywords: Counselling, donor-assisted conception, welfare of the child

Introduction

Third party reproduction has been considered a contentious way to build a family since its beginnings (Katzorke, 2008). Although donor insemination (DI) has been carried out for over 100 years (Gregoire & Mayer, 1965), implicit or explicit criticism of this practice has not subsided. Inseminating a married woman with the semen of a man she is not married to remains a controversial issue (Baumann-Höhlze, 2001; Mieth, 2001) and paternity, as a result of the involvement of two men (the semen donor and the social father), is seen to be ambiguous and testing for the child and his/her parents from a psychological perspective (Fechting, 1997; Baumann-Höhlze, 2001). For many decades, therefore, medical professionals recommended secrecy: parents should share the conception neither with the child nor with significant others (Daniels & Taylor, 1993). Recently, however, this recommendation has been challenged. Especially psychosocial professionals (e.g. Daniels & Taylor, 1993; Haines, 1993; Blyth, 1995; Thorn, 2001; Wiemann, 2001), patient organisations (Donor Conception Support Group, Australia; Donor Conception Network, United Kingdom; Information donogene Insemination, Germany) and (young) adults conceived with the help of DI (Cordray, 1999/2000; Turner & Coyle, 2000; Anonymous, 2002; Hewitt, 2002) are asking for openness. In Germany, as in other countries, adults conceived with the help of DI demand legal changes. A young woman, who wishes to remain anonymous, has helped to establish an internet-based advocacy group for donor conceived offspring. On their homepage, these adults protest against anonymous donation and demand compulsory counselling of the intended parents prior to treatment, legal protection of the donor and central documentation of the records for 50 years (www.spenderkinder.de).

In some countries, legislation and professional guidelines support information sharing by granting offspring access to the identity of the donor (for example, Sweden, Austria, The Netherlands and Switzerland). In the UK, such regulations were introduced 3 years ago. This change was influenced by lawsuit filed by a woman conceived with the assistance of DI as well as by the mother of a DI offspring (Rose vs. Secretary of State, 2002) and also by public consultation. In the 2002 case, the judge already considered knowledge of biological origin to be a vital part of individual identity, protected by the European Convention for Human Rights (Blyth, 2004), and legislation was changed to this effect in
April 2005. All children conceived with the assistance of donor gametes after this date have the right to access the identity of the gamete donor (HFEA, 2004). Experiences from Sweden, where legislation had already been changed in 1984, indicate that, in contrast to initial expectations, the number of donors does not decline in the long-term (Lalos et al., 2003). In the UK, one clinic also confirmed that it was possible to recruit donors willing to be identified (Adam & Pease, 2008).

Recent research indicates that disclosure rates have been rising (Rumball & Adair, 1999; Gottlieb et al., 2000; Greenfield, 2002; Leeb-Lundberg et al., 2006; Daniels et al., 2007). For psychological, ethical and medical reasons, an increasing number of parents talk to their children about their conception. Recent research (Lycett et al., 2004; Scheib et al., 2005) as well as the clinical experience of the authors suggest that children fare better if disclosure takes place at an early age. Suitable booklets supporting parental disclosure and educational literature have become available in English (e.g. Frost Vercollone et al., 1997; Daniels, 2004; Montuschi, 2006; Kirkman et al., 2007) and in German (Thorn, 2006; 2008). However, longitudinal studies investigating the implication of third party reproduction for parents and their offspring, from childhood to adulthood and including large numbers of subjects are still to be conducted (Wischmann, 2008).

In Germany, the ongoing taboo, as well as legal omissions, contribute to discomfort over disclosure (Thorn & Daniels, 2007). Legal paternity of the semen donor remains ambiguous and there are no binding guidelines regarding documentation and the right of access for offspring (Thorn & Wischmann, 2008). These unregulated issues often result in a lack of confidence, not only for couples intending to pursue DI, parents and children conceived by DI (Thorn & Daniels, 2007), but also for medical (Thorn & Daniels, 2000) and psychosocial professionals as well as for semen donors (Thorn et al., 2008).

As a result of the German Embryo Protection Act, and the prohibition of divided motherhood, it is not relevant from a legal perspective to explore psychosocial issues regarding oocyte or embryo donation. However, the daily experience of German infertility counsellors indicates that an increasing number of couples consider travelling abroad to more permissive countries for such treatment (and a certain number actually do travel abroad), indicating a need for psychosocial counselling. In these situations, counselling includes controversial issues such as the danger of commercial exploitation and the potentially risky medical procedure for the oocyte donor, possible financial pressure placed on her and the right or possibility of offspring to have access to his/her biological origin.

The uncertainties and controversies in the area of third party reproduction are reflected in the issues raised and explored during counselling sessions. They include managing the taboo, social stigma and legal uncertainties, the meanings attributed to the donor for the intended parents and the child, the donor’s anonymity or identifiability as well as sharing the information with the child and significant others. Clients considering treatment abroad also face the dilemma that their desire for a child may only be realized by undergoing treatment prohibited in Germany. In the 2006 amendment, the German Federal Medical Chamber recommends an initial counselling session to be included in the medical consultation as well as further qualified psychosocial counselling (Bundesärztekammer, 2006). However, as a result of the taboo, such further counselling is rarely taken up. Given the many complex issues gamete donation raises, the German Infertility Counselling Network (Beratungsnetzwerk Kinderwunsch Deutschland e.V. – BKID), similarly to other infertility counselling organisations (Australian and New Zealand Infertility Counselling Association, 2003; American Society for Reproductive Medicine, 2006; British Infertility Counselling Association, 2006), recommends the offer of counselling to be mandatory prior to treatment and has established the guidelines described below.

As counselling in the area of gamete donation requires specialist skills, BKID has conducted comprehensive training seminars with over 30 accredited infertility counsellors who have been awarded additional accreditation by BKID. These practitioners can be identified on the online list of counsellors (http://www.bkid.de/beraterliste.html).

The guidelines below can also be accessed online (http://www.bkid.de/engl/bkid_gd_guidelines.pdf). In addition, BKID has compiled an information sheet for intended parents explaining the relevance of counselling prior to treatment as well as sample letters regarding the decision and uptake of counselling which are available via the online version of the BKID guidelines.

**Guidelines for psychosocial counselling in the area of gamete donation (GD-Guidelines of BKID)**

Building a family with the assistance of donated gametes (semen, oocytes or embryos) is associated with specific issues which differ from building a family with the gametes of both intended parents. Third party reproduction impacts on family relationships. Parenthood based on biological origin as well
as social ties results; the male biological genitor being a person who – in most cases – does not become a family member. This has far-reaching and profound implications for all parties involved: the intended parents; the children thus conceived; the donors and their partners; the parents both of the intended parents and the donor as well as (future) children of the intended parents and the donor. In order to protect the welfare of all parties involved, especially the welfare of the child to be born as he/she cannot be involved any decisions, the ‘Beratungsnetzwerk Kinderwunsch Deutschland e.V.’ (Infertility Counselling Network Germany – BKiD) has developed the following guidelines for counselling in this area. These guidelines aim to contribute towards informed consent in the area of gamete donation by reflecting both short-term as well as long-term implications of third party reproduction. In Germany, legislation only permits DI. Therefore, these guidelines are limited to this type of third party reproduction. If oocyte donation and embryo donation were permitted, similar issues for counselling would be recommended.

Counselling in the area of gamete donation should be carried out by qualified professionals (e.g. those who are accredited by BKiD) prior to medical treatment. There is no legal regulation for counselling in this area. However, BKiD considers it essential for medical professionals involved in gamete donation to ensure that intended parents take advantage of counselling and to provide a context for this, for example by establishing continued collaboration with psychosocial professionals. Counselling in this area involves sensitive and intimate aspects of life. Therefore, it is important to frame counselling as a constructive process of managing a family composed differently from the norm and for which, until now, little educational literature is available. Counselling aims to fill possible gaps in information and to support intended parents in their process of exploring and understanding social and biological parenthood so that they can develop their own short- and long-term management strategies.

Furthermore, BKiD recommends that medical or psychosocial professionals inform intended parents of the content of counselling. The decision of the intended parents regarding their take-up or refusal of counselling should be documented and BKiD counsellors should issue a written confirmation after counselling has been completed. Semen donors should also be made aware of the availability of counselling.

These detailed guidelines inform about the various areas pertinent to counselling. They comprise counselling issues for the intended mother and father as well as the semen donor.

A. Counselling the intended mother and the intended father

1 Provision of general information
1.1 Information regarding the legal possibilities of gamete donation regulated in the Embryo Protection Act and the German Citizens’ Code.
1.2 Information regarding the professional guidelines developed by the German Medical Chamber.
1.3 Information regarding medical treatment centres, basic information regarding medical treatment, success rates and fees.
1.4 Information regarding patient support organisations and professionally facilitated educational groups.

2 Reflecting the infertility experience
2.1 During the counselling process, efforts needed to fulfil the desire for a child should be adequately considered and acknowledged. Intended parents may need to mourn the fact that they have not been able to fulfil their wish for a child biologically related to both partners. The mourning phase can vary in length and intensity between both partners. Both should allow adequate time for this so that the decision to use DI is based on a conscious process.
2.2 In this phase, counselling also includes exploration of family building alternatives such as adoption, a foster child or living without children.

3 Family building with the assistance of DI
3.1 The intended mother and father need to understand their emotional reactions towards building a family which comprises both biological and social parenthood. Such reactions may vary between intuitive rejection and uncritical acceptance.
3.2 Partners within a relationship may have different attitudes towards biological and social parenthood. These should be respected and explored. Building a family with donor gametes should be affirmed and desired by both partners. The decision for this different way of building a family should be allowed to mature and not be rushed because of the emotional distress of one partner.
3.3. The intended mother and father should reflect upon the conventional meanings of biological and social parenthood. Counseling can assist in the development of appropriate terminology for the donor and
the intended father, for example by using ‘donor’ for the semen donor and ‘father’ for the intended father. This clarifies the different roles of the two males. Further interventions can help to reframe notions such as ‘conception’, so that the intended mother and father understand their decision process towards DI as a symbolic ‘conception’ of their future child.

3.4 The meaning of DI for relatives, especially for existing siblings and the grandparents-to-be should be explored.

3.5 If the intended mother and/or father are from a different ethnic background, counseling must respect her/his cultural values.

3.6 During medical treatment and pregnancy, both partners may develop ambivalent feelings towards the fact that the female partner carries the semen of an unknown man or has become pregnant with this semen. Counseling can contribute towards an understanding to such reactions and help in managing them.

4 The needs and welfare of the child

4.1 Research projects so far indicate that the psychological and social development of children conceived with the assistance of donor gametes (irrespective of whether they grow up in heterosexual or homosexual families and of the kind of donation) does not differ from the development of spontaneously conceived children. However, one issue parents must take into account during their life as a family is that of sharing information with the child. Even though, from the perspective of developmental psychology and family dynamics, early disclosure is recommended, this remains the parents’ autonomous decision. If intended parents decide against disclosure, they should continue to have access to counseling so that they have the opportunity to reflect upon their decision with professional support after the birth of the child.

An increasing number of parents overcome their anxieties of rejection and stigmatisation and intend to disclose the use of donor conception to their child. However, when disclosing the nature of conception, the fertility disorder of the male partner also becomes known, an issue still associated with a taboo. It can be helpful for intended parents to know that, in many cases, the reaction towards DI is less negative than anticipated. Furthermore, parents may be uncertain how and at what age the child can be told of the nature of his/her conception. Intended parents can be made aware that, from the perspective of developmental psychology, early disclosure (between the age of 3 and 6 years) is appropriate. Talking to children can be made easier by providing educational literature or by developing a script that parents can use for telling their child. It is also important to know that disclosure is not a single event but a process. The older the child, the more complex the questions will be which the parents will need to answer at greater depth.

If parents prefer to keep the conception a secret, the potential implications for the family should be considered and reflected upon with the intended parents. It is helpful to explore whether this decision is in accord with parental values such as openness and honesty within the family.

4.2 Even if the donor remains anonymous, disclosure is recommended as parents avoid a family secret and do not endanger the trustful relationship between themselves and the child.

4.3 Counselling should also explore the meanings the child may attribute towards the donor. Intended parents may fear that the child feels drawn towards the donor once he/she is aware of the biological link, may consider the father to be secondary and eventually reject the father, say, during puberty. It is important for the intended parents to know that the social father is the only actual father for the child as the donor is not a significant person who is present in the child’s life.

Furthermore, intended parents may fear that the method of conception impacts negatively on family dynamics resulting in problems in bringing up the child for the parents as a couple. It is important for intended parents to know that families built with the assistance of DI encounter all the typical stresses of family life and that not all conflicts may be associated with the nature of the child’s conception. Successful psychological integration of the knowledge of the conception is closely related to the parents’ open attitude and the avoidance of secrecy.

4.4 Teenagers and young adults may voice the need to have information about the donor or to meet him personally. This should be considered a natural need which does not imply a problematic relationship between the child and his/her parents.

4.5 As a result of progressive destigmatisation of DI, not only parents of young children, but
more and more parents of teenagers and (young) adults are likely to inform their children of their conception. Late disclosure can result in an identity crisis and in more or less severe traumatisation, especially if disclosure takes places during unfavourable circumstances (for example during the divorce of the parents). Counselling can support disclosure under these circumstances, so that the (adult) child can manage the information regarding his/her origin and the meaning attached to it constructively.

4.6 In some cases, medical professionals are willing to facilitate contact between the donor and offspring. To explore and clarify the needs and attitudes of both, initially, prior counselling should be offered to both, donor and offspring individually. Subsequently, joint counselling sessions can be carried out. In this context counselling can mediate between the offspring (and his/her parents if applicable) and the donor so that contact between these parties is a positive experience.

4.7 Offspring may be interested in getting to know half-siblings. Medical professionals can be asked to support this by providing contact details of others conceived with the semen of the same donor if they consent.

5 Rights of the child

5.1 According to professional guidelines established in 2006 in Germany, medical professionals are required to retain documents regarding the semen donor and the recipient couple for a minimum of 30 years. Prior to 2006, documents had to be retained for a minimum of 10 years. As there is no legislation providing legal clarity in this area (apart from the documentation of semen donors regulated in the Act of Organ Transplantation), the right of the child to access these documents should be ensured by drawing up a legal document with a public notary and by retaining the documents regarding the donor's identity so that the child can access this information. Parents should be recommended to inform the medical professional who provided treatment of the birth of the child.

5.2 Documentation for a period longer than 30 years can be agreed upon and should be ensured by a contract drawn up by a public notary.

5.3 Currently, in Germany there is no legislation regulating the circumstances under which a DI offspring has the right to access the identity of the semen donor. As a result of a legal ruling by the German Constitutional Court and interpretation of German legislation, legal experts assume that every person has the right to know of his/her biological origin upon reaching legal age. However, if the documents have been destroyed after the legal period for documentation, this right cannot be exercised.

6 Non-anonymous semen donors

6.1 A semen donor can also be known to the intended mother or father, as is often the case if lesbian couples or single women carry out self-insemination. The role of the semen donor (and the biological and social mother, if applicable) in the future family should be explored. The meaning of the semen donor may change over time. Therefore, if necessary, the possibility should remain open to re-discuss and clarify the needs of the intended parent/s and the donor once the child has been born and at any time after this. Joint counselling should be offered to the intended parent/s and the semen donor prior to treatment, in addition to individual counselling.

6.2 Intra-familial donation (for example, using the semen of the brother or cousin of the intended father) results in complex family compositions which should be explored prior to treatment. If the familial relationship is not intended to be disclosed to the child, the underlying reasons for this should be explored. Whether secrecy in this case is realistic or advisable should be reflected.

6.3 To protect the ability of the donor to take an independent decision, it should be ensured that he does not donate as a result of emotional coercion or a feeling of responsibility.

B Counselling of the semen donor

1 Provision of general information

1.1 Information about the procedure and time requirements for semen donation.

1.2 Information about the financial compensation.

1.3 The donor is to be informed of current legislation and professional guidelines, especially regarding his legal responsibilities when donating for various recipient groups (married and de-facto couples, lesbian and single women).

1.4 He is to be informed of the duration and the scope of documentation of his data.
1.5 He is to be informed about the right of the child to access this documentation.

2 *Psychosocial exploration*

2.1 The donor should be given the opportunity to reflect upon his motives for donating. It must be ensured that his actions are based on a voluntary and autonomous decision and that he does not donate as a result of economic need or emotional coercion.

2.2 He should have the opportunity to reflect upon the meaning of a child conceived with his semen living in a different family. If he is in an on-going partnership, his partner can be involved in this reflection.

2.3 He should be able to determine which recipient groups he would like to donate for (married couples, de-facto couples, lesbian or single women).

2.4 He should be able to determine the number of offspring conceived with his semen. The maximum number of 15 offspring determined by the Arbeitskreis für donogene Insemination (German Medical Association for Donor Insemination) should not be exceeded.

2.5 If desired, the semen donor can be informed by the medical professionals or the semen bank about the number of offspring conceived with his semen.

2.6 In rare cases, offspring conceived with the assistance of donated semen are affected by genetic diseases that can be traced back to the semen donor. The semen donor should have the opportunity to decide whether he would like to be informed about such diseases so that he can use this information in his own family planning decisions.

3 *Exploration of short- and long-term implications*

3.1 Donating semen can be associated with a taboo for men. The donor should have sufficient opportunity to explore if he wishes to share information about his donation with significant others and what implications this may have.

3.2 The donor should be made aware of the fact that the meaning he attributes to offspring conceived with his semen may change over time, especially after he has fathered children within his own family.

3.3 His own (future) children are half-siblings of the offspring resulting from his donated semen. He should have the opportunity to explore whether he would like to share with his own children the fact that he has helped to create other offspring.

3.4 If a man donates semen to a woman known to him, he should explore his role in this future family. To provide all parties involved with the opportunity to explore the meaning of the donor in such a family, joint counselling sessions should be offered (see A 6).

3.5 If an adult conceived with the help of DI is interested in meeting the donor, the donor should have the opportunity to use counselling to prepare for such a contact and to explore his needs and attitudes (see A 4.6).

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**Notes**

1 We thank the Journal für Reproduktionsmedizin und Endokrinologie where this article appeared originally for the right to republish it in English.

2 According to current legislation, heterosexual parents cannot contest paternity of the husband if both agreed to carry out DI. The child, however, cannot be denied the right to do so. Legislation does not restrict the use of DI to heterosexual couples. As there is no male partner in those cases where DI is used by lesbian or single women, and as there is no general legal exemption for donors, they run the risk of having legal responsibilities towards the child. In 2006, in Germany, several medical guidelines as well as the Organ Transplantation Act were amended to extend the period of documentation of donor records to a minimum of 30 years. However, the right of offspring to access this information is enshrined neither in guidelines nor in legislation. For further details regarding regulations and legislation in Germany, see Thorn, Katzorke & Daniels 2008.

3 This became evident during the first part of the training seminars ‘Psychosocial counselling in the area of gamete donation’ during the Spring Conference of the German Infertility Counselling Network on 1 March 2008.

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