

A Post-Structural Analysis of Female Egg Donation in New Zealand

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ABSTRACT

Since the introduction of Assisted Reproductive Technologies (ARTs) in the 1980s, such practices have become increasingly commonplace internationally. In New Zealand alone, egg donation (ED) accounts for approximately ten per cent of all treatment cycles at fertility centres. New Zealand differs to many other jurisdictions in that anonymous donation is prohibited. This is enforced by the Human Assisted Reproductive Technology (HART) Act 2004, which recognizes the rights of offspring to have access to their genetic information. Donor-conceived individuals can access this information at age of majority, or earlier by application. Research suggests that ED involves potential complexities around donors' motivations, experiences of ED, disclosure arrangements, and contact between the donor and recipient family. Psychological support is generally provided for egg donors to aid them in decision-making, navigating implications and dealing with adversities that may arise, however this support is often deemed inadequate by women and families in New Zealand and internationally. Research exploring the complexities of ED and women and families' support needs in the New Zealand context is relatively limited. Therefore, the current inquiry aimed to explore egg donors' motivations and experiences to better understand how preparation and support around this process could be provided for them, and to inform policy and practice.

Ten women donors who had donated their eggs to someone known or previously unknown in New Zealand were interviewed about their motivations and experiences of ED. A post-structural feminist discourse analysis approach was adopted to identify the discourses surrounding ED in New Zealand, how these 'frame' ED and make available subject positions for women, how women take up or critique these positions, and how power operated to enable and constrain possibilities for women in these positions. The implications of these discourses for women's experiences, wellbeing and support needs were also explored.

Converging and competing discourses were identified in the findings. A dominant genetic discourse was identified, which enabled woman egg donors' to assume a more involved position in the ED process as an extended relative, but could jeopardise the recipients' position. A contesting altruism discourse was also identified, which

minimized donors' position following ED, and made available uninvolved/unattached positions, such as the 'bystander'. From these positions, competing constructions of donors as 'mothers' or 'not mothers' arose. Women positioned themselves in various ways that exhibited a constant drawing near and distancing process in relation to the donor-conceived child (DCC) and the DCC's family, which indicated discomfort with the positions available to them.

The findings demonstrate how women grapple with a genetic discourse to negotiate a role in the ED process. In this study, women are trying to find ways to care for/relate to children and families, in the context of some restrictive constraints that need not be such barriers. A genetic discourse was assumed and resisted in women's' construction of eggs, the DCC, and the ED process. In this construction of eggs, this assume/resist action suggests there are tensions in the attachment women hold for their eggs, which evoked conflicting emotions for donors. In the construction of the DCC, donors drew on the genetic discourse to draw near and resisted the discourse to distance themselves from the DCC. This can be seen as a form of self-protection, suggesting that although women desire a level of involvement, too much involvement may be difficult for women. In the construction of ED, women drew on a genetic discourse to highlight that donating genetic material carried significant weight, in terms of ongoing consequences. Donors, therefore, resisted the discourse to enable their decision to donate and to protect themselves. Donors demonstrate a significant difficulty in negotiating the genetic, social and gestational discourses of motherhood available to them. These discourses can be seen as reinforcing traditional norms of kinship and enabled too much or not enough involvement for donors. These restrictive discourses required donors to position themselves as not mothers or mothers. Neither of these were comfortable for donors, therefore, a genetic discourse was drawn on in a different, less powerful way by donors to challenge traditional constructions of kinship and position themselves as only 'partly mothers'. This enabled women to have some involvement within particular boundaries and circumscribed responsibilities (e.g. concern for the child's welfare and responsibility to disclose genealogy). These implications suggest more support is needed for women to enhance their health and wellbeing. A suggestion for ongoing counselling to consider the ongoing consequences of ED and the effect on donors' lifetime trajectories, setting donors up for a relationship that is organic, can shift and change and may require

further support or may not. Ongoing counselling should also focus on promoting a critical awareness of the multiple meanings of ED in women's lives, by encouraging women to engage productively with discourses of motherhood and promote creativity to construct new terms of engagement that work for them. Implications for policy and practice are also suggested, including: a more thorough assessment of recipients in to facilitate selection, considering birth certificate annotations to enhance policy around disclosure, and relationships-focussed training approach for medical staff. Directions for future research are also outlined.

TABLE OF CONTENTS

ABSTRACT	II
ATTESTATION OF AUTHORSHIP	VII
ACKNOWLEDGEMENTS	VIII
INTRODUCTION	9
LITERATURE REVIEW	13
MOTIVATIONS TO DONATE.....	15
EXPERIENCES OF DONATION.....	20
PHYSICAL AND PRAGMATIC ASPECTS OF DONATION – THE PROCEDURE	20
PSYCHOSOCIAL ASPECTS OF DONATION – PRETREATMENT AND ONGOING COUNSELLING.....	21
<i>Factors Contributing to a Positive Donation Experience</i>	22
<i>Factors Contributing to a Distressing/Challenging Donation Experience</i>	23
<i>Concerns when donation was successful/unsuccessful – known donors</i>	23
<i>Concerns when donation was successful – anonymous donors</i>	24
<i>Unknown donation outcomes for donors</i>	24
DISCLOSURE – DONOR-CONCEIVED CHILDREN AND THE DONOR’S ‘OWN’ FAMILY	25
<i>Reasons for disclosure</i>	26
<i>Reasons for non-disclosure</i>	26
<i>Issues for donors when recipients disclose</i>	27
<i>Impact of non-disclosure on donors</i>	28
CONTACT BETWEEN THE DONOR AND THE RECIPIENT AND DONOR-CONCEIVED OFFSPRING	29
SUPPORT NEEDS.....	32
FEMINIST PERSPECTIVES ON ED	32
THIS INQUIRY.....	33
STUDY AIMS	34
METHODOLOGICAL UNDERPINNINGS AND METHODS	35
POSTSTRUCTURAL FEMINISM.....	35
DISCOURSE	37
SUBJECTS AND THE NOTION OF SUBJECTIVITY	38
POWER/KNOWLEDGE.....	40
SCOPE AND RESEARCH QUESTIONS	42
COUNSELLING PSYCHOLOGY LENS.....	42
RESEARCH QUESTION.....	42
RECRUITMENT	43
THE PARTICIPANT INFORMATION SHEET (PIS).....	43
PARTICIPANTS	44
INTERVIEWS.....	44
TRANSCRIPTION	45
ANALYSIS	46
<i>Table 1: Questions and analytic stage</i>	49
ETHICAL CONSIDERATIONS.....	49
INFORMED CONSENT.....	50
CONFIDENTIALITY.....	50
PARTICIPATION AND RIGHT TO WITHDRAW	51
PARTICIPANT VULNERABILITY AND RISKS.....	51
RESEARCHER SAFETY	52
RESEARCH RIGOUR	52
CREDIBILITY AND COHERENCE	52
REPRESENTATIVENESS.....	53
REFLEXIVITY	53

<i>Personal Reflexivity</i>	54
CONCLUSION.....	55
FINDINGS.....	56
DISCURSIVE CONSTRUCTIONS OF EGGS.....	56
<i>Eggs as physical resource</i>	56
<i>Eggs as ‘not yet a baby’</i>	58
<i>Egg donors as ‘not mothers’</i>	59
DISCURSIVE CONSTRUCTIONS OF THE DONOR-CONCEIVED CHILD(REN) (DCC).....	61
<i>DCC(ren) as ‘half-siblings’/ or ‘not half siblings’ to the donor’s own child(ren)</i>	61
<i>DCC as ‘belonging to the recipient’ – ‘not my child’</i>	63
<i>DCC as a ‘niece/nephew’ or ‘special’</i>	67
DISCURSIVE CONSTRUCTIONS OF EGG DONATION (ED) PRACTICE.....	70
<i>‘A big life decision’</i>	71
<i>‘A selfless gift’</i>	75
CONCLUSION.....	80
DISCUSSION.....	81
FERTILITY INDUSTRY, BIOPOWER AND THE DOMINANCE OF THE ALTRUISM DISCOURSE	81
TENSION IN DONORS’ ATTACHMENT TO THEIR EGGS – THE GENETIC DISCOURSE	86
NEGOTIATING CONNECTION TO DCCs AND FAMILIES.....	87
DEFINING AND NEGOTIATING MOTHERHOOD.....	90
<i>Motherhood as genetic – Donors as ‘partly mothers’ and the concept of ‘shared parenting’</i>	90
<i>Motherhood based on gestation and birth – A narrow view</i>	92
<i>Mothering defined by social practices involved in child-rearing</i>	94
<i>Motherhood as imperative/vortex</i>	96
IMPLICATIONS.....	97
<i>Assessment/selection of recipients</i>	98
<i>Policy around Disclosure</i>	99
<i>Training for medical staff – a relationships-focussed approach</i>	100
<i>Counselling</i>	101
<i>Consent processes</i>	101
<i>Promoting a critical awareness of the multiple meanings of ED in women’s lives</i>	102
STUDY CHALLENGES AND RECOMMENDATIONS FOR FUTURE RESEARCH	103
CONCLUSION	104
REFERENCES	105
APPENDIX A - CONSENT FORM.....	118
APPENDIX B- PARTICIPANT INFORMATION SHEET.....	119
APPENDIX C – INTERVIEW SCHEDULE – INDICATIVE QUESTIONS.....	122

ATTESTATION OF AUTHORSHIP

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements) nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

Signed:



Rebecca Thurlow

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INTRODUCTION

It is estimated that 15-20% of couples in New Zealand experience infertility at some stage in their reproductive lives (Fertility Associates, 2019), with female factors such as ovulation disorders and endometriosis accounting for 42% of the cause of infertility (Righarts, Dickson, Parkin & Gillett, 2015).

Infertility is described in the literature as emotionally challenging and stressful, involving significant grief and loss, negatively affecting ones' identity, and is linked with depression, and anxiety, particularly in pronatalist society contexts (Carter, Applegarth, Josephs, Grill, Baser & Rosenwaks, 2011; Goedeke, 2014; Maroufizadeh, Karimi, Vesali & Oman Samani, 2015), where motherhood is seen as an inevitable and natural part of being a woman and childlessness is experienced with significant grief and loss (Daniels, 1993; McArthur & Moulet, 2004). Cousineau and Domar (2007) for example, report that couples struggling with infertility experience stigmatization and a significant disruption in the developmental trajectory of adulthood. Women in particular may be positioned as emotionally vulnerable, even irrational in terms of the lengths to which they will go to have children (Goedeke, 2014). Indeed, a discourses of infertility tend to position women as 'mad, bad or sad' (McLeod & Ponesse, 2008; Payne & Goedeke, 2009).

Infertility across the world has led to the development of various assisted reproductive technologies (ARTs), and an associated ART industry. ED may be an option for women with ovarian conditions, early menopause, where chances of pregnancy are low due to advanced age, or where pregnancy has not resulted following In-Vitro Fertilisation (IVF) (Bracewell-Milnes et al., 2016). ED treatment involves two parties directly, the donor and the recipient. The egg donor undergoes two invasive procedures: ovarian stimulation to produce a sufficient number of eggs and transvaginal oocyte retrieval under conscious sedation, or general anaesthesia. Once the oocytes are retrieved they are fertilised with sperm and transferred to the recipient (Fertility Associates, 2017). ED has been reported since the 1980s (Bracewell-Milnes et al., 2016) and has become increasingly

commonplace internationally, accounting for approximately 10% of all treatment cycles at fertility centers in New Zealand (Fertility Associates, 2019). Egg sharing is a form of ED where a female fertility patient donates a portion of her eggs to a matched recipient to receive free or subsidized fertility care. The eggs are split equally between the egg share donor and recipient. Egg sharing has been practiced in the UK since 1998 and now exists in Australia, Denmark, Belgium, the USA and Israel (Platts, Bracewell-Milnes, Saso, Abdalla & Thum, 2019). It is however, prohibited in New Zealand (Wang, Farquhar & Sullivan, 2012) (and as such, is not a focus of this literature review).

ED can take place in a range of ways. In New Zealand, donors may include known or personal donors (known to recipients prior to the donation, e.g. family member or friends) or clinic-recruited/previously unknown donors (those recruited through the clinics, through advertising, or increasingly through the use of online media). Previously unknown donors may become known to the recipients through the donation process. In other countries, donors may be anonymous or open identity (where the open identity donor consents to possible future contact with donor-conceived offspring from her donation), paid or altruistic, and involve known or unknown recipients (Bracewell-Milnes et al. 2016).

The advancement of third-party assisted reproduction (e.g. oocyte, sperm and embryo donation) has been rapid, sometimes ahead of research into the potential psychosocial and political implications of these practices which may be potentially challenging for all the parties involved: the recipient, donor, offspring and the wider family network (Goedeke, 2014).

Currently, there is an imbalance of donor to recipient numbers (being talked about as a shortage of donors), and so donor experiences and motivation has become a topic of interest nationally and internationally (Bracewell-Milne et al., 2016; Nuffield Council, 2011; van den Broeck et al., 2013), including New Zealand (FertilityNZ, April 9, 2018; Warhurst, Newshub, 13 May 2016). Research suggests this may be due to a number of reasons, although research pertaining to

the New Zealand context is relatively limited. Therefore, the current inquiry aimed to explore not only what motivated woman egg donors in New Zealand to donate, but also how women experience ED in New Zealand, to identify the implications of ED on women's health and wellbeing and policy and practices. An overview of this thesis is as follows.

Chapter one: Literature review

The first chapter will explore the existing literature around ARTs and gamete donation, with a specific focus on ED. The research has focussed on donors' motivations, experiences of ED, disclosure arrangements, and contact between the donor and recipient and donor-conceived child(ren). The support needs that arise from the complexities surrounding these aspects of donation will also be outlined. How this review constructs the rationale for the current study will be discussed.

Chapter two: Methodological underpinnings and methods

Chapter two will define the poststructural feminist analytic lens adopted in the current study. Foucault's notions of discourse, subjectivity and power will be discussed and related to this inquiry. The method adopted, Foucauldian Discourse Analysis, will also be described. The counselling psychology lens will also be defined. Each stage of the study will be outlined as follows: recruitment, participants, interviews, transcription, and analysis (and analytic questions). Ethical considerations and research rigour will also be outlined.

Chapter three: Findings

Chapter three will present the various discourses identified in the data, the subject positions made available and how this enabled and constrained possibilities for women egg donors and their health and wellbeing..

Chapter four: Discussion

An interpretation of the way discourses enable and constrain woman egg donors will be discussed. Critical feminist perspectives of ED will be integrated to interpret the findings. How woman egg donors, the fertility industry, and legislation take up and resist these discourses will be discussed, as well as the implications this has for counselling psychology, supporting women's health and wellbeing, and policy and practice.

LITERATURE REVIEW

This chapter will begin by describing the possible explanations for the current imbalance of donor to recipient numbers. In this section, legislation enforced in egg donation (ED) in New Zealand, which differs to other jurisdictions, will be outlined. The remainder of this chapter aims to explore the research around donors' motivations, experiences of ED, disclosure arrangements, and contact between the donor and recipient and donor-conceived child(ren) (DCC). The support needs suggested by complexities around each of these aspects of ED will be identified and discussed. This review will provide the rationale for the current inquiry and aid in forming the research question.

While donation has become more common, a larger number of prospective recipients than egg donors is reported in many countries (Bracewell-Milne et al., 2016; Nuffield Council, 2011; van den Broeck et al., 2013), including in New Zealand, where long waiting lists for an egg donor may be standard (FertilityNZ, April 9, 2018; Warhurst, Newshub, 13 May 2016). This may be due to a number of factors. Although anonymous donation is not practiced in New Zealand, some researchers in other countries link the imbalance to the introduction of legislation prohibiting anonymous donation (e.g. Craft et al., 2005; Pennings, 2015). However, this is not backed up by research which suggests that numbers have stabilised to pre-legislation levels (Human Fertilisation and Embryology Authority, HFEA), 2013).

Legislation in New Zealand includes the Human Assisted Reproductive Technology (HART) Act 2004 which prohibits anonymous donation as it recognizes the rights of offspring to have access to their genetic information. This legislation formalized what had already become common practice in most New Zealand clinics since the early 1990's (Daniels & Douglass, 2008), and children conceived through donor treatment may access identifying information about their donor at the age of majority, or earlier by application. One of the reasons this legislation was introduced is that restricting DCC(ren) from receiving information concerning their conception was believed to

result in psychological adjustment and identity problems in the future (Golombok, Blake, Casey, Roman & Jadva, 2013; Nordqvist, 2014). Research indicates that parental disclosure decisions and donor identification are ethical issues that may impact the DCC's wellbeing, as well as the lack of a genetic link to the parents (Golombok et al., 2013). However, Freeman (2015) found that the quality of the parent-child relationship is of greater importance than genetic relatedness in ensuring the DCC's wellbeing.

Others have suggested this 'donor shortage' is due to a lack of payment for gametes. Advocates of payment state that payment may increase supply, by acknowledging donors' time, 'inconvenience', risks and invasiveness of procedures, which is particularly relevant to ED (Pennings et al., 2018). There are many concerns about payment however, including exploitation, compromised informed consent, commodification, eugenics, misrepresentation of donors' histories, how offspring will make sense of payment, and that payment may nullify the concept of 'gifting' (Lee et al., 2017; Pennings, 2015). Further, limited gametes available for donor conception may prompt patients to go overseas where payment is allowed (Bracewell-Milnes et al., 2016) but raises concerns around quality and safety issues, legal implications, and psychosocial consequences for donors, recipients, and offspring (Rodino et al., 2014), including the issue that overseas donors may not necessarily be identifiable (as is required in New Zealand).

The prevalent imbalance of recipient and egg donor numbers may also be due in part to a lack of knowledge around ED practices. Research indicates that the general population, outside of those directly involved in donation, have poor knowledge of ED and the controversies surrounding its practice (Platts et al. 2019; Straehl et al. 2017). Even the infertile population report limited knowledge of ED. In a recent study, among participants undergoing ARTs, six percent reported they had 'never heard' about oocyte donation (Straehl et al. 2017).

Given that donor numbers are low, that recipients travel overseas for donors and that there are problems associated with cross border reproductive care, it has been suggested that there is a need to consider what ‘motivates’ New Zealand donors, and what their experiences, challenges, and concerns are to better understand this area and possibly inform policy and practice to potentially increase supply.

Feminist perspectives on ART and ED are more likely to take the perspective of women donors, and women’s health and wellbeing as their point of departure, rather than analysis of supply of gametes and demand (Curtis, 2010; Gal & Kligman, 2000; Leve, 2013; Mamo, 2010; Mahjouri, 2004). These perspectives encourage taking a step back from ART as economy, to examine the conditions of possibility for ED and women’s involvement/positioning in this process.

Motivations to Donate

The most common factor influencing the decision to donate is reported to be altruistic motivation (Bracewell-Milnes et al. 2016; Gezinski, Karandikar, Carter & White, 2016; Platts et al., 2019). Altruism is defined in egg donation as *‘the wish to help another couple (or woman) have a child’* (Bracewell-Milnes et al., 2016, p. 459).

This desire to help is described as powerful and selfless, and includes a strong element of self-sacrifice (Acharaya, Bryant & Twiddy, 2017). For example, having empathy for women experiencing infertility is an altruistic motivating factor reported by most donors, regardless of whether they are known, previously unknown, or anonymous donors (Bracewell-Milnes et al., 2016; Graham, Jadv, Freeman, Ahuja & Golombok, 2016; Pennings et al., 2014). Identity-release donors in the UK perceived donation as something they could do to relieve the pain and sadness of childlessness that infertile women experience by enabling them to have their ‘own child’ (Graham et al., 2016). In another study, donors expressed a desire to help another woman to have a child from a sense of solidarity or ‘sisterhood’ (Kirkman, 2003). The expression of ‘gifting’ another women oocytes with no desire for compensation is commonly found in the literature (Almeling, 2006; Kirkman, 2003; Lee et al. 2017; Pennings, 2015).

Another altruistic motivation reported in the literature is the donors’ appreciation of the powerful desire for motherhood (Kirkman, 2003). Both recipients and donors of

eggs and embryos describe an innate 'need' to be a mother (Kirkman, 2003). The importance placed on being a mother has led to active participation from donors and recipients in donation practices. Recipient women awaiting oocytes believed parenthood would provide happiness, enrichment, purpose and meaning to their lives (Carter et al. 2011). Donors highlighted the importance of motherhood and parenting in their own lives, indicating it as the most important aspect of their lives, and therefore, were motivated to donate to enable others to experience motherhood as they had themselves (Bracewell-Milnes et al., 2016; Graham et al. 2016; Jadva et al. 2011; Kirkman, 2003; Purewal & van den Akker, 2009).

Kirkman's (2003) study highlights that donors who were motivated to enable another woman to experience motherhood, saw their eggs as otherwise wasted. Therefore, their motivations were mixed altruistic and practical. Egg donation was seen as a way of utilizing their 'otherwise wasted' eggs. These donors saw motherhood as defined by social (nurturing and raising the child) and gestational (pregnancy and birthing the child), rather than genetic discourses, which motivated them to donate (Braverman & Corson, 2002; Kirkman, 2003). Culley & Hudson (2009) found conflicting findings, where women could not imagine themselves donating their eggs due to the embodiment of motherhood, the attachment women have to their biological material, where even 'detached' reproduction was seen as carrying emotional ties.

Known donors report mixed altruistic motives. However, their primary motivation is reported to be the close relationship between the recipient and donor, particularly if the recipient was a relative (Bracewell-Milnes et al. 2016; Byrd, Sidebotham & Lieberman, 2002; Purewal & van den Akker, 2009; Yee et al. 2011). For known donors, being a part of the recipient's journey of infertility and failure of ARTs such as IVF can be a significant motivating factor (Graham et al. 2016; Winter & Daniluk, 2004). Carter et al. (2011) examined the emotional, physical, sexual, and quality of life impact on infertile women awaiting oocyte donation. The experience of reproductive assistance was described by recipients as 'excitement followed by crushing disappointment', a 'rollercoaster', 'traumatic, devastating and disempowering' when treatment was unsuccessful or as 'a good experience' if treatment was successful (Carter et al. 2011). After seeing other relatives struggle with infertility, one donor imagined that infertility would be a 'soul destroying'

experience for these women (Graham et al. 2016). Donors from larger families, (e.g. with three or more siblings), indicated that positive family experiences had influenced them to donate (Bracewell-Milnes et al. 2016). Winter and Daniluk (2004) explored the experiences and motivations of three women who donated their eggs to their sisters and identified mixed altruistic motivations. These donors framed egg donation as a ‘gift of love’ (p. 487) and held empathy for their recipient’s inability to conceive a child. One donor saw the close relationship with her sister and their shared genetic and social history as contextual factors that would benefit the DCC (Winter & Daniluk, 2004).

Research on donor motivations suggests that donors’ motivations may be multifaceted (Pennings et al., 2014; Van den Broeck et al., 2013). Therefore, other factors may come into play influencing the decision to donate. For example, altruism may be accompanied by financial gain or need, curiosity, or for self-gain (which may include checking ones own fertility, to create a positive self-image, or to feel good about ones self).

In the United States, commercial egg donation is allowed and indeed, studies suggest that egg donors in the US seem to be more financially motivated than donors in other countries (Lindheim, Chase & Sauer, 2001), such as Canada, where legislation only allows for altruistic gamete donation (Yee, Hitkari & Greenblatt, 2007). Lindheim et al. (2001) explored the potential ramifications of increasing payments to donors. They found that those receiving lower compensation (before financial remuneration for services rendered was increased from USD 2,500 to USD 5,000), expressed altruism as the sole motivation, followed by ‘empathy’, ‘gift-giving’ and ‘curiosity’. When the financial remuneration for services rendered was increased (to USD 5,000 in 1998), greater financial motivation was reported from donors. However, this USD 5,000 average is no longer the case in the US, as the fertility industry is now largely self-regulated (Johnson, 2017). The ASRM did recommended ‘reasonable’ compensation from USD 5,000, but not exceeding USD 10,000, which was considered inappropriate (Krawiec, 2014). However, this was challenged in a lawsuit, where four former egg donors sued the ASRM claiming these guidelines constituted illegal price-fixing (Johnson, 2017). Nonetheless, Lindeheim et al. (2001) findings

suggest escalation of payment has become a dominant motivating factor increasing interest in participating in ED (Lindheim et al. 2001). This financial incentive may cause young donors to donate without adequately weighing up the risks of ovarian hyper stimulation and oocyte retrieval against the benefits of monetary reward (Lindheim et al. 2001) or attract women to donate for the ‘wrong reasons’ (i.e. financial gain alone) (Byrd et al. 2002). This may result in issues with adequate informed consent (Lindheim et al., 2001), which may lead to regret in the future as a result of impaired future fertility (Fertility Associates, 2017), and where issues related to contact from the offspring might arise (Daniels, Kramer & Perez-y-Perez, 2012).

Financial need due to economic circumstances may be another reason financial motivations are reported across different countries in Europe, such as Greece, Russia and Ukraine (Pennings et al. 2014), as well as in India (Jadva et al. 2016). Although financial gain is a factor, it usually is not the only factor influencing women’s decisions to donate. The decision is often multifaceted, with mixed financial and altruistic motivations commonly reported (Bracewell-Milnes et al. 2016; Jadva et al. 2016; Lindheim et al. 2001; Nelson & Hertz, 2017; Pennings et al. 2014). However, identity-release egg donors in the UK were not motivated by the recent increase in financial compensation in the UK. The idea of payment created unease for women donating their eggs. These findings suggest that women donating for purely altruistic reasons, may consider monetary reward the ‘wrong reason’ to donate (Graham et al. 2016). A desire to pass on genetic material is another motivating factor reported, although less frequently than others in the research (Gezinski et al. 2016; Platts et al. 2019).

Donors without children reported a desire to give another women that chance and to check their own fertility. Becoming an egg donor was seen as something that would also increase the donors’ self-worth (Braverman & Corson, 2002; Graham et al. 2016) and create a positive self-image (Acharya et al. 2017).

Motivations to donate differ according to culture and gender (e.g. between egg and sperm donors) (Almeling, 2006; Culley & Hudson, 2009; Jadva et al. 2016). Different cultural and religious contexts may effect motivations and willingness to

donate. Culley and Hudson (2009) found that in South Asian cultures, childless couples frequently experience social scrutiny as parenthood is seen as culturally mandatory and childlessness as socially unacceptable. In this culture, infertile women commonly experience negative behavior from their husband's family, where in-laws may convince the husband to remarry to have children. This highlights parenthood as a dominant discourse in this culture. The social stigma surrounding childlessness in India was reported as a motivating factor for egg donors, who felt they wanted to help remove the blame and burden of infertility for other women (Jadva, Lamba, Kadam & Golombok, 2016). Egg donation was considered a more natural, accepted process than sperm donation in South Asian cultures. This was because the recipient mother could make a biological connection with the DCC and embody motherhood through gestation. Fatherhood however, was defined by genetic relatedness in a patrilineal context and "the introduction of non-conjugal sperm into the (married) female body was equivalent to adultery" (Culley & Hudson, 2009, p. 256). Therefore, egg donation was a more socially accepted practice than sperm donation in this context that enabled the mother and father to feel connected to the DCC (Culley & Hudson, 2009). Given that the stigma surrounding childlessness encourages fertile women to donate and that ED is a more socially accepted practice, it may be more common than sperm donation.

Almeling (2006) identifies that ED is consistently framed as a 'gift' as opposed to sperm donation, which is seen as a 'job'. The author suggests the motivations in donor profiles are heavily polarized by gender, with fertility agencies in the US influencing women to highlight altruism as a motivating factor, whilst accepting men's answers about financial compensation. In some countries (e.g. Canada), potential oocyte donors are rejected if financial gain is reported as a motivating factor (Yee, Hitkari & Greenblatt, 2007). Coercion, therefore, is an ethical issue to consider where donors discuss their decision to donate.

Although motivations to donate have been explored in many different countries, existing studies have generated inconclusive results (Curtis, 2010). Little research has explored the motivations of donors in New Zealand, where legislation varies to other countries, as payment for donation is prohibited. In this way the notion of

ED as an altruistic or selfless act, largely for the benefit of another, is reinforced by New Zealand law. Accordingly, Fertility Associates, a leading ART provider in New Zealand advertises for “women in the community who are motivated to give the ultimate gift to help a women who is hopeful to become mum” (Fertility Associates, 2015). The current inquiry aims to understand not only donors’ motivations in this context, but how women position themselves in relation to motivational possibilities and with what implications. For example, if women position themselves as ‘helping others’ or ‘gifting life’, what happens when their donation is unsuccessful or when the recipients do not express gratitude or thanks? For example, Yee et al. (2011) found that donors who reported receiving gratitude from their recipient helped strengthen their emotional bond following donation, increasing satisfaction of the donation procedure. However, one donor discussed an ‘unappreciative attitude’ from her recipient, “making her feel that she was only ‘a means to an end’ (p. 412).

Experiences of Donation

Physical and pragmatic aspects of donation – the procedure

Becoming an egg donor involves undergoing an intrusive process of IVF with an extensive list of possible side effects. This process is essentially split into two parts. The first involves the egg donor taking medication to stimulate the ovaries to produce more eggs; the second involves the egg retrieval through transvaginal ultrasound aspiration, which is performed under conscious sedation. This procedure involves the placement of a suctioning needle into each ovary where mature oocytes are removed from the follicles (Fertility Associates, 2017). This medication and travel to and from the fertility clinic can add to the stress of the procedure. There is a possibility of eggs being left behind, which means contraception must be used by the donor following the process to avoid becoming pregnant. Following donation, it is likely that the donor will experience a heavier period earlier than normal.

There are side effects women becoming egg donors may experience during IVF, e.g. post-menopausal like symptoms, mood swings due to changes in hormone level, a sharp pain when eggs are collected where a needle punctures the ovaries, bleeding from the vagina one to two days after donation, sore ovaries for one or two days, nausea and not remembering the procedure due to sedatives and narcotic medication,

abdominal discomfort, and bleeding from the cervix (Fertility Associates, 2017). Other risks include respiratory depression, pelvic infection, internal bleeding, vaso-vagal reaction (i.e. causes the heart to slow, blood pressure to drop, and fainting), uterine infection, ectopic pregnancy, ovarian hyper-stimulation syndrome (OHSS) which can cause blood clots, stroke and death, ovarian torsion which could cause the loss of an ovary, and potential compromised future fertility (Fertility Associates, 2017). The list of possible side effects and risks is extensive, therefore, understanding donors' experience of this process is important to understand how better care can be provided and why women would be prepared to go through this procedure to donate.

Psychosocial aspects of donation – pre-treatment and ongoing counselling

The Australian and New Zealand Infertility Counsellors' Association (ANZICA, 2018) outlines the counselling guidelines involved in egg donation. It is mandatory for all donors and recipients, as well as their respective partners (if applicable) to attend pre-treatment counselling. NHRMC guidelines require clinics to provide readily accessible counselling services to support participants' decision-making process before, during and after ED procedures. Pre-treatment counselling includes both decision-making and implications counselling, where: chosen recipients, motivations, donors' feelings about non-genetic parenting, risks and benefits of ED, short and long-term consequences for all parties (including potential adverse outcomes), expectations of all parties regarding the relationship with the DCC, exploration of disclosure (to the DCC and to others), DCC's potential interest in contact with the donor and relevant legislation are outlined and explored. Supportive, crisis and therapeutic counselling are also available on an ongoing basis. Donors are required to have at least one individual counselling session, as well as a joint counselling session with recipients before providing signed informed consent. Further sessions are available as needed by the donor or recipient party or at the discretion of the counsellor if issues arise. Time between counselling and signing consent forms is also recommended to facilitate considering all the issues and longer-term implications of donation (ANZICA, 2018).

Factors Contributing to a Positive Donation Experience

In terms of the experience of donation, Bracewell-Milnes et al.'s (2016) systematic review identified that the overall experience of donation was positive for most donors (i.e. both known and anonymous oocyte donors, and whether or not the donation successfully resulted in a child). Most stated that they experienced being able to help as the most rewarding aspect of donation. The findings indicate that overall, the entire process of donation was well tolerated, confirming previous research (e.g. Purewal & van den Akker, 2009a; Winter & Daniluk, 2004; Yee et al. 2011). Known donors indicate they were 'highly satisfied' with both the emotional and physical treatment they received, more so than unknown donors (Bracewell-Milnes et al., 2016; Byrd et al., 2002; Yee et al., 2007). Pre-treatment counselling was experienced by known donors as 'thorough and invaluable' (p. 460) in facilitating preparation for the treatment process and navigating disclosure decisions (Bracewell-Milnes et al., 2016; Winter & Daniluk, 2004; Yee et al., 2007).

Donors in spousal relationships emphasized the vital role their partners played in the donation process in providing practical support and supporting their decision to donate (Yee et al. 2011). Although intra-familial donation may have an emotional impact on family members due to the relationship ties, donors report neutral or positive influences on their decision to donate and support from family members. Donors reported that friends, colleagues and acquaintances showed high levels of support and praise for their decision to donate, as well as personal support (Yee et al. 2011). A strong relationship with the recipient in known donation scenarios facilitated a positive emotional journey (Yee et al. 2011). The majority of donors were satisfied with the medical and emotional care provided, with mandatory pre-treatment counselling described as invaluable in preparation for treatment and making decisions about future disclosure and contact arrangements (Bracewell-Milnes et al. 2016).

Factors Contributing to a Distressing/Challenging Donation Experience

Known donors reported that although the process of donation was manageable, it was painful and stressful (Byrd et al., 2002; Purewal & van den Akker, 2009). The most notable factors contributing to a challenging experience were the practical inconveniences of donation (e.g. number of visits to the clinic, time commitment, and long traveling distances to fertility centres) (Bracewell-Milnes et al. 2016; Purewal & van den Akker, 2009a; Winter & Daniluk, 2004). In Winter & Daniluk's (2004) study, one known donor who donated to her sister had significant support from her partner, described the practical inconveniences of ED as having a significant impact on their family. Research indicates failed treatment cycles may have a significant psychological impact, particularly if the recipient was a sister or close friend (Bracewell-Milnes et al., 2016; Wyverkens et al., 2015). Research also found that women can feel unappreciated and like a 'commodity' at the end of donation due to cold, impersonal medical staff (Kalfoglou & Gittelsohn, 2000; Purewal & van den Akker, 2009; Winter & Daniluk, 2004). Bracewell-Milnes et al. (2016) report that although the vast majority of anonymous/volunteer donors found donation a positive experience, and felt supported by clinical staff, some reported that they held a desire to contact the DCC, but were unable to, which caused some anxiety.

Concerns when donation was successful/unsuccessful – known donors

Known donors held various concerns when donation was unsuccessful. Winter and Daniluk (2004) report that known donors found themselves 'tremendously invested' in the outcome of the donation. This strong investment triggered various emotional reactions. Known donors felt they had to hide their distress and concerns around failed cycles from their recipients to avoid burdening them. Others reported anxiety and shared the fears and emotional devastation of their recipients. When donation was successful and the recipient was a sister, donors feared they may share similarities with the donor-conceived child, and that this may impact their sibling relationship (Winter & Daniluk, 2004).

Concerns when donation was successful – anonymous donors

Concerns were also present when donations were to an unknown recipient. While most donors reported feeling comfortable with the anonymity of donation (Platts et al., 2019), some donors expressed longer term anxiety about a lack of knowledge about the DCC resulting from their donation (Kenney & McGowan, 2010; Purewal & van den Akker, 2009) and reported a desire to know more about the recipient couple. This was to ensure their recipients would be ‘good parents’, to avoid consanguine relationships between their children, know more about the use and storage of their oocytes, and prepare for possible future contact from offspring. This is supported by follow up research which suggests that knowledge about the donor-conceived offspring and their welfare, may be important concerns for donors (Graham et al., 2016; Isaksson et al. 2014; Kirkman, 2003; Kirkman et al. 2014).

Unknown donation outcomes for donors

Kalfoglou and Geller (2000) explored donors’ experiences, knowledge and attitudes about the use of their oocytes and the outcome of donation. Twenty-two women donated anonymously (i.e. no information about the recipients), three donated to friends, four met their recipient via the internet and one through the clinic. The researchers found that anonymous donors did not receive full disclosure about the use and storage of their oocytes and seventy-six percent were not informed about whether a pregnancy had occurred. This lack of knowledge has implications for recruitment. Platts et al. (2019) explored the psychosocial aspects (e.g. attitudes, motivations, and any issues surrounding donor disclosure and anonymity) of potential oocyte donors and found that despite a lack of general knowledge around ED, most had a generally positive attitude towards oocyte donation, confirming previous research (e.g. Purewal & van den Akker, 2009b).

The current inquiry explored factors influencing the recruitment of donors. Disclosure of all relevant information to donors may improve the acceptability of oocyte donation and willingness of women to participate, ultimately improving recruitment numbers (Kalfoglou & Geller, 2000). Byrd et al. (2002) suggest

providing education and encouragement for women to come forward and help each other and increasing the age limit from 35 to 37 could be a start. However, research suggests that advanced donors' age (35-49 years of age) was associated with lower pregnancy and live delivery rates per embryo transfer (Wang, Farquhar & Sullivan, 2012). Gezinski et al. (2016) suggest information should be tailored differently for different groups. For example, mothers with lower education may need more substantive information than those that have the capability and take the initiative to do their own research to ensure they are not exploited.

Disclosure – donor-conceived children and the donor's 'own' family

In New Zealand, disclosure of the child's conception story is encouraged but not mandatory. This can be seen as contradicting the policies prohibiting anonymous donation in NZ (e.g. HART Act 2004). Given that donors consent to releasing their identifying information when the child reaches the age of sixteen-to-eighteen, the current inquiry explored donors views, concerns and experiences about disclosure and non-disclosure.

While research highlights the importance of disclosing information about conception to donor-conceived peoples to promote their psychological wellbeing and sense of identity (Baccino, Salvadores & Hernandez, 2014; Kelly & Dempsey, 2016; Nordqvist, 2014), in some jurisdictions anonymous donation is permissible, thus restricting the information recipients may share with their offspring even if they choose to disclose. Even in open identity contexts, whether or not disclosure occurs rests in the hands of the recipients who are the legal parents of the child, and who may choose not to disclose. In the case of known or personal donors, disclosure and information-exchange may be more likely to occur than when previously-unknown donors (such as those recruited through the clinics or through advertising) are used, particularly if the recipient is a family member or close friend (Van Berkel, Candido & Pijffers, 2007).

While a small number of jurisdictions which support open identity practices, such as Victoria in Australia, have added annotations to birth certificates to ensure that

offspring will have access to knowledge about their conception and genetic heritage, New Zealand falls short of such practices. Here the Human Assisted Reproductive Technology (HART) Act 2004 recognises the rights of offspring to have access to their genetic information and has as one of its principles that offspring should be made aware of their genetic heritage, but this is not enforceable. While the parents' disclosure is encouraged by counsellors prior to donation (Sutherland & Postlewaight, 2011), donors have no control over disclosure. Although in cases of donations to unknown recipients they may request information from the fertility clinic about the number of children conceived. A rise in genetic testing agencies (e.g. 23andME and ancestry.com) may compromise anonymity, should the recipients choose not to disclose to the child.

Reasons for disclosure

Bracewell-Milnes et al.'s (2016) systematic review explored the psychosocial aspects (e.g. attitudes towards ED, experiences of ED, motivations and disclosure) of oocyte donation for egg donors, recipients and egg-sharers. They found that the majority of recipients intended to disclose donor conception information to the DCC during childhood (Baccino, Salvadores & Hernandez, 2014; Bracewell-Milnes et al., 2016), while one third did not intend to disclose (Bracewell-Milnes et al., 2016). Recipients intending to disclose believed the DCC should know the truth about their conception (e.g. genetic origins). They also valued maintaining a healthy parent-child relationship that was open and honest (Baccino, Salvadores & Hernandez, 2014). Open lines of communication about donor conception from an early age, rather than their conception story being revealed at an older age, is considered the most beneficial method for disclosure for parents (Baccino, Salvadores & Hernandez, 2014; Nordqvist, 2014; Yee et al. 2011).

Reasons for non-disclosure

Applegarth et al. (2016) and van Berkel (2007) found recipients that did intend to disclose postponed sharing their conception story for various reasons. Secrecy was kept to protect the child from experiencing an 'identity-crisis' or 'misery' around the truth of their conception, for cultural reasons, embarrassment and shame

around their infertility, and a concern the child would not be accepted by the wider family. Secrecy was also a way to avert existing anxieties and ambivalence about telling the child the truth (van Berkel et al., 2007). Recipients also chose not to disclose to minimize the perceived role of the donor, especially if their perspective shifts from gratitude to fear and resentment toward the donor. Non-disclosure can be a risk where the recipient has confided in other close family or friends as sudden inadvertent disclosure may occur, which could result in an emotional crisis for the child (Graham et al. 2016).

Issues for donors when recipients disclose

Yee et al. (2007) conducted a study in Canada to understand the views of altruistic known donors and recipients regarding disclosure to donor-conceived offspring and the donors own children. They found that the majority of recipients and donors were in concordance regarding disclosure, particularly when a child resulted from the donation (Bracewell-Milnes et al. 2016; Yee et al. 2007).

The research suggests donors take varied approaches to tell their own children (usually conceived before the time of donation) about their donation. Some start discussing it from a young age, using the ‘seed-planting’ strategy and others the ‘helper’ story, (e.g. where the donor is referred to as a ‘helper’ to aid the recipient to have a baby), to avoid any sudden shock (Van Berkel, Candido & Pijffers, 2007; Yee et al. 2011), however, some donors waited until the recipient had told the DCC (Yee et al. 2011). Ultimately, donors wanted to tell their own children before they found out via another route, particularly when they had disclosed to friends and family (Baccino, Salvadores & Hernandez, 2014; Nordqvist, 2014; Yee et al., 2007). In known donation circumstances, negotiation of disclosure decisions (e.g. timing and ways of sharing information) occurred over a period of time. Both parties found deciding an appropriate age difficult (Yee et al., 2007). A small minority of donors, however, had no preference for disclosure or non-disclosure and left this to the recipient (Yee et al. 2011).

Impact of non-disclosure on donors

Non-disclosure by recipients may have implications for egg donors. Making a disclosure plan with recipients of how to tell the DCC and the donor's own children was described by donors as 'somewhat difficult' or 'very difficult'. Research indicates that donors' may conform by not telling their own children if the recipient chooses not to disclose to the donor offspring (Yee et al. 2007). Yee et al. (2007) and Yee et al. (2011) found that secrecy may limit communication, add pressure to those keeping the secret, and cause stress in the family unit. For example, one donor described non-disclosure as equivalent to 'pretending' and admitted this caused tension (Yee et al., 2011).

Research suggests that disclosure and non-disclosure may impact the DCC at different ages and stages. Golombok et al. (2013) compared the psychological adjustment of children conceived through egg donation with children conceived through surrogacy at ages 3, 7 and 10. They found that mothers showed elevated levels of distress if they had not disclosed to the child. However, this maternal distress had a more adverse effect on children who were informed of their conception. The findings also suggest that biological relatedness is not essential for positive child adjustment as the absence of a gestational connection to the mother (e.g. surrogacy) appears to be more problematic for children than the absence of a genetic link (e.g. those conceived through ED) (Golombok et al. 2013). Research indicates that the quality of the parent-child relationship is significantly more important than genetic relatedness (Freeman, 2015). However, more recent research suggests that the absence of a genetic link between mothers and their children may have an adverse effect on mother-adolescent relationships than the absence of a gestational link when the child reaches fourteen years of age (Golombok, Ilioli, Blake, Roman & Jadva, 2017). Research suggests that disclosure may affect family dynamics in both the donor's and the DCC's family (Yee et al., 2007).

Donors may or may not choose to disclose to others about their role as an egg donor. Jadva et al. (2016) found that culture may be a restricting factor, as half of

the Indian egg donors in the study chose not to disclose to wider family due to a cultural belief that egg donation is equivalent to ‘selling’ a baby. Negative societal attitudes were also apparent, restricting their willingness to share (Culley & Hudson, 2009; Jadva et al. 2016). Yee et al. (2011) also found that donors avoided disclosing to individuals with strong religious views, where unfavourable reactions were likely.

Contact Between the Donor and the Recipient and Donor-conceived Offspring

Bracewell-Milnes et al. (2016) report that seventy-six per cent of volunteer donors were positive about future contact with adult offspring. However, Isaksson et al. (2014) found that fourteen per cent of donors were negative toward, or did not want future contact with the DCC. Some donors are invested in knowing about the offspring and would like contact, not necessarily for themselves, but for their children (Isaksson et al. 2014; Jadva et al. 2011; Jadva et al. 2016; Kalfoglou & Geller, 2000; Nelson & Hertz, 2017). Research indicates the level of contact between donors and donor-conceived offspring is partly dependent on the conditions of donation, e.g. known versus unknown, open versus anonymous (Purewal & van den Akker, 2009). For example, Jadva et al. (2015) in India, and Isaksson et al. (2014) report that a number of unknown or volunteer donors may not be open to contact, or prefer to have limited contact with the offspring. Further, even where donors support contact, most tend to believe that the offspring should initiate contact (Bracewell-Milnes et al. 2016; Kirkman, 2003; Kirkman et al. 2014; Isaksson et al. 2014; Sutherland & Postlewaigh, 2011).

Research indicates that many donors, even those who did not want future contact, held the child’s best interest at heart (Isaksson et al., 2014; Jadva et al., 2016; Kalfoglou & Geller, 2000; Purewal & van den Akker, 2009). One sperm donor declared that he hoped the child would be happy in his own family and would not desire contact with him. However, others identified the importance of genetic origin for the child stating if the child made contact in the future that she would “take it as it comes, with great sensitivity and rely on your gut feeling” (Isaksson et al., 2014, p. 1163). Some wanted to know more about the offspring and their

recipient families to be sure the DCC was well taken care of (Purewal & Van den Akker, 2009). These conflicting findings indicate that donors desires for contact varied, however, the majority of donors held concerns for the welfare of the child.

In the UK, identity-release donors are requested to complete a pen portrait and good-will message for donor-conceived children to access at the age of majority. Graham et al. (2016) found that donors who chose not to complete this task feared this would make them a ‘person’ as opposed to ‘just an egg’, placing too much significance on their role. Donors believed the letter could be hard for recipients to see and add to their stress and frustration around their infertility or cause the child to question who their ‘real’ mother is. Donors also worried the child may want future contact and that this could negatively impact their own families. However, donors believed it was their responsibility to be available for any questions the offspring may have in the future (Graham et al. 2016; Yee et al. 2011).

Where contact occurs this may be complex with challenges in terms of how the donor, recipients, and children regard the donor and her role in relation to the family (Kirkman, 2003). Kirkman (2003) for example, reports that those that donated to a close, known recipient may position themselves as in an Aunty-niece/nephew relationship with offspring (particularly when the recipient was a sister), where they love and are close with the child, although they are clear that this love did not equate to maternal feelings. Donors consistently differentiated the love they had for the donor-conceived child to the love they had for their ‘own children’, while highlighting the gestation period as key in forming maternal feelings for the child (Kirkman, 2003; Winter & Daniluk, 2004). Similar experiences have been described by volunteer (or previously unknown) donors, but with a greater feeling of distance from the donor offspring and not necessarily expectations or desires of having contact (Bracewell-Milnes et al., 2016). Nelson and Hertz (2017) found that oocyte donors perceive their role differently from that of sperm donors. For example, while sperm donors tend to view themselves as fathers of their offspring, women do not view themselves as mothers. Egg donors in this study experienced feelings of ‘concerned responsibility’ for the donor

offspring, while men created a sense of 'prideful lineage'. However, for those in open contexts that have been reported to have minimal to no contact, until this was sought by the adult offspring, there appeared to be fears related to crossing the line from 'unattached' to 'attached emotionally' (Kirkman, 2003).

Indeed, some researchers have pointed to the potential for significant challenges to be experienced in terms of attachment relationships, negotiating roles and responsibilities where there is contact, and how these may affect the wider family units of both the donors and the recipients (Daniels, Kramer & Perez-y-Perez, 2012). Daniels et al. (2012) found that although all sperm and oocyte donors were open and willing to have future contact with the offspring, there were issues and implications for their families. For sperm donors with partners, three quarters were open for them to meet the offspring, however, many partners negotiated boundaries and limits to contact. Some did not want the donor to have contact, with one specifying that it would make herself and her daughter feel they are 'not enough'. Other concerns involved the impact contact may have on the family, and the 'unusual nature' of the donor offspring relationship. Two thirds of the donors' own children were interested in meeting their half-siblings and one third were not. For the donor, difficulty was experienced in balancing contact with the recipient and offspring and nurturing their own family relationships. This study identifies the complexity of future contact, as this not only affects the recipient, donor and offspring, but also the entire family of the donor (Daniels, Kramer & Perez-y-Perez, 2012). The longer-term implications of donation and how donors negotiate the ongoing challenges of information-exchange and contact remain unclear however.

Overall, it appears that ED produces multiple and ongoing relational implications for donors, DCC and families on both sides of the ED relationship. Support for this ongoing and potentially iterative process is important. Some jurisdictions, such as Victoria in Australia, have set up donor-linking services which facilitate gradual and graded contact between donors, recipients, offspring and their family members and provide counselling for all parties (VARTA, 2019). However, New Zealand falls short of these practices (Bracewell-Milnes et al. 2016). The age of

majority for children born under the legislation of the 2004 HART Act is coming up in 2022, therefore, there may be more of these issues arising in New Zealand.

Support Needs

A wide range of research indicates a need for more psychological support in the process of ARTs, in particular, for third party assisted procedures, for all parties involved (Bracewell-Milnes et al. 2016; Cousineau & Domar, 2007; Isaksson, Sydsjo, Skoog Svanberg & Lampic, 2014; Maroufizadeh et al. 2015; Platts et al. 2019; Winter & Daniluk, 2004; Wyverkens, Parys & Buysse, 2015; Yee, Hitkari & Greenblatt, 2007).

A lack of support past pre-treatment counselling is reported in the research (Bracewell-Milnes et al. 2016; Winter & Daniluk, 2004; Wyverkens et al. 2015). Given the significant short term psychological impact on donors (e.g. anxiety and distress in response to donating to someone known and failed treatment cycles), and long term impact (anxiety about future contact and concerns for DCC and their wellbeing), ongoing support is needed for both successful and unsuccessful donations (Acharya et al. 2017; Isaksson et al. 2014; Jadva et al. 2011; Purewal & van den Akker, 2009a; Van den Akker, 2006; Winter & Daniluk, 2004; Yee et al. 2007; Yee et al. 2011). Specifically, support on how to navigate their emotions during the pregnancy and how to tell their own children about their donation (Winter & Daniluk, 2004). Applegarth et al. (2016) suggest support is also needed for recipients to encourage and navigate disclosure after the birth of the child. Donors also discussed the importance of ongoing counselling prior, during, and after contact between donor and offspring takes place (Isaksson et al. 2014; Winter & Daniluk, 2004). Support from counsellors or psychologists specialising with families that have a knowledge of gamete donation may be beneficial not only for the recipient, donor and offspring, but also the donor's family (Daniels et al. 2012; Isaksson et al. 2014 Scheib, Ruby & Benward, 2017).

Feminist perspectives on ED

Feminist perspectives on ART in general and ED in particular have emerged recently, but have not always converged. Feminist scholars suggest ARTs in Neoliberal contexts, such as America, where third-party reproduction is not regulated (Mamo, 2010), shifts responsibility for delayed and declining child-bearing rates from the state to the individual. Mamo (2010) and Mahjouri (2004) suggest it is this individualization of a social problem which has led to commodification of the maternal body (Mamo, 2004), where the exploitation of women's bodies and reproductive parts are encouraged (Leve, 2013). ARTs are also seen as further twining women to patriarchal biogenetic aspects of motherhood (Mahjouri, 2004; Mamo, 2010). Curtis (2010) argues it is, in fact, the way in which the fertility industry frames ED as 'giving the gift of life and motherhood' and employs altruism and empathic rhetoric in advertising to encourage donors to donate 'from the goodness of their hearts' which has led to the commodified maternal body (Mahjouri, 2004). He suggests women may be taken for granted by giving this gift, where nothing is received in return, as 'true' altruism involves a strong element of self-sacrifice. Curtis (2010) also argues that advertising an exploitative procedure such as ED (Shaw, 2007), in such a way, reinforces gendered assumptions of labour, which assumes women are responsible for nurturing and caregiving (Curtis, 2010; Gal & Kligman, 2000). Gupta and Richters (2008) argue ARTs, such as ED, break down women's maternal bodies into their component reproductive parts and uses them to make profit within patriarchal capitalism, positioning women as child-bearing machines.

However, Waldby & Cooper (2008) suggest ARTs can be liberating when understood from a labour within biocapitalism perspective, which does not reiterate notions of women as self-sacrificing or deny their rights. Instead, egg donors can be seen as "savvy participants of the Neoliberal economy where citizenship is equated with buying power" (as cited in Leve, 2013, p. 278). This is seen as a way for women to capitalize on their maternal reproductive bodies and to participate in a 'mans' world of the marketplace and medicine.

This Inquiry

Bracewell-Milnes et al., in their 2016 review, specifically call for further studies exploring the psychosocial issues surrounding donation by different donor groups. Schieb et al. (2017) similarly suggest that more research is needed in order to understand donors' experiences and thus how best to prepare and support them psychologically. This relates directly to Counselling Psychology practise which aims to support individuals to explore challenging experiences and understand why they do the things they do. Counselling Psychology can help to consider ED from a holistic perspective that considers the impact of donation on the donor and all the parties that may be affected – donors, recipients, offspring and both their children and wider family networks. Counselling Psychology can also help understand that individuals may need support in the lead up to, during, and post-donation experiences (Farrell, 2013; Stanley, 2013). The New Zealand context of donation differs from many other jurisdictions in terms of its emphasis on open identity donation and altruistic donation, which further underscores the need to explore both donor motivations and experiences in this country. This research may thus help inform policy and practice with regards to donor recruitment, preparation, and support.

Study Aims

The current inquiry aimed to:

- Identify some of the discourses surrounding ED in New Zealand;
- investigate how these discourses construct or 'frame' ED and make possible/available various subject positions for women to take up or have imposed on them
- investigate the implications of these discourses and subject positions for women's experiences, wellbeing and support needs
- investigate the implications of these discourses and subject positions for clinic practices and policies.

METHODOLOGICAL UNDERPINNINGS AND METHODS

“Believing that... man is an animal suspended in webs of significance he himself has spun, I take culture to be those webs, and the analysis of it to be therefore not an experimental science in search of law but an interpretive one in search of meaning (Geertz, 1973, p. 5).

Conducting qualitative research is about immersing oneself in a particular scene and making sense of it (Tracy, 2019). Qualitative research aims to understand social theories that are constructed by “ever-changing, biased, and contextualized social conditions of their production” by understanding the rich contextual stories from those within the particular social context being studied. The researcher serves as a research instrument in mind and body by bringing their own subjectivity (background, values, and beliefs) into each stage of the research process, whilst practicing self-reflexivity. Being self-reflexive involves fostering an awareness and being thoughtful about this background and its influence on the way research is approached and conducted. A qualitative research approach claims that meaning cannot be separated from thick contextual descriptions. Therefore, this approach will facilitate providing ‘thick descriptions’ of egg donors’ experiences where conclusions are drawn from small, but ‘densely textured facts’ rooted in the participants’ particular culture, their construction of collective life, as well as the complex specifics of their experiences (Tracy, 2019). As opposed to quantitative research which focuses on statistics, Tracy (2019) states qualitative research is suitable for “richly describing a scene, or for understanding the stories people use to narrate their lives” (p. 6). In the context of understanding the experiences and motivations of egg donors, qualitative research is the most suitable approach. Post-structural feminist discourse analysis feeds further into these ideas of individuals as complex entities and the importance of culture in terms of context to drive in-depth data analysis.

Poststructural feminism

Feminism is a politics directed at changing power relations between men and women by achieving equality in all areas of life (e.g. the family, work, education, welfare, and politics). Feminist ideology was inspired by the ideas of Enlightenment and the French Revolution in the 18th century, where the traditional subjection of women was challenged and cries for liberty, equality, and fraternity surfaced (Grimshaw, 2013). In the 19th and 20th century, Kate Sheppard pioneered the women’s suffrage

movement, which advocated for women's rights by challenging the "sphere" given to women, which constrained them to speak and act inside the realm of femininity (Brewerton, 2018). The Women's Liberation Movement began in the 1960s, which involved considering what is enabled and constrained for women in terms of sexuality and femininity, and how to redefine these aspects of being woman (Weedon, 1987). Poststructuralism builds on the insights of structuralism which identifies patterns in social arrangements, most commonly language. However, poststructuralism holds all meaning to be fluid as opposed to there being one objective truth that is universal and predictable (Barker, 2010).

Poststructuralism and feminism are two significantly influential political and cultural movements of the late twentieth century (Weedon, 1987). The current inquiry is positioned within feminist poststructuralism and draws on key concepts developed by the philosopher Michel Foucault.

Poststructural feminist writers aim to analyse data by exploring the complexity of power relations that construct the identities and social practices of women. They explore theory and research in terms of how they reveal assumptions about the options for living and being currently available for women, by paying close attention to the historical contexts of discourses, subjectivities and power relations (Gavey, 1989). Current subjectivities enforced by social regimes are questioned by identifying and challenging assumptions that underlie the way we live, thus enhancing awareness for living differently (Allen, 2008; Gavey, 1989; Gavey, 2005). Therefore, further possibilities can be identified and created for women (Butler, 1990; Gavey, 2011; Weedon, 1987).

Feminist work portrays a frustration with the diagnostic approach to our present knowledge and practices (in Foucault's earlier work), which seems to constrain facilitating change (Weedon, 1987). However, later works by Foucault engage with the possibilities that exist in terms of self-transformation (e.g. Foucault, 1983, 2010). Amy Allan is a poststructural feminist writer drawn on in the current inquiry that has engaged with Foucault's later work in a way that is open and responsive to a poststructural feminist take on research inquiry.

Although the convergence between feminist and Foucauldian theories has been debated (e.g. Alcoff, 1988; McNay, 1992, 2010), particular overlaps suggest the suitability of integrating these philosophical approaches and associated analytic methods. For example, both Foucauldian and feminist writers value Foucault's theories of discourse and power and the implications of these for agency and political action. In the following subsections, the key aspects of Foucauldian Discourse Analysis (FDA) that are taken up by poststructural feminists and specifically in this study will be outlined. Discourses, subjectivity and power will be discussed with reference to the multiple kinds of selves which may be enabled or constrained for egg donors in New Zealand.

The current study aims to explore what it is like to be positioned or position oneself as an egg donor, and what kind of actions and experiences are compatible with such positionings. Unlike discursive psychology, which is concerned with interpersonal interactions and communication, poststructural feminism's interest in language goes beyond the immediate context in which language is used and explores the relationship between discourse and subjectivity, practices and the material conditions within which these experiences occur (Willig, 2010). Adopting a poststructural feminist lens allows us to critically reflect on the positionings made available through discourse for egg donors, as well as how power works to enable or constrain their possibilities for living and being in the world.

Discourse

Foucault (1972) defines discourses as “practices that systematically form the objects of which they speak” (p. 49). Discourses enable objects, practices, entities or phenomena to be conceived of, enacted and discussed in the world at a particular point in time. Foucault's teaching of discourse has been interpreted as composing objects, and interpreting events and phenomena in a particular way (Kendall & Wickham, 1999; McNay, 1994; Stevenson, 2014). Discourses are not about objects and they do not identify objects, instead discourses “constitute them and in the practice of doing so conceal their own invention” (Foucault, 1972, p. 49). Discourses make things happen and inspire the things that people do, they do not just form social meaning. Discourses are composed of: attitudes, beliefs, ideas, courses of action, and practices (Fadyl et al. 2013). For example, our current understanding of ‘health’ tends

to be constructed in a Western biomedical discourse, which explains health as related to biology.

In the current inquiry, eggs, ED, and donor-conceived children are objects of knowledge that are established and transformed through discourse. Discourses position female egg donors in various ways at different times according to different contexts, which enables and constrains certain opportunities for them and their wellbeing.

Subjects and the Notion of Subjectivity

Foucault (1972) describes discourse as a way of understanding and constructing our relationship to ourselves, our social relationships and the conceptual frameworks we have for understanding ourselves and others. Discourses construct what can be said, and thought, by whom, in different contexts, with what authority. For example, Foucault (1972) outlines that biomedical discourses construct various subject positions for ‘medical professionals’ and ‘patients’, which have certain implications for how these people are able to behave and speak. ‘Medical professionals’ are placed in a hierarchical position of power, with authority to make medical decisions impacting the health of the patient.

Foucault believed that the language used by individuals to describe or retell an experience is from an available framework of discursive understandings, located within a particular context or history (Mills, 1997). In society, many different discourses exist and operate alongside others, competing for dominance and power. A notable overlap exists between the Foucauldian concept of subjectivity and the poststructural feminist lens adopted in this study. Both hold that discourses construct available subject positions, structuring social spaces and playing a significant role in historical change (Stevenson, 2014).

The notion of subjectivity refers to the different ways in which we research ourselves in order to understand ourselves (Grant & Giddings, 2002). Our ‘selves’ are made up of multiple subjects positions that are always available for us to take up or disregard made available by discourse, but power relations influence which ones we are encouraged or able to take up and when (Gavey, 1989; Kendall & Wickham, 1999;

Weedon, 1987). This affects what is possible in our lives in terms of where we choose, or are pushed to position ourselves in the world. Our position in the world is not always autonomous, as subjects are active in positioning themselves as subjected to power (Kendall & Wickham, 1999). For example, when looking at cultural perspectives of infertility, South Asian communities exhibit stigma around childlessness for females and married couples. Therefore, power in these communities may position women as ‘incapable’ or ‘abnormal’, influencing their place within this culture. Power then works to enable or limit certain opportunities for women in this position.

Within these restraints, individuals take up and act out many different subject positions. For example, an individual may be a mother, a wife, an egg donor, a gambler, a student, a business women, etc. There are thus multiple subject positions available for any one individual. As individuals we are constructed by these different subject positions in relation to different contexts or relationships by descriptions that give experiences meaning. There is no unitary self that remains the same in different contexts at all times but rather, contradictory discourses which shape us (Pinkus, 1996; Semp, 2006). In exploring egg donors’ motivations to donate and their experiences of donation, various and contesting subject positions may be identified as they are constructed by discourse in relation to power.

Foucauldian concepts have much to offer in that they may draw attention to the discourses that construct and shape our experiences and practice, while offering an analysis of the social, cultural and historical issues related to these (Goedeke, 2014). This approach is particularly suited to the current inquiry which aims to understand the complexity of women’s motivations to donate and their experiences of ED in how they and others construct ED through language and practice (e.g. clinic practices). This layered analysis approach provides the opportunity to gain in-depth understandings of ED, in the New Zealand context, where research is limited and predominantly quantitative.

Power/Knowledge

In a Foucauldian approach to discourse analysis (DA), discourses and discursive practices are suggested to have regulated our knowledge of the world, made it difficult to think outside of these constructions, and shaped our social practices historically (Allen, 2013; Burr, 2003; Gavey, 1989; Goedeke, 2014; Pauw, 2009; Weedon, 1987). Foucault believed that knowledge and/or dominant constructions of the world prevailing at any one particular time are intrinsically linked or tied to power. For Foucault, knowledge is so closely tied to power that they are seen as inseparable. Foucault wrote of a knowledge-power nexus or couplet (*pouvoir-savoir*), meaning that the ways in which we are able to make sense of something discursively, influences how we are able to act in the world (Burr, 2003; Foucault, 1972; Kendall & Wickham, 1999). Poststructural feminists perceive power as not necessarily repressive, but productive (Weedon, 1987), referred to as ‘energy sources’ that ‘keep things going’ (Kendall & Wickam, 1999). Power relations are described as what connects the visible and the sayable (i.e. the two poles of knowledge). Power is a process, not a ‘thing’.

Burr (2003) reflects on the concept of power by arguing that what we call knowledge are the constructions of phenomena that have received a ‘stamp of approval’, and are therefore considered truth in our society. This societal knowledge influences what is possible to say or do. Power is located in a web of relationships between discourses, implicated in social structures and institutional practices (Burkitt, 1999; McHoul & Grace, 1997). In other words, Hook (2001) describes discourses as something that is “both constituted by, and ensures the reproduction of, the social system” (p. 522). Foucault describes “disciplinary power” as an external mechanism of discourse, which are sanctioned or embedded in institutions and social practices. Bentham’s description of the panopticon illustrates how the power of surveillance in prison operates to achieve social control. The panopticon refers to the architectural concept of a circular-shaped prison which enabled the separation of prisoners whilst maintaining continual surveillance of prisoners by prison guards (Payne, 2002). The panopticon served as an alternative to using force to control prisoners and achieve social control, as its architectural design made it apparent to prisoners that they were under constant surveillance. As a result, prisoners would comply and self-regulate

with the expected norms. Foucault states that various forms of practice in contemporary society can operate as similar to the panopticon to cause individuals to control and regulate their own behaviour according to social standards (McHoul & Grace, 1997). This form of 'disciplinary power' managed and regulated difficult individuals by subjecting them to the scrutiny of others (Burr, 2003).

Goedeke (2014) highlights that Foucault's (1976) concept of biopower, of how the body, and in particular sexuality, became a site of power relations, is of particular interest in studies concerning third-party assisted reproduction:

At the heart of this economic and political problem of population was sex; it was necessary to analyse the birth rate, the age of marriage, the legitimate and illegitimate births, the precocity and frequency of sexual relations, the ways of making the fertile or sterile, the effects of unmarried life or of the prohibitions... Things went from ritual lamenting over the unfruitful debauchery of the rich, bachelors and libertines to a discourse in which the sexual conduct of the population was taken both as an object of analysis and a target of intervention" (as cited in Burr, 2003, p. 70).

Power is circulated through particular discourses which are given more dominance in society when taken up by the majority of individuals. Power operates through discourse to produce women in certain ways and not others. For example, in a historically restraining society, women would be constructed as the 'child-bearers', but not the 'bread-winners' (Appolis, 1998). This example demonstrates how power can also be constraining for women (Nicholls, 2008). While some have argued that resistance to such discourses is itself restricted, Arribas-Ayllon & Walkerdine (2008) state that the concept of power is not absolute, and the possibility of resistance and indeterminacy will always exist. Foucault describes the link between power and resistance, where dominant discourses are constantly under threat from alternative, contradictory discourses, which may challenge and ultimately dislodge them from their position as truth (Burr, 2003). Indeed, new and contrasting discourses in modern society may be identified which offer women more possibilities of being.

This inquiry identified how power works to produce certain subject positions as more dominant than others for egg donors. How resistance operated to produce contradictory discourses that challenged dominant discourses was also explored. Looking at these contrasting discourses made it possible to identify the positions and subjectivities enabled and constrained for egg donors in New Zealand.

Scope and research questions

The aim of this feminist post-structural analysis was to investigate the power relations that are part of the way discourse works to produce various subject positions for female egg donors in New Zealand. Exploring the way power operates to open up and constrain certain subjectivities for egg donors seeks to identify the multiple ‘truths’ of women’s experiences’ of ED. Examining how donors ‘frame’ ED and how this enables and constrains particular action possibilities and subject positions for women may have important implications for strategies aimed at improving their experiences and providing support. Revealing some of the assumptions that may enable or limit what is done for and by female egg donors in New Zealand, may allow us to identify and open up possibilities for women. These findings may inform current recruitment, clinic practices and policies in the New Zealand jurisdiction, which differs from those of many other countries.

Counselling Psychology Lens

This research approach has parallels to Counselling Psychology practise, which seeks to understand individuals by taking a holistic approach that includes considering their context and culture. Social context and culture are seen as ‘pillars of the self’, integral to understanding people’s experiences and directing therapeutic treatment. Identifying the multiple ‘truths’ made visible through discourse fits well with counselling psychology which discourages labelling (diagnosis) or generalisation of individual experience, in favour of an understanding of the individual as a complex entity and as shaped by their context.

Research Question

What are the discourses in play in relation to women as egg donors in New Zealand?

The following subsections describe the recruitment of participants, data collection and data analysis. I also consider ethical issues relevant to this study and research rigour.

Recruitment

In this study, donors were recruited through the fertility consumer support network FertilityNZ who advertised the study on their website and social media pages. The advertisement invited women who had donated eggs in New Zealand to another woman (either one previously known to them, such as family member or friend, or someone previously unknown, such as through a clinic) to share their views about their motivations for and experiences of donation. Egg donors interested in participating were asked to contact the project supervisor directly via email or telephone. Donors were given two weeks to respond to the advertisement. Donors that contacted the supervisor were thanked for their interest, and sent a copy of the Participant Information Sheet (PIS) (see appendix B) which outlined the purpose of the study, the consent processes, ethical concerns, the interview process, and the risks and benefits of the study. The PIS outlined that interviews would be conducted by postgraduate students in Psychology. Donors were asked to read the Information Sheet and to make contact with any questions they had as a result, and to confirm their interest in participating.

Qualitative research is not driven by the quantity of data collected, but the quality and depth (Holloway, 1997; Kvale, 2008). In poststructural research, it is believed that data saturation is not possible, as it is impossible to have access to the totality of discourse. Ten participants were recruited in order to gain access to a range of glimmers of discourse, as it is possible for a range of discourses to be drawn on by a few people.

The Participant Information Sheet (PIS)

Once participants had confirmed their interest, their contact details were then passed on with permission to myself to schedule interview appointments either by phone or email. In this process I reiterated the aims of the study and invited any concerns or questions before requesting to set up an interview time. A time and place convenient to the participant was then arranged accordingly. Participants could choose to be

interviewed either in their homes or at the AUT Akoranga North Shore campus, or, if they were located outside of Auckland, they could choose to be interviewed by phone or via skype.

All participants were required to provide signed consent prior to the interview commencement. The consent forms outlined that participants had the right to withdraw from the study at any point prior to, during and after the interview. Participants were asked to indicate if they would like a copy of the resulting research.

Participants

In the current inquiry, where the number of potential donors available for recruitment was small, I aimed to interview eight to ten English-speaking egg donors that had donated in New Zealand to either known or previously unknown recipients.

Six participants donated to recipients previously unknown to them and four participants donated to known recipients. As some participants donated more than once, in total the participants donated sixteen times, fourteen of which were successful (resulting in the birth of a child). Only one participant was single at the time of donation. One participant did not reach the transvaginal oocyte retrieval stage of donation, as the ovarian stimulation procedure had not resulted in a sufficient number of eggs to continue.

Donors varied in age from thirty to forty-eight years of age and were predominantly New Zealand European, however, two participants did not disclose their age and ethnicity. Donors were from across New Zealand (North and South Island).

Interviews

The interviews were conducted in an area or via an online application of the participant's choice in order to respect their autonomy (Hague & Mullender, 2005) and privacy, and ensure a safe, comfortable environment to discuss sensitive topics. Two participants chose to complete the interview face-to-face on campus at Auckland University of Technology. One participant elected to be interviewed face-to-face in her home, while the other participants completed the interview via online applications (e.g. Skype, Facetime, Zoom) from their homes.

Interviews were semi-structured, with a set of questions derived from the literature (See Appendix C for interview schedule), however, the interview began with a general question (e.g. “if we could start with what brought you to thinking about donating to your eggs and then if you could go on to tell me about your experience”) to allow the participant to direct the conversation. Opportunity was provided for the donor to direct the interview and discuss topics as they emerged. This approach fits well with counselling psychology practise, which is client-centred, and allows the client to direct the interaction (Stanley, 2013). Towards the end of the interview, the interviewer directed the participant back to topics that had not been discussed from the interview schedule. Topics discussed included their reasons/motivations for donation, experiences of the donation process in its entirety, expectations and experiences on an ongoing basis, experiences of disclosure of donation, reflections on donation, and potential advice to others.

Certain verbal skills such as open-ended questions, prompting questions, reflections, minimal verbal encouragers, as well as non-verbal skills (e.g. eye contact, body language, silences, and tone of voice) were utilised in the interview process to develop rapport, facilitate the interaction, and maintain the flow of the conversation (Hill, 2014). Rapport was established by approaching participants with warmth, respect, and empathy. Self-disclosure was used during introductions as well as asking the participant about themselves. Flexibility with the duration of the interviews was apparent to give participants an opportunity to share their experiences. Coming alongside each participant helped to explore different aspects of relevance, co-construct knowledge, and develop a greater insight into the donors’ experiences (Kvale, 2008).

The good response rate highlighted the investment from donors in sharing their motivations and experiences of ED, where interviews ranged in duration from one to one and a half hours.

Transcription

Oliver, Serovich and Mason (2005) describe interview transcription as an ‘object of study in its own right’ (p. 1273), meaning data analysis begins at the point of

transcription. Therefore, the author transcribed the interviews to familiarise herself with the data using a 'denaturalized transcription convention'. Main speech features such as 'um', 'pauses' or emotive indicators (e.g. laughter) were included to accurately transcribe the participants' language. Once transcription was completed, each transcript was sent to the corresponding participant for review. Transcripts were modified according to requests from participants.

Analysis

Foucault never outlined an actual method for analysing discourse, instead, he developed rules for identifying discursive formations and discourses (Stevenson, 2014). The data were analysed through the stages of discursive analysis as outlined by Willig (2010), Payne (2002) and Davies and Harre (1999). This involved careful reading of the texts with a view to identify the discourses that make certain subject positions available to egg donors and the power effects of these subject positions.

The first stage of data analysis outlined by Willig (2010), aimed to identify the ways in which discursive objects/practices were being constructed by participants. Transcripts were read and re-read to gain understanding of the data (Davies & Harre, 1999; Payne, 2002). Hardcopies were used to facilitate the move across and back from one transcript to another with ease. Then, the discursive objects/practices (e.g. eggs, ED, and donor-conceived offspring), were identified within the data. Close attention was paid to how women discussed these discursive objects/practices in order to identify the discourses constructing them. The first question during data analysis was therefore "what objects and practices are being spoken of here?" (Payne, 2002, p.49).

All instances of reference to these discursive objects were highlighted. Implicit as well as explicit references to these objects/practices were identified. Willig (2010) outlines that where a text does not contain direct reference to the discursive object/practice, this can tell us a lot about the way the object is constructed. For example, if a known donor talks about their relative's infertility without directly naming it, this may construct infertility as 'unspeakable' or 'emotionally challenging' and highlight stigma surrounding this experience. The excerpts extracted from the transcripts discussing discursive objects/practices were then organised, with all

excerpts on the same discursive topic collated in one place. Hardcopies were referred back to to avoid losing the context behind the excerpts (Payne, 2002).

The next stage outlined by Willig (2010) involves identifying discourses. This stage involved identifying the various constructions of the discursive object (Payne, 2002; Willig, 2010) – e.g. ‘how is this object/practice being spoken about here?’. Willig (2010) highlights how the same discursive object may be spoken of through varying discourses in the interview. For example, a woman speaking about the experience of her sister’s infertility may draw on a biomedical discourse (e.g. discussing ART options), a psychological discourse (e.g. discussing the psychological suffering associated with infertility), and a social/family discourse (e.g. discussing the way they donated their eggs to alleviate infertility). Therefore, the sister’s infertility is constructed in various, potentially competing, ways by one individual. During this stage it was important to identify not only how discursive objects/practices were constructed differently between the ten transcripts but also different constructions within individual transcripts. One strategy used in this step to identify differences was to put the various discourses beside each other and to investigate the different objects or practices they constitute. The second strategy was to put varying constructions of the same object/practice beside one another to look for how it was being constructed differently or similarly.

The third stage involved identifying the subject positions made available through discourse (Payne, 2002; Willig, 2010). A subject position provides a discursive location for individuals from which to speak and act in the world when taking up that repertoire (Davies and Harre, 1999; Willig, 2010). Discourses not only construct objects/practices but also subjects, making available positions within networks of meaning that speakers can take up or place others within. Taking up various subject positions may have direct implications for subjectivity. One technique adopted from Payne (2002) to identify the speaking positions, subjectivities or identities offered by discourse involved looking at how women talked about themselves and others involved in the donation process. Davies and Harre (1999) suggest extracting excerpts where speakers talk autobiographically to assist in identifying these positions. These excerpts may provide an understanding of how the speakers think of themselves and others.

The fourth stage involved investigating the relationship between discourse and practice (Willig, 2010). This step involved exploring the ways discursive constructions and subject positions may open up or close down particular action possibilities for women. Once various discourses had been identified, the question ‘what does this enable or constrain for women as egg donors’ in New Zealand’ was asked to tease apart the action possibilities for women. This stage allows us to understand what can be said and done from within particular discourses (Willig, 2010).

The fifth stage involved exploring the relationship between discourse and subjectivity. As Davies and Harre (1999) outline:

“Once having taken up a particular position as one’s own, a person inevitably sees the world from the vantage point of that position and in terms of the particular images, metaphors, storylines and concepts which are made relevant within the particular discursive practice in which they are positioned” (p. 35).

This involved investigating what the consequences of the subject positions are for the participants’ subjective experience. This stage is concerned with the implications this may have for female egg donors. The question; how do these subject positions enable or limit what can be thought, felt and experienced by donors was asked. This stage involved identifying which discourse/subject positions were most dominant in the data, what the power relationships between discourses are, and thinking about what this enables and constrains for women.

By following these integrated steps (Davies and Harre, 1999; Payne, 2002; Willig, 2010), a sense of the discourses in play in donors’ discussion of ED was gained to understand their experiences as egg donors in New Zealand. Understanding the implications for egg donors, as well as for policy and practice was important to produce in-depth findings.

Table 1: Questions and analytic stage

Key Questions	Analytic Stage
<ul style="list-style-type: none"> • What objects and practices are being spoken of here? • How is this discursive object constructed through language? 	Stage 1: Identifying discursive objects/practices
<ul style="list-style-type: none"> • How is this object/practice being spoken about here? • How is this discursive object/practice being constructed by discourse? • What discourses are drawn upon? • What is their relationship to one another? • How do these constructions relate or how do they differ? 	Stage 2: Identifying discursive constructions and discourses
<ul style="list-style-type: none"> • How do women talk about themselves and others involved in the donation process? • What subject positions are made available by the available discourses? 	Stage 3: Identifying subject positions
<ul style="list-style-type: none"> • What does this enable or constrain for women as egg donors? 	Stage 4: Positioning
<ul style="list-style-type: none"> • How do these subject positions enable or limit what can be thought, felt and experienced by donors? • Which subject position/discourses were most dominant in the data? 	Stage 5: Subjectivity
What role has the researcher played in the construction of discourses	Reflexivity and critical reflection

Ethical Considerations

As the study involved interviewing participants about their personal and potentially emotionally provoking experiences of ED, ethical approval was necessary from the

Auckland University of Technology Ethics Committee (AUTEK). Approval was granted May 2019 (AUTEK Reference number 19/148).

A range of ethical issues were relevant to the current inquiry and are outlined in the following subsections.

Informed Consent

Informed consent was addressed by providing all participants with a detailed Participant Information Sheet (PIS) after their initial response to the advertisement. The PIS clearly stated the aims and purpose of the study, the process and its duration, the potential risks and benefits, protection of privacy, contact details for the lead researcher (Dr Sonja Goedeke) for any further questions or concerns and the timeframe they had to consider the invitation to participate. The PIS explained that interviews would be conducted by postgraduate students. Once they had agreed to participate, with their permission, their details were passed on to myself to set up interview times. Prior to conducting the interview, participants were given (in-person interviews) or sent (interviews conducted via online applications) two consent forms (one for the researcher and a copy for the participant to retain) (see appendix A for consent form). These were signed before interviews commenced. Participants were invited to discuss further questions or any concerns before the consent form was signed and the interview process began.

Confidentiality

With small-scale qualitative research and given the small population of New Zealand, where a small minority may undergo third-party assisted reproduction, there is a chance participants may be recognised by those that know them in their stories. To respect the participants' right to privacy and to protect confidentiality, all identifying details were disguised in the transcripts. For example, participants were provided the opportunity to select a pseudonym by which they would be known in the research. Only one participant chose a pseudonym. The remaining participants were randomly assigned pseudonyms. I was responsible for transcribing all of the interviews, which were shared with the lead researcher (Dr Sonja Goedeke) only. This was made apparent to the participants during the consent process.

Throughout the transcription process, I was aware that participants, in sharing their stories, were also sharing the stories of their recipient families and the conception stories of the donor-conceived child. This was particularly relevant for donor-recipient parties where disclosure arrangements were not apparent. Therefore, to protect the privacy of the recipient families, any resulting offspring named in the interview process were disguised under the generic term Donor-conceived Child(ren) or DCC. This was to ensure the name or gender of the resulting offspring was not revealed in the data. Other names in the recipient families were disguised by assigned randomly selected pseudonyms.

Participation and right to withdraw

The participants were informed that participation in the study was voluntary and that they could withdraw from the study at any time (e.g. before, during, and up until data analysis completion). Participants did not have to justify their withdrawal from the study. However, no participants elected to withdraw. Those that requested research summaries will be sent a summary of the findings following the submission of this Practice Research Project in partial fulfilment of Masters of Counselling Psychology.

Participant vulnerability and risks

As participants were asked to discuss what could be potentially sensitive topics, there was potential for a level of discomfort. However, in New Zealand all donors have to undergo counselling prior to donating their eggs, so it is possible that many of the issues raised in the interview had already been previously discussed by the donors in counselling. Furthermore, I was mindful of managing any discomfort experienced. Prior to conducting the interview, I outlined that participants could choose to not answer certain questions and could withdraw at any stage, take a break or move on to the next topic. Through my training to be a Counselling Psychologist, I understand the importance of building rapport and expressing empathy and respect to create a safe space for participants to share (Holloway & Jefferson, 2004). I was aware that the donation process may be difficult for people to revisit during interviews, particularly where the donation was unsuccessful, where dynamics in relationships changed following donation, or where the recipient was known to the donor. Therefore, these skills were used to promote the participants' safety without crossing the contextual boundary from an interview to therapy. Finally, in the event that

participants experienced discomfort related to the research, FertilityNZ, had also agreed to provide additional support. This information was included in the PIS.

Researcher Safety

To ensure my safety, a researcher safety protocol was developed for interviews completed in participants' homes, which included contacting a friend before and after the interview.

Research Rigour

When conducting FDA, multiple methodological challenges are evident as FDA posits that there are multiple social realities constructed in language through discourse (Greckhamer & Cilesiz, 2014). The following subsections outline the challenges effecting research rigour and how research rigour was upheld in the current inquiry.

Credibility and coherence

The first challenge outlined by Greckhamer and Cilesiz (2014) "is conducting data analysis by applying frameworks that enable rigorous analyses informed by and coherent with the respective epistemological and theoretical assumptions underlying and guiding a study" (p. 425). As FDA aims to reveal multiple constructions of reality, it relies heavily on interpretation. Engaging in systematic and rigorous analysis and interpretation processes without conforming to approaches that standardize the process is important. This was achieved by combining frameworks from various researchers (e.g. Davies & Harre, 1999; Payne, 2002; Willig, 2010) to create a substantiated method by which to conduct analysis. I systematically detailed the process of analysis by outlining each stage to provide opportunity for the research as a whole to be scrutinized.

Avoiding over-interpretation of the data is also important to refrain from producing inaccurate findings (Grant & Hardy, 2003). This was achieved by including large amounts of excerpts from interviews, and providing verbatim examples. I also engaged in personal reflexivity, to remain awareness of the influence of my own background (Burr, 2003), and to enhance the rigour of this inquiry (detailed below).

I also followed the recommendations from Crossley (2000), that suggest to ensure the interpretations and arguments discussed stemmed from the data and were grounded in theory by rereading and checking these. Throughout data analysis, I reflected on and shared my analysis with my primary and secondary supervisors. I stated the limitations of the research and was cautious in claiming my findings as truthful in their entirety, as I was aware that in identifying discourses, I was contributing to, or creating discourses.

Representativeness

As qualitative research relies on a small number of participants, it is not as concerned with reliability as quantitative methods. However, where the aim of the study is to explore the experience of ED relevant to the population of the study's participants, the issue of representativeness must be considered (Willig, 2010). Once a particular experience is revealed, although we do not know how many others share that particular experience, our research highlights it is available within that particular culture (Willig, 2010). By interpreting the results and relating social constructions to discursive, social and institutional practices, these may be open to generalization (Willig, 2010). Due to the low uptake of ED in New Zealand, the findings may indicate a greater likelihood of the current study's representativeness.

Reflexivity

According to social constructionism, objectivity is impossible, as our world view is always 'from somewhere' (Haraway, 1991; Tracy, 2019) and we interpret phenomena from varying positions or subjectivities. Therefore, as researchers, we are unable to be entirely self-aware of our own biases and varying perspectives that may contaminate constructions. Consequently, not only the participant, but also the researcher are constrained by the culture in which she finds herself (Pauw, 2009; Tracy, 2019). Burr (2003) states that questions that arise in research stem from our own assumptions, and may shape research. Parker (1992) points out that to identify a discourse requires taking a certain position. Therefore, we must pay close attention to our intrinsic involvement in the research process and "consider the contribution of the researcher to the construction of meaning (reflexivity)" (Goedeke, 2014).

Willig (2010) outlines the two types of reflexivity:

1. Epistemological reflexivity – refers to the awareness of how the questions are asked and methods are utilised may contribute to particular constructions or understandings of the topic (Willig, 2010). I have addressed epistemological reflexivity by clearly outlining the methodological underpinnings and the methods adopted in the current inquiry. I also reflected on the challenges that arise when adopting a qualitative FDA approach to data analysis in the subsections above.
2. Personal reflexivity – requires the researcher to explicitly reflect on the role of his or her expectations, beliefs, values, interests, social identity, relevant personal and historical background and wider aims in life may have on the research, as well as how the research may have impacted her as the researcher (Willig, 2010). Coffey (2002) states to demonstrate personal reflexivity is to make the author’s position visible, consequently enhancing the credibility of the research.

Personal Reflexivity

To demonstrate personal reflexivity, it was integral to acknowledge my position as novice on the topic of ED, with no personal experience on the matter. Apart from the extensive reading I had done on ED, I had relatively limited knowledge. Therefore, my position was emphasised to the participants in that I hoped to learn more on the topic from the participants, positioning them as the ‘expert’ in the room through the interviews. This required maintaining a level of curiosity throughout the interview process and inquiring further about aspects I had little knowledge.

From this position, it may have been easier to refrain from personal biases, which may be stronger for an individual that had personally experienced infertility or participated in ARTs. However, building rapport and trust was more difficult where I could only imagine but not personally relate to the participants’ experiences. I aimed to allow the participant to direct the conversation to ensure the data produced was not contaminated by my own assumptions, although Burr (2003) states interviews are inevitably contaminated by human interaction. I reflected on each interview completion to maintain awareness of the role the researcher plays in co-constructing the data (Parker, 1999; Tracy, 2019).

It was also important to reflect on my position as a student, with mainly theoretical knowledge around psychology but little practical experience. My educational background, which was made evident from the outset in the PIS, may have made participants more comfortable to participate and share during interviews. I believe my background in Counselling Psychology helped to facilitate the research process, making me more conscious of and sensitive toward people's stories. My ability to build rapport and show empathy helped create the conditions for participants to share with me. However, in this particular context I was situated as a researcher, so maintaining boundaries to refrain from crossing over into a therapist role was important during interviews.

Conclusion

The aim of this chapter was to make explicit the methodological underpinnings adopted and the method followed in the research. I have outlined FDA and the poststructural feminist lens adopted and where these approaches converge. I have also outlined the data collection method and my approach to data analysis. I have discussed the ethical considerations that arose and the ways to increase rigour when adopting a qualitative approach, particularly FDA. In the next chapter, I analyse the discourses identified in the data collected, and subsequently the subject positions made available or constrained through discourse and the implications for egg donors.

FINDINGS

In this chapter, the data collected and transcribed from the interviews with donors are analysed. In the first section, discourses related to donors' constructions of eggs are identified. The next section focuses on the various discourses donors drew on to construct the donor-conceived child (DCC) and the subject positions made available by these discourses. The final section outlines egg donation (ED) as a discursive practice and the subject positions made available for donors by the discourses of ED. These positions are discussed in terms of how they affect donors' experiences of ED.

Discursive constructions of eggs

Data analysis identified a range of discourses drawn on by donors to construct their eggs in various ways. These discourses made available an 'unattached' subject position for donors which helped to enable their decision to donate. An 'unattached' subject position could be difficult/challenging to maintain in the context of competing discourses constructing eggs as personified or 'almost a baby'.

Eggs as physical resource

A dominant discourse donors drew on was a medical discourse which constructed eggs as a physical resource intended for achieving a pregnancy or a means to an end that was not valued or important in itself but was useful in achieving an aim. Some donors that drew on this discourse described their eggs as 'disembodied objects', which suggested they hold little meaning to the donor:

Bobby: Um it's just, a means for another person to have a baby.

Brianna: it's just the ingredient that someone needs to make a child.

Susan: So it really is just providing a piece of the puzzle for someone else to then actually, generate the puzzles themselves.

Rachel equated the value of her eggs to hair, which suggested that eggs are disposable, and reflected the little attachment she has for them:

Rachel: It's my DNA but as a, as a physical thing I see it as just another body part..., you cut your hair you're not going to be attached to your hair so, you know when you have a haircut you just throw it out.

Nina and Susan similarly constructed their eggs as a physical, unneeded resource, as “just DNA” (Nina) or just ‘cells. *It’s just a cell to me. It’s a cell that I don’t need.*’ (Susan).

By constructing eggs as a physical resource, donors were able to consider how these resources were being underutilized or ‘wasted’ in the hands of the donor and were enabled to think about their eggs as a means for someone else to have a child. By drawing on this medical discourse, donors positioned themselves as ‘unattached egg-bearers’.

This position enabled donors to donate their eggs because they hold little attachment to them. For example, Susan suggested that drawing on this biological discourse with her ‘*black and white thoughts about the egg being just a cell*’ made it easier to donate with an attitude of: ‘*just take it and do what you want with it (laughing)*’.

Brianna suggested that referring to eggs in this way enables the donor to refrain from getting caught up in the meaning of genetics:

Brianna: I mean, genetically they’re attached to me but they’re not my children and yeah, so I’ve never really got too caught up on the fact that they’re my eggs and that, yeah.

Rather, donors think about the practical use and value eggs might have for someone else. Rachel commented ‘*I might as well give them to someone that does need them*’. Georgie described how utilizing her eggs by donating them to someone else increased their value:

Georgie: while they’re of incredible value to someone else, and the children that will totally come from them are very valuable, they’re just something I happen to have that may be useful to someone else.

Nina suggested that constructing eggs in this way may help to define the donor’s role after the birth of the child as clearly ‘not the mother’ of the child:

Nina: I never connect the, the egg and the embryo with anything to do with my children or me being a parent or me being a mother...

Eggs as 'not yet a baby'

One donor however, suggested that thinking about the child that would develop from her eggs may be more difficult than thinking about her genetic material *before* it had developed into a child:

Margaret: I was worried about it, like, even though I tried to be ... a bit displaced about it in the sense that I say, it goes to waste every month, and it is quite true but, one of my friends said, but will you feel that way when the baby's born? And I said I've thought hard and long about this.

However, the donor minimized her worry, by separating herself from her involvement in the donation and equated giving away her eggs to giving blood and organ donation:

Margaret: but the more I thought about it, ... it's got nothing to do with me, I've just given a little bit away, I donate blood and I'm a organ donor for when I die, is it any different? Like, is it really any different?

Minimizing the value of her eggs and her involvement in the donation process made it easier to donate from an 'unattached' position.

Participants however, highlighted the difference between an egg and a baby pointing to the difference in the tangible nature of what was being relinquished. Margaret, for example, referred to her eggs as '*giving it away before it's even anything*', suggesting that the level of attachment is weak at this point of the child's development. Phoebe drew on this discourse, constructing her eggs as 'not yet a baby' or 'not a part of her', stating '*I don't feel like they're actually a part of you until they're developed into something that's a living, breathing, little human being*' and confirmed '*but I think the fact that it's growing from something that isn't actually anything*' facilitated her donation. Therefore, constructing eggs as '*before it's even anything*' may make it easier to donate them to someone else without feeling a significant attachment to them.

Bobby extended this discourse to differentiate between eggs and embryos, suggesting that giving away her own genetic material through egg donation was much easier than embryo donation would be, since it involved giving away a combination of her and her husband's gametes. She suggested her attachment would be stronger to an

embryo that is jointly created and possibly planned to become a child for her and her husband:

Bobby: ' they don't mean as much to me as I feel they've meant to other people. Because it's not a child, and it's not a child created by me and my husband so I've got very little attachment. Yep.'

While oocytes were not seen as having much meaning, embryos were constructed as equivalent to a child. Where previously donors seem to minimize the role of genetics, here genetics comes to the fore, suggesting genetics do hold some meaning: *'and yeah, we're not about to donate an embryo, but I would be happy for him to donate his sperm, so, but not a full child'*. This somewhat contradicts the construction of genetics as holding little meaning, as suggested above, and may also highlight that in embryo donation (unlike gamete donation) the embryos were formed as a joint project between partners and for donors' own reproductive needs, not those of recipients.

Egg donors as 'not mothers'

In order to donate, most of the women needed to position themselves as 'not mothers', by drawing on constructions of eggs as physical resources and 'not yet a baby'. This involved buying in to a narrowed construction of 'real motherhood' as linked to gestation and birth. Doing mothering was therefore considered not compatible with being 'a donor', as good donors must be unattached and uninvolved. Margaret differentiated between egg donation and surrogacy, commenting that *'I don't think it's going to worry me. I don't think I could be a surrogate I'll be honest with you, once you grow it and you birth it, it's hard not to love it, so my fear would be I'd want to keep it.'* Her comment suggest both that having an actual, tangible baby would be different in terms of donation, and that the gestation period strengthens attachment, making it more difficult to give the child away. This is a narrow view of motherhood when considering that in some contexts, DNA confers parenting status, and that in other methods used to become a parent, such as adoption, social mothering is significant in defining motherhood,.

Indeed, one donor specifically drew on social practices involved in child-rearing to construct what makes a mother. Nina states that *'what makes you a parent is being*

there and being invested every day and being committed to this kid in your life for eighteen plus years and that *'it takes more than just genetics'*. She also states that if you have *'stepchildren or you adopt a child' ... you're just as much their parent than if they biologically came from you*. She emphasized the *'time spent and desire to have connection with that child'* as pivotal in defining motherhood. But again, this construction of motherhood allowed her to assume a position of *'not mother'* in relation to the DCC. One comment from Susan is interesting however, where she used language to position her stepchildren as belonging to herself and her husband (*'we've got three'*), drawing on child-rearing discursive practice as defining motherhood, but still made a distinction between her husband's children and her *'own'* biological child. This sentence is indicative of the contradictory discourses surrounding motherhood:

*Susan: He's got two so together we've got three already, one already, one of my **own**.*

From this *'unattached egg-bearer'* position, a property discourse was drawn on to construct eggs as *'intended for'*, even *'belonging'* to recipients. Rachel commented that she *'always felt like they were the eggs intended for whoever the recipient was, I never felt like these are my eggs... it always felt like they were theirs*. Nina commented *'yeah that everything is, is kind of their property (recipients)'* after the extraction procedure, suggesting there is a transition of ownership of the eggs from the donor, to the recipient once they have left the donor's body.

By constructing eggs as *'belonging to'* or *'intended for'* the recipients, donors do not take ownership of their eggs. They turned down a maternal or *'attached'* position, making the donation process less psychologically/emotionally challenging.

However, Rachel highlights that when eggs are constructed as the recipient's property, donors may be constrained as they are no longer informed of the progress of their donation, causing tension. Rachel suggested this may be problematic and cause donors discomfort: *'yeah and like they might not be our eggs but we still kind of want to know what's happening'*.

By taking up this ‘unattached egg-bearer’ position and constructing eggs as a physical resource, donors resist a maternal discourse to construct their eggs as personified, as ‘not quite a baby’. Isabelle comments that *‘as an egg and embryo, it feels like ...I didn’t give away a baby, it wasn’t a baby that I .. gave up by any means’*. This resistance to a maternal discourses suggests a competing construction of ‘eggs as almost’ or ‘on the way’ to being a baby that is ‘connected to me’ was drawn on by some donors. Although donors chose not to position themselves within this discourse, they defended themselves against it, which suggests this discourse was available to them to be drawn on. Some women expressed conflicting , desires to remain uninvolved and involved. Phoebe drew on this discourse when she constructed eggs as having *‘the potential to always be a part of you’*. This contradicts constructions of eggs from an unattached position, by suggesting an ongoing relationship/connection. This discourse constructs eggs as holding more meaning than physical resources. Where donors compared egg donation with surrogacy, the embryo, and expressed a ‘difficulty’ in transferring eggs as property from an unattached position but still wanted to be informed about the stages of donation, they confirm this competing construction. This suggests a tension may exist in the attachment donors hold for their eggs.

Discursive constructions of the Donor-Conceived Child(ren) (DCC)

Donors construct their eggs in various ways that enable their decision to donate.

However, the way they construct what their eggs will become, i.e. DCC(ren), as well as the relationship of this child to the donor and the donor’s own children, is also significant in influencing decision-making. The next section analyses constructions of DCC(ren) and the implications of these constructions for the donors’ experience of ED.

DCC(ren) as ‘half-siblings’/ or ‘not half siblings’ to the donor’s own child(ren).

Donors chose language to construct the DCC as either a half-sibling or **not** a half-sibling to their own children. Where DCC(ren) were referred to as ‘half-siblings’, donors drew on a genetic discourse, suggesting genetics bestows immutable social relations between the DCC and the donor’s own children. Several donors drew on this genetic discourse:

Phoebe: it is a half-sibling for my children.

Susan: my son who has you know, biologically a half sister.

This genetic discourse made available the subject position of ‘the protective mother’, a notion of mothering, where ‘good mothers’ are considered those who protect their children. Donors took up this position by taking responsibility for protecting their ‘own’ children from inappropriate relationships with the DCC. Here, the donor’s own naturally conceived children were constructed as distinct from the DCC. This distinction suggests donors hold less attachment for the DCC, and feel more responsible for their ‘own’ child(ren). From this position, donors make disclosure with their own children a priority to protect them from consanguineous relationships with the DCC. Rachel talked about how ‘*accidental incest is a bit scary*’ and therefore she would like to ‘*know where they (the DCC(ren) are in the world*’ to make sure her own children do not accidentally enter into consanguineous relationships.

Georgie drew on the social relationship to ensure the safety of her children, :

Georgie: I mean I want them to have that relationship... because then there’s no chance that my daughter’s going to run into him in the future and find him quite attractive.

This position was constraining for one donor, who felt she had to limit the number of donations she completed to protect her own child. Margaret commented that what stopped her from donating again is ‘*the genetic bit of it*’ because she has a ‘*daughter who’s gonna have half-siblings*’:

Constructing the DCC as a half-sibling made it more important for Phoebe to discuss her decision to donate with her husband. She explains that it ‘*affected him in a way, creating you know... it is a half sibling of, for my children*’.

Donors seemed to separate out genetics from social relationships in different ways. They both drew on, and resisted, the genetic discourse which constructs genetics as bestowing immutable social relations. For example, at times, donors drew on the

social relationship bestowed by genetics to avoid consanguineous relationships, but also resisted the term ‘siblings’ and instead restricting genetics to a ‘link’ shared between the DCC and the donor’s own children. For example, Ellie comments ‘*it’s not our baby in any way or their sibling or anything like that*’ and Brianna states ‘*not really along the lines of half sister*’. Instead, this genetic link constructed the DCC as ‘*connected but also disconnected*’ (Ellie) or ‘*genetically linked*’ (Brianna) to their own children, but not as a half-sibling.

Brianna described this genetic link to her children in terms of the similarities the DCC and her own children may share:

Brianna: she might have some similarities to them like... the same eyes or the same hair... just like a brother or sister would, but not ever as a half-sister.

There is a real ambiguity between donors constructing the DCC as a half-sibling or genetically linked. Donors justified their decision to turn down the ‘half-sibling’ title, as being due to technicalities. For example, Ellie explained to her children that the DCC is not a sibling as ‘*you need a dad as well*’. Margaret similarly states ‘*there was no marriage*’ and therefore, titles such as ‘half-sibling’ were not employed.

The term ‘sibling’ was seen as implying a greater level of involvement or contact. Therefore, where donors chose to turn down this title, they had to limit the level of contact and expectations their families had about the child and keep their decision to donate ‘*personal and private*’ (Susan), as a way of keeping the DCC at a distance:

Susan: I don’t want them thinking ooh we’ve got another grandchild coming... This baby’s not related, you know this baby is not ours but there’s a life, but don’t try to impose yourself on these people.

DCC as ‘belonging to the recipient’ – ‘not my child’

Most donors used language to construct the DCC as not their child(ren), and as belonging to the recipient(s). To do this they created a strong demarcation between ‘social mothers’ responsible for and able to participate in parenting, providing the necessities of life and social connection, and ‘genetic mothers’ who were expected to

be ‘bystanders’ technically required to enable the life but barred from doing mothering. By constructing the DCC as belonging to the recipients, donors turned down a maternal discourse which may position them as a caregiver or mother to the DCC and drew on an ownership/property discourse to position the recipient(s) as the parent(s) of the DCC. For example, Brianna commented *‘I never at any stage felt like it was my baby or anything it was just always that this is their baby.’* Constructing the DCC as ‘belonging to the recipient’ aligns with donor’s constructions of eggs, where genetics was minimized in defining motherhood.

Ellie expressed a frustration around those who did look at the DCC as their own child, suggesting mothering was the ‘wrong reason’ to donate:

Ellie: I had someone say to me ‘oh I was thinking about doing it because I really feel like, my pregnancies were awful but I really feel like I haven’t finished having kids’ and it was a little bit like ding dong well it’s not your kid, you can’t.

By positioning the recipient(s) as the parents, the donor takes up the position of a ‘bystander’, where they may be present but not involved in the child’s life. Where donors aligned themselves with this position, they construct the DCC as a liability and hand over responsibility for the child to the recipients. This suggests that ‘social mothers’ have an obligation to support their children, including financially:

Bobby: Well good because there’s no come back on me either... that child can’t wherever it’s created can’t come back to me and go well you need to pay for my university now.

Taking up the ‘bystander’ subject position also enabled the donor to leave important parenting decisions to the recipients, such as the child’s religion, upbringing, vaccinations, and future contact with the donor:

Margaret: if they were to raise Petal as Catholic it wouldn’t worry me. Their baby their choices.

Nina: when I’ve met them and gone round and just their different styles of parenting... they’re doing what works for them and their family... it’s their family and they can do what they want.

‘Mothering’ in its broad social sense, was positioned by some as a biological and social imperative/vortex you can get drawn in to against your will. Donors suggested a need to protect themselves from getting drawn in by setting up strict boundaries that ensure they do not cross the line from ‘unattached’ to ‘attached’. This relates to the above constructions where donors take up or resist the ‘sibling’ title, and express ambiguity about whether donation/genetic ties imply social ties and relationships. Women, therefore, are positioning themselves in relation to some ‘involvement ideal’, where taking up the ‘bystander’ role involved being very careful to not overstep any boundaries. Susan comments that when meeting the DCC she was *‘watching my tongue’* and *‘was very careful’* not to refer to the DCC as *‘my girl’* to ensure the recipient would not be thinking *‘well it’s my girl not yours’*. Margaret also describes maintaining strict boundaries, reassuring the donor, *‘I don’t want you to ever think that she’s mine’* or that *‘I’m overstepping my mark’*.

Behaving within these boundaries restricted how women were able to be around the child during times of contact. Phoebe worried about *‘crossing a line’* by telling the child not to do something as this was considered acting as *‘part the mother’*. She admitted she felt she may be *‘consciously thinking... am I paying this child too much attention’*. Nina indicated that she would *‘sort of let them lead in that sense’*, when discussing future contact with the DCC, suggesting the ‘bystander’ position can be experienced as constraining. These boundaries leave little room for creativity in negotiating a role for women donors, as decisions are in the recipients’ hands. Donors abide by boundaries to avoid stepping into a ‘mother’ role, in fear of jeopardising the recipient’s role as the mother and possibly jeopardising their ability to have some involvement.

Margaret discussed her concerns around overstepping boundaries with her recipients, which positively influenced her experience of the donor-recipient relationship:

Margaret: That’s when we had the big conversation... you’ll always be special to us and we hope she’s (DCC) special to you but I don’t feel threatened... it was kinda cool that, I already knew that they were gonna be open and honest because they’d said that right from the start with their child.

Behaving in a way that stays within the boundaries of a 'bystander' and not a mother enabled donors to remain a safe distance and avoid becoming attached to the DCC:

Ellie: to me it's like I feel no real connection... so I didn't really feel any kind of connection except that it was just amazing that I've been able to help something amazing happen.

Maintaining distance from DCCs and DCC families was identified as necessary (to protect the self and recipient mother) but not always experienced as comfortable for the women donors. Where donors did not have contact, they expressed a desire for more to satisfy their curiosity for the DCC. For example, Nina commented that she '*hadn't seen any photos or met*' one of the DCC(ren) and although she is '*really curious*' and would '*love to know what he looks like and if he looks like the others*' that it is '*up to them (recipients) and I completely respect their choice and they know where to find me*'. Donors prioritise the comfort of the recipient, but by minimizing their voice in the negotiation of contact, their own needs are constrained from being met in a position of a 'bystander'. Both the recipient and donor perhaps grapple with this 'not mother' position. Therefore, binary and narrowed constructions of 'mothers' and 'mothering' may potentially cause problems where women seek to negotiate arrangements that meet their particular needs.

A 'good donor' is constructed as one that maintains a safe distance from the child, staying in contact with the recipient, but watching the child's progress from afar. This constrains donors to stay an arms-length away from the DCC, limiting the level of contact they can have with the child. Rachel comments that she '*just sees what they're up to with photos on Facebook*'. Isabelle states they her recipients usually send her family a photo '*around Christmas time*', as a yearly update.

Some donors spoke of how this distant contact satisfied their curiosity about the DCC. Isabelle commented '*it's always interesting looking and seeing if you see any familiarities in the children*'. For Isabelle this worked, as she states she was not interested in '*mothering someone else's children*'.

Some donors suggested that maintaining these boundaries to remain unattached enables them to donate again:

Rachel: But that's what makes it kind of easier to donate again because I know that I'm not going to feel that... I don't feel anything.

Margaret admitted she did worry that she would *'feel something a bit strong that might create a, you know, a thought process in the back of my head'*. One donor acknowledged how difficult it would be if they were to feel a strong connection and that this may impact the way they experienced egg donation:

Ellie: I think it would be awful if you did feel a strong connection to the baby it would be very difficult.

These discourses which encourage donors to 'stay in their lane' are strong. Disconnection seems to also be about self-preservation for women - protecting themselves from the pain of rejection and conflicting feelings of possibly wanting to mother, in a way that makes sense to them, but being unable to.

DCC as a 'niece/nephew' or 'special'

Where the construction of the DCC as 'belonging to recipients' indicates that donors try to distance themselves from the child in the role of mother, they are brought closer again when they construct the DCC as a 'niece/nephew' or as 'special'. Some donors drew on a social/family discourse to construct DCC(ren) in this way. By drawing on this discourse, donors could position themselves as 'Aunties', and as 'linked' or 'connected' to the child.

Margaret: As far as her mum's concerned, I'm the special Aunty

Brianna: I really just think of her more like I would think of a niece or nephew, so more than just a friend's child but, but not as much as my own child... like a friend's baby or a friend's child that we had this extra special link with.

Where donors drew on this discourse and acknowledged a connection to the DCC, they were offered a position as a 'guardian' or 'extended relation', from which they were able to negotiate a role in the DCC's life. This enabled them to demonstrate their care for the DCC. Margaret comments:

Margaret: that little bit of care that is there. I mean, I'd be absolutely devastated if something happened to Petal, not to the same level of my own child because that's a love, that's a pure, life or death type thing and it would absolutely break me but I'd be devastated if something happened to Petal, because I still do have that care.

Another significant tension can be seen here, where donors construct the DCC as 'not mine', 'not attached', but they care and would be 'devastated'. Other donors implicitly showed a care for the DCC in their hope that the child would be happy and loved by their recipient family, suggesting a different construction of mothering as a 'collective':

Margaret: My big thing is as long as she's not going to end up as horribly treated as some of the poor children when they get abused and I know for a fact she's not going to because why would they have spent all this time to try and do it. My only condition was love, that was really it... love, in this case, love is enough.

This position offers donors a place where they can have a role/interest in nurturing and caring about the child, allowing them to do more than assume a 'bystander' position. Their care for the child is highlighted in their consideration of the child's welfare. Considering the welfare of the child involved assessing the environment the child would be going into prior to donation. Rachel comments 'you can't predict the future but you can give things the best chance they can have.' Bobby drew on the discursive practice of choosing her recipients, which involved considering the stability of the recipient's relationship to ensure the child would grow up in a secure environment:

Bobby: the profile was very empty... if they can't communicate to each other and he fill in her side of the story, then what kind of environment is that child going into... it's nice to know that the child's going to a home that's stable and it, had communication.

From the guardian position, donors take responsibility for the child's upbringing if they start having difficulties later in life. Bobby drew on a psychological discourse, discussing the mental health of the DCC in the future as well as how she would cope knowing the child was 'mentally not okay because of the whole thing'.

Phoebe again highlights the ambiguity of constructing donors as ‘belonging to recipients’ which is contradicted with constructions of the DCC as ‘partly’ the donors’. She suggests that knowing the child was struggling psychologically, medically or if they had picked up negative traits from her would be more difficult as her donation was to someone known. She also takes responsibility by worrying that the child may blame her if their upbringing had been unpleasant:

Phoebe: if you have this child that’s part yours and it’s with someone that you know, if that child starts having difficulties... would you feel responsible... obviously if you gave the egg to someone you didn’t know then, I don’t know how much I would think about that child... you have no control obviously over that child’s upbringing... if they hadn’t had a pleasant experience, are they going to think you’re responsible?

By taking up this position, donors also held a responsibility to the child in the future if they had any questions or reached out for future contact. Isabelle discussed that she would answer the DCC’s questions so they could learn more about their identity and to ensure they did not feel rejected:

Isabelle: I mean if they did, I would happily meet them and answer any questions... if that’s something the kids felt like they needed to do to find their identity or to learn more about my biology, (laughter), I don’t know, then yeah I’d be open to that... I definitely wouldn’t want to reject them and say no I can’t meet you or you can’t meet my family.

Margaret commented that she would be open for future contact with the DCC and that she would care for the DCC:

Margaret: she’s more than welcome to come in, and sit, and I’ll talk about it, any questions she wants. And I’ll tell her that I’ll care for her.

Nina, although she stated that she was open to contact and answering any questions the DCC may have, she implied that she would utilize this interaction as an opportunity to define the role of the recipients as the parents and herself as a ‘helping hand’, again emphasizing her role as ‘not a mother’:

Nina: your parents really wanted you and they’re the ones that are invested in your lives and stuff and I was able to do this little thing to help but you know, those are the people that are your family... but yeah I’d be happy for any contact if they wanted it but I don’t think they would want any like, relationship in terms of a maternal thing from me.

Aligning themselves with the 'guardian' role involved engaging in practices that were oriented to protecting both the woman's own children and the DCC. Taking up the guardian role also involved acknowledging the child's right to know their conception story. Some donors drew on a genetic discourse to emphasise the importance of the child knowing them, in order to have a meaningful connection to their biological inheritance, bringing genetics to the fore yet again:

Margaret: I do believe everyone needs to know their genetic makeup, because we all know that there's so many more genetic diseases or links there.

Georgie commented that she would not have agreed to donate to a couple that withheld information about the DCC's conception from the DCC. This was a stipulation for who she agreed to donate her eggs to:

Georgie: I would have just said no thanks. Like I said I sort of, I would have liked the odd photo and to know that the people were happy to, happy for the child to be able to contact me if and when they wanted to.

As guardians, donors also considered the serious implications non-disclosure could have for the DCC:

Bobby: I'd like to think that the parents talk about that from the very beginning... it makes life easier for everybody so it's not this huge revelation. Um, because that could be really mentally damaging.

For Susan, donating to a close friend who had also experienced working with troubled youth and the 'anxiety and stress' they experience 'when they don't know where they're from' enabled them both to consider the best options for the child. 'That they would grow up knowing...who I was and where they came from'.

Discursive constructions of Egg Donation (ED) practice

The discourses drawn on to construct ED, as well as the subject positions made available by these discourses, are described below. How these constructions may affect how ED is experienced by donors and the implications this has for subjectivity is also discussed.

‘A big life decision’

Donors constructed egg donation as a big life decision by drawing on two key discourses. The first was a practical discourse which constructs ED as ‘a big commitment’. Donors drew on this discourse to discuss the practical commitments of ED, such as clinic appointments and the intensity of the physical procedure:

Isabelle: It was quite a big commitment and a bit of a hassle... there’s a lot of appointments and meetings and then doing all the injections and scans and blood tests... and you’ve got your egg harvest at the end, which is a big day.

Ellie spoke of how, “*physically, it probably has more effect than you’d realise*” and how the impact her donations had on her body constrained her from donating again:

Ellie: Um I’d love to do it again but I think the impact on my body has been enough now um, so that would be the reason why I wouldn’t.

This discourse was also drawn on to outline the inconveniences of ED such as travel, medical risks, time off work and the impact on the family:

Isabelle: I guess there’s always that medical risks with all of the procedures... It was time consuming... the day they harvested, my husband took the day off work to look after the kids and to drop me to the appointment... it was a bit commitment as a family.

This construction of ED as a big commitment extends to a construction of ED not as a once off event, but as ‘a big life decision’ with long term ongoing consequences.

This construction invites donors to acknowledge the importance of preparing themselves by giving the decision to donate a lot of thought:

Nina: thought through all the things and all the what-ifs, like if this happens in the future or if I have a child or a partner or whatever, or if the child wants to meet them when they’re older or wants a relationship.

Phoebe: I just talked to other people just like you would when you’re making a big life decision.

Considering all of these factors enabled donors to donate in a way that worked best for them:

Nina: some people can't and that's fine and some people only want to do it with someone they do have some involvement with going forward and some people feel better knowing that it's completely anonymous or they just go and do their own thing separately.

A discourse of ED as a big commitment, and as a life decision, positioned donors as 'invested' in the process of ED and the recipients' journeys. From this position, they were invested in the outcome of ED and drew on a psychological discourse to describe how they shared the recipients' joys and disappointments. This works against earlier constructions of eggs as just resources that hold little meaning to the donor. By positioning themselves as invested, donors were however, constrained by the lack of control they had over the ED processes:

Nina: um so I was really happy for them that it had worked... yeah because it's weird like I knew that it wasn't my fault but I still felt bad even though it's out of my control.

...
you can't help but be yeah, invested and involved.

Positioning themselves as invested also led them to experience egg donation as 'challenging':

Georgie: it's an experience with a lot of emotion tied up... it's a very intense process.

Phoebe: Yeah, just the scan where they said I hadn't produced enough eggs... I found that really disappointing... it was well, sad, frustrating, yeah annoying for me...

Donors found failed embryo transfers particularly emotionally challenging. Margaret described feeling 'gutted' and guilty that it was her problem, her eggs that were 'not working'. Phoebe also described feeling guilty when she did not produce enough eggs for egg retrieval.

Donors also experienced the physical challenges of ED (above). Rachel acknowledged the ED procedures as 'invasive' and stated this as a reason that 'it's really important we're not seen as the same as sperm donors'. She suggests that ED 'it's not just something that women are going to want to donate and forget about' reiterating the 'involved' position, where ED is seen as having long term

consequences that affect donors for a lifetime. Rachel comments that because of this ‘*contact is actually a good thing*’ and egg donation followed by no contact creates risk for the DCC and the donor/woman.

When donors drew on this construction of ED as ‘a big life decision’ and position themselves as ‘invested’, they also position themselves as needing support. Ellie discussed how she needed practical and emotional support from her partner due to these challenges:

Ellie: you need their support, you need their emotional support... I couldn't have done it without my partner's..., to pick up the kids and other things like the few days after in your recovery you need help... I don't think it really would have been possible.

Where donors emphasized the need for further support, they constructed counselling as useful, needed and important. Donors constructed counselling as helpful in unpacking the factors considered when ED was constructed as a ‘big life decision’. For example, Nina suggested counselling was useful in discussing ongoing contact with her recipients. However, for Nina this was a chance for her to prioritise the recipients’ wishes around donation, which again demonstrates ambiguity for donors positioning themselves as ‘invested’, ‘unattached egg-bearers’ or ‘bystanders’ by minimizing her role as a donor:

Nina: it was helpful during that session because we could unpack some of that and they could say what they were comfortable with, and I could tell them that was totally fine.

Georgie constructed counselling as useful for those that have not already discussed the different factors that demonstrate the complexities around donation with their recipients. She commented ‘*yeah, but obviously it would have been very useful if we hadn't covered that but we had so*’. Susan constructed counselling as beneficial, particularly for her and her friend’s partner ‘*because she saw him open up and ask some questions and she kind of felt that he had been quite quiet about it.*

For some that aligned themselves with the ‘invested’ position, they chose to discuss the ins-and-outs of ED with their recipients prior to the mandatory counselling session. Therefore, counselling was described as a ‘non-event’. When counselling

was constructed in this way, donors emphasize it as a mandatory, tick box event in order to proceed with donation:

Georgie: the counselling they didn't really bring up anything that we hadn't talked about already so it was kind of a non-event. Just did it for the sake of doing it, yeah.

Margaret described the importance of counselling more holistically, by considering the importance of counselling in life in general to enhance health and wellbeing. By constructing counselling in this way, Margaret was able to consider how services around donation could be improved, by increasing the availability of counselling:

Margaret: So I think that counselling is a very very important part of life... I think we should be seeing more mental health professionals when we're down... so yeah I think there should be more counselling offered.

Phoebe also constructs counselling as a 'thought provoking process' that enables you to explore emotions. For her, the counselling she received did not live up to her expectations:

Phoebe: I get that they had to do it but I didn't find it a particularly enlightening or thought provoking process... I don't really remember them preparing you for that, um disappointment that it might not work. Maybe they did, I don't recall... my memory of it was kind of that it was just, didn't really touch on your emotions or even give you ideas of how you might feel.

This suggests that ED counselling may be too narrowly focussed (e.g. on altruism etc.) at the expense of broader considerations of the possibilities, meanings and practices of ED within a particular ED relationship. Her expectation was that counselling would be a way of 'safeguarding my experience of it (ED) in my lifetime, maybe that's what it is, it's not just about that moment of actually doing the egg donation cycle, it's about how it affects me for my whole life'. Emphasizing the importance of 'safeguarding' how ED affects her 'whole life' is a powerful way of adding to the construction of ED as 'a big life decision'.

Constructing counselling/support in these more expansive ways enabled donors to consider how support could be enhanced and improved. Ongoing counselling after the birth of the DCC was seen as a useful way of navigating issues once the baby is

born such as future contact with the DCC, unexpected difficult feelings that may arise, and navigating the new relationship form that could grow/change over time. Nina suggests that ongoing counselling would be useful as *'once the child's been born it's like, it's really happened and it's a bit more real and concrete... in that first counselling session you haven't done the implant yet.'* Bobby similarly suggests *'some offer of support going forward (an emotional follow-up)'* is needed, in case the donor was *'losing my mind going oh my god I've given away my eggs and now what?'* Constructing ongoing counselling in this way again reiterates ED as a 'big life decision' that affects donors (and the other parties involved) for a 'lifetime'.

'A selfless gift'

Donors used language to construct ED as the act of 'giving a gift'. Margaret commented *'it is a gift to give someone a child.'* She states that *'doing it as a gift'* meant the sacrifices she made by travelling and taking time off work were worthwhile for what she was able to do for the recipients. Where donors described their experience of failed embryo transfers, the gift was described as *'not working'* (Margaret), as *'the gift that does not work'*. Donors took responsibility for these failed transfers, *'feeling guilty'* (Phoebe) and asking themselves *'is it my fault'* (Margaret).

Constructing ED as giving a gift enabled donors to take up powerful altruistic subject positions. Nina commented *'it's such a... altruistic I think when you just donate for no, without there being anything in return'*. From this position donors constructed themselves as selfless, empathic, self-sacrificing and generous. Ellie commented *'it was just a really cool feeling, like you are giving something to someone with absolutely no chance of ever getting anything in return, it's just completely selfless.'*

Donors suggested that in order to take up this altruistic position, it takes a certain type of person and that they have to go into it *'for the right reasons'* (Ellie). Ellie suggests the 'right reasons' involve being in *'the right head space, that you're thinking about it as a gift and not, that it's not about you'*. Isabelle suggests that this depends on *'your age and stage of life'*.

Donors also used language to construct ED as *'a pretty small minor thing for me that would help them in a big way'* (Nina). Rachel comments *'It seems like such a little thing that I can do to make such a big difference... there's that saying like you might not be able to change the world but you can change the world for one person... that's kind of what it embodies to me.'*

Constructing ED as a 'small thing' for donors, that helps a prospective mother in 'a big way' enabled donors to think about their motivation for donating their eggs and made available a subject position for donors as 'helpers':

*Brianna: if that's something that I can do to help it seems fairly minor.
Yeah that's my motivation.*

From this altruistic position, donors drew on a discourse of solidarity with other woman as a way of enabling women to have their 'own' child. Donors also drew on a maternal discourse to emphasise the importance of the gestation period in becoming a 'mother'. Conceiving a child was constructed as a 'natural' ability for women, a key purpose defining femininity that had been 'taken away' and infertility was described as 'unfair'.

In positioning themselves as selfless gift-givers, donors sought to normalise ED. Phoebe states that in *'fifty years time there'll be a lot more of this, it won't be so unusual'*.

By resisting discourses of ED as 'abnormal' or 'unnatural', donors took up the position of an 'advocate' to encourage ED, contributing to the recruitment of egg donors:

Brianna: I'd like to think that by telling people that it might encourage others to do it, which you know, that then helps other people in that way.

Donor were strongly motivated to give the gift of natural womanhood which was bound up with maternity. Donors took up the 'helper' position, which them to donate with empathy for the recipient woman's inability to conceive and innate desire to have a child:

Isabelle: they just really want a baby of their own, and the pregnancy and everything that goes along with it and I think it's nice if we all get that choice and obviously it doesn't work for everyone... so I guess egg donation does give women the choice on that, and being able to be part of that and give someone else that choice it's through usually no fault of their own... it's been taken away from them for whatever medical reason that might be.

Margaret: I believe that everyone who wants to have a child should have the chance to have a child. That's honestly my belief, whether they're male or female. If you really want to be a parent, I think, it's a shitty that life deals you a hand that most likely, means you could be an incredible parent but your body doesn't want to work along with it and I think that, that's unfair... and so that's what I did it for.

From this position, donors were able to use the 'helper' story to describe their involvement in ED to their own children. Isabelle explained ED to her children as 'someone that couldn't have a baby and I can do this to help them to have a baby.'

When donors align themselves with altruistic positions, they assert that they do not want anything in return (e.g. contact arrangements, praise from others or gifts from the recipients):

Ellie: I don't want them to feel like they owe me anything at all.

Susan: while I'm proud to say to people that I'm an egg donor I also don't want all the praise and attention for it.

Constructing ED as making a big difference in the recipient's life associated with giving the 'gift of motherhood' made available a position of great nobility and selflessness which made donors and others around the donor proud:

Margaret: my parents told me they were very proud of me... I'd be lying if I said I wasn't even proud of myself... it is a really proud thing to do, and to know that you've helped somebody it makes you feel really good about yourself and it's not that hard.

From this position, donors who did want something in return for their donation were constructed as 'selfish':

Margaret: there are some who say... I need to know that I'm going to be allowed contact with the child and stuff... I personally feel, that's a bit selfish, because, I'm giving it as a gift.

The altruistic position also implied that donors were unable to accept payment for gametes. Rachel spoke of the idea of payment for her eggs as *'insulting'* and felt *'it cheapens it, it cheapens it!'* She adds to the construction of ED as a gift, by suggesting *'it-it's not something you can put a price on.'* Susan similarly commented that donation was *'not about getting money.'* Susan described her recipients' efforts to thank her in material terms as *'uncomfortable... when they actually became pregnant and they would, were so grateful and like they kept wanting to buy us stuff and they shouted us like a special night out... it was like that's really nice thank you but don't'*. This gratitude and gifting from the recipients may have been more uncomfortable for Susan because the recipients were close friends. Indeed, Bobby experienced gratitude and thanks from her previously unknown recipients differently. She was given *'a thank you card... a wee gift bag... a lovely greenstone'* and a voucher to get flowers. She described this as *'lovely'* and *'cute'*, clearly appreciating the acknowledgement for the gift given.

Issues could also arise when donors positioned themselves as altruistic donors, with no intention of receiving anything in return. For example, Georgie described feeling side-lined when told by her recipients that they were going to use a surrogate for her eggs, she comments *'am I going to feel a bit side-lined and I had to stop and think, actually I'm doing this so Julie and Tim can have a baby, my feelings while they may be real and relevant to me, aren't actually the main point here'*. Although she tries to minimize her feelings around the situation and emphasises the success of the donation for recipients as more important, she drew on a psychological discourse that positioned her as undervalued and *'dehumanized'*.

By constructing donation as a gift, some grateful acknowledgement of the role of the donors was invited. This could complicate a traditional position of selflessness as concerned more with the needs and wishes of others than with one's own. Practices in which the donors' role was minimized or unacknowledged, were experienced as painful/challenging. For example, for Rachel, she expressed frustration that in the counselling session, the counsellor made the discussion around disclosure to children *'all about the recipients'*. She commented: *'they didn't have anything to say about my kids, it was all about how the recipients would tell their children and I just sort of*

stole that information to pass on for my kids'. She suggests that at the point where the eggs are fertilised, it becomes all about the recipients and not about the donor: *'I do understand that as soon as those eggs are fertilised, they don't have to tell us anything. Like I think that yeah, I think that some of that stuff could change?'* Several donors also expressed distress at being treated like 'just a number'. The language they used to describe how they were treated during the ED process suggests the ED process itself and the treatment they receive from staff minimized their role in a way they experienced as 'dehumanizing':

Susan: I remember at the time being quite frustrated and feeling like another number... overall feeling was we're part of a factory.

Rachel describes the treatment from staff as not seeing her *'as a whole person... there's no like how're you feeling? ... because I mean they don't really want to know you anyway... as soon as your bits done they just cut the contact.'* This comment highlights the ongoing tension again. Rachel's discomfort with being treated as 'just bits' suggests her eggs are not in fact, 'just bits' of her, which contradicts the construction of eggs as 'physical resources'. She also commented *'at the end of the cycle all I got was like a letter saying thank you, we've frozen this many embryos'* and that *'it would be nice to get a phone call'* to update her on the progress of her eggs during the incubation period. The disappointment she expresses when the clinic 'cut the contact' abruptly after her part was done suggests that when donation is constructed as giving a gift, the gift also needs acknowledgment.

Being positioned in this way by staff at the clinic had implications for how donors experienced ED. Isabelle described *'not having control over and finding out information because it's really in the couple's hands'*, which caused her to feel like finding out things involved *'a long wait'* which was difficult during the pregnancy stage where she felt *'invested'*. Bobby also shared her *'frustration'* when waiting for updates from the clinic. She comments *'it would be nice to just have a generic email, this is what's happening right now'*. Rachel suggests she felt disrespected when the clinic did not *'even send a letter to our GP to say we've had this procedure. Like where's the respect for my medical history and medical notes?'* She also states *'it would be nice if that voice was heard just a little bit more'*. She also feared that the recipients would just *'cut and run and then there's no, there's no obligation for*

anyone to keep me updated other than to tell me like, a baby was born. The donors' lack of control when positioned as 'just a number' in the ED process evoked uncomfortable feelings for donors.

Donors thus suggest the ED process '*could be managed better*'. While donors spoke of the clinic not acknowledging their role, donors discuss how their friends and families acknowledge their gift as 'amazing':

Margaret: Most of the comments were oh wow that's amazing... everyone's been very positive about it.

Bobby: Whenever I tell people that I'm doing it they say oh my goodness this is such a great gift, you're such an amazing person, I couldn't do it myself.

Competing discourses constructing ED as 'a big life decision' and 'a selfless gift' could result in donors feeling ignored and underappreciated while also unable/unwilling to articulate their needs/desires.

Conclusion

Various contesting discourses were identified in the interview transcripts, which were both assumed and resisted by donors, leading to a constant tension in how women chose to position themselves or how they were positioned. These findings highlight how women were often struggling with finding ways to care for/relate to the DCC and DCC families in the context of some powerful discourses operating to separate them and limit their involvement. The next chapter will discuss how these contesting discourses are seen in other literature, how they may be explained from a critical feminist perspective, and the implications of these discourse on women's health and wellbeing and policy and practice.

DISCUSSION

The aim of the current inquiry was to understand donors' experiences of egg donation and their motivations to donate in New Zealand. A poststructural feminist lens and discourse analysis method was adopted to identify and examine discourses of ED, the subject positions made available through these discursive constructions and the implications for subjectivity. The next section reflects on the findings of this analysis, and seeks to critically consider implications for women generally and donors specifically, as well as for practitioners, for clinic practices and for donation policies.

In the current study, contesting discourses were drawn on and resisted by woman egg donors. The first section will outline how the discourses of ED link with Foucault's notion of biopower. The next section will discuss how women define and negotiate motherhood by drawing on various discourses. These contradictory discourses highlight how ARTs may both reinforce and challenge traditional understandings of kinship and family. The final section will discuss the implications of these discourses for women's health and wellbeing and policy and practice, as well as how this opens a role for the Counselling Psychologist. Challenges encountered during the completion of this practice research project and directions for future research will also be outlined.

Fertility industry, biopower and the dominance of the altruism discourse

We live in a pronatalist society, where motherhood is viewed as a natural and inevitable part of being a woman (Daniels, 1993; McArthur & Moulet, 2004). In pronatalist societies, 'population policy' is on the agenda. This can be seen in a recent NZHerald article titled "*Urgently seeking another baby boom in baby making*", where the reporters state "*The demographic equation for New Zealand is not adding up to healthy growth, at one end of the scale statistics show women are no longer having children at population replacement levels*" (Hewitson & Carter, 2002).

This article can be linked to Foucault's ideas about biopower and governmentality (Foucault, 1976), where press and statistics may work to influence people to consider taking up pro-natalist positions to influence the productivity of the population's

reproductive practices (Esposti & Pavone, 2019). The way in which the fertility industries adopt the altruism discourse to encourage women to ‘give the gift of life and motherhood’ can also be related to this concept of biopower, reiterating Foucault’s (1976) idea about how the “*sexual conduct of the population (is) taken both as an object of analysis and a target of intervention*” (as cited in Burr, 2003, p. 70) in ARTs.

The construction of ED as ‘giving a gift’, where donors want nothing in return is an altruistic discourse which is taken up by women and also promoted by the fertility industry (Curtis, 2010; Esposti & Pavone, 2019; Shaw, 2007). This discourse positions the recipient as the ‘real’ mother. Power operates through this altruism discourse to reinforce a historically constraining discourse, constructing women as ‘child-bearers’ (Appolis, 1998). The power of this altruistic discourse influences potential donors to experience empathy for infertile women, encouraging them to donate. Here, fertility clinics hold power to shape donors as altruistic to serve the health/productivity needs of the infertile population.

Many critical feminist scholars have argued that the altruistic discourse is problematic for women. Corea (1985) argues that when ED is framed as ‘altruism’, the female reproductive body is commodified and fragmented and consequently, women are exploited as ‘mother machines’ (as cited in Leve, 2013). Altruism is defined as “disinterested and selfless concern for the wellbeing of others” (Altruism, 2019). Therefore, a strong element of self-sacrifice is involved, simultaneously with a neglect for one’s own needs (Curtis, 2010). This enables a construction of ‘giving a gift with nothing in return’, which donors took up in the current study. The altruism discourse facilitates egg donation as “a gift that carries few or no social obligations” (Curtis, 2010, p. 81). Curtis (2010) argues that altruism is constructed as alternative to a selfish and greedy desire for monetary reward. Altruism is seen as a form of ‘working for love’. Being “‘motivated by altruism’, necessarily involves a reduced capacity to advocate for one’s own financial, relational, spiritual needs/desires in relation to ART processes. This makes it difficult for donors to negotiate mixed motivations, and needs, which are commonly reported in the literature (Bracewell-Milnes et al. 2016; Byrd, Sidebotham & Lieberman, 2002; Purewal & van den Akker,

2009; Yee et al. 2011; Winter & Daniluk, 2004), in a context where only one is acceptable (Curtis, 2010).

Almeling (2011) states that “through organizational framing (gendered practices and discourse) and interactions with clinic staff, egg providers are encouraged to draw on gift rhetoric when discussing their decision to donate” (in Leve, 2013, p. 281). Curtis (2010) found that agency websites used empathic rhetoric, as well as rhetoric of emotion, caring and kindness, where terms such as “gift”, “altruism”, “miracle” and “making dreams come true” were used and egg donors were referred to as “angels” (p. 87). Therefore, coercion may be an issue (Almeling, 2011; Shaw, 2007), where fertility clinics elicit this ‘gift’ rhetoric to serve the fertility industry. Donors take up this discourse to position themselves as ‘selfless’, ‘altruistic’ individuals, which is not only described as ‘noble’ (Esposti & Pavone, 2019), but ‘exalted’ and ‘valued’ by the fertility industry (Curtis, 2010, p.82). This can be seen where donors construct their eggs as ‘a means for someone else to have a child’, and the ED process as ‘giving a gift’ or a ‘small thing to do that helps in a big way’, where women demonstrate an appreciation of the powerful desire for motherhood (e.g. Kirkman, 2003). Curtis (2010) argues it is not the agency alone that holds these ‘gendered expectations’ of women egg donors, which are also demanded by recipients, clinics and agencies, and can be taken up by donors themselves to avoid reflecting on the risks they are taking.

Curtis (2010) argues that altruism rhetoric is gendered in a way that women are required (and expected) to position themselves as emotionally invested in the recipients they donate to, and that this investment is constructed by ideals of motherhood and encourages risk-taking and self-sacrifice (Curtis, 2010; Esposti & Pavone, 2019). This investment often leads to donors donating more than intended, putting their bodies at additional risk, to help particular couples succeed (Curtis, 2010). This can be seen in the current study, where one donor agrees to donate again with a surrogate added into the procedure to carry her eggs into gestation, which she states is a scenario she experienced as undesirable and a stipulation of her donation before becoming emotionally involved. Although this made her feel ‘side-lined’ she continued to donate to meet her recipients’ needs. This investment can also be seen

where donors construct their eggs as ‘the gift that does not work’ and expressed feelings of guilt and disappointment in response to failed cycles.

Houston (1990) argues that to take up the altruism discourse, donors must align themselves with gendered assumptions of labour, which assumes women are responsible for caretaking and nurturing (as cited in Curtis, 2010) and to womanhood ideals linked with to motherhood and home (Douglas & Michaels, 2004; Gal & Kligman, 2000; Welter, 1996; Curtis, 2010). Andrews (1992) states “[I]n most instances, when society suggests that a certain activity should be done for altruism, rather than money, it is generally a woman’s activity” (as cited in Curtis, 2010, p. 94). Curtis (2010) highlights that the focus of the industry is to ensure donor reliability and marketability to recipients, more so than ensuring women make informed decisions.

The construction of ED as ‘giving a gift with no strings attached’ contradicts the genetic discourse, where sharing a genetic connection is seen as bestowing immutable social relations. Although donors construct ‘not wanting anything in return’ for their gift and could not accept payment, confirming previous research (Almeling, 2006; Kirkman, 2003; Lee et al., 2017; Pennings, 2015; Winter & Daniluk, 2004), acknowledgement for the gift was however invited. This suggests that a relationship in gifting exists (Goedeke & Daniels, 2016; Kirkman, 2003; Shaw, 2007; Yee et al., 2011). Shaw (2007) suggests that in any gift giving context, there is an expectation for and degree of reciprocity, inviting a social relationship between gift giver and recipient. When the gift is also constructed as a genetic gift, the gifting relationship is further complicated, as it involves ties to the gift-giver/donor.

ED policies of openness, identifiability and prohibited anonymous donation practice in New Zealand (Daniels & Douglass, 2008), made law by the Human Assisted Reproductive Technology Act (2004), “have created an environment where giving and receiving reproductive material is not an entirely anonymous or impersonal affair for those involved” (Shaw, 2007, p. 294). ED is a practice of reciprocity as opposed to a one-way exchange, where the donor exchanges their eggs with recipients for mutual benefit (e.g. future contact, involvement in disclosure arrangements and parenting decisions). Therefore, although eggs were constructed as physical resources

intended to achieve a pregnancy, as disembodied, disposable objects, and as a 'gift', donors suggest they hold much more meaning. Shaw (2007) confirms this meaning by defining the gift-exchange as a gesture of human solidarity, as found in the current study, and social connection. It is a gift that cannot be 'given away' as the genetic ties suggest ongoing connections to the gift-giver. This suggests bodily parts cannot be gifted because they are not disembodied parts, in fact, they are biologically and emotionally attached to their owner, who may hold maternal feelings for them or the baby they have the ability to create (Culley & Hudson, 2009; Curtis, 2010; Goedeke, 2014; Shaw, 2007). Carrier (1990) argues this 'gift' is not only tied to the donor, but "part of a complex web of social relations" (as cited in Curtis, 2010). Shaw (2007) also comments it is the nature of the gift, the context in which the gift is given which makes it difficult to give away. Where the fertility industry 'frames' donation as an altruistic 'gift' it does not see the 'invasive service' required to give the gift (Curtis, 2010; Shaw, 2007). This is demonstrated in the construction of ED as a big life decision above. Almeling (2006) suggests egg donation is more meaningful than sperm donation because women hold maternal feelings for their eggs and the resulting offspring. Sperm donation is comparatively seen as a job, as something you get paid for. In the current study, donors state they do not want to be seen the same way as sperm donors, highlighting ED may be more meaningful to woman as it is 'not something they want to do and forget about', and many desire future contact with the DCC (as in Nelson & Hertz, 2017).

The way the genetic discourse was assumed and resisted by donors demonstrates how biomedical eggs as physical resources and ideas about child ownership operate to restrict relationship forms and creativity available in ED for women to define their role. It also suggests an ambiguity in how to construct eggs, as women suggest they do not want to forget about their donation, but they fear becoming too involved. Therefore, there seems to be a lack of comfortable positions for women to assume, which could have a negative impact on their wellbeing.

Although ED was framed as 'a gift where nothing was desired in return', a contesting genetic discourse was also taken up to advocate for ongoing connection. The next section will discuss such discourses and the implications for woman egg donors.

Tension in donors' attachment to their eggs – the genetic discourse

Donors both resist and take up a genetic discourse in their construction of eggs.

Donors resisted the genetic discourse in that they constructed their eggs as physical resources, wasted by donors if not put to use (as in Kirkman, 2003), as a means to an end, as disembodied cells. These constructions help donors to minimize a connection with and their attachment to their eggs, which facilitates donation. Further, they constructed the eggs as “not yet a baby”, where the shared genetics they have to the egg/DCC are minimized by the fact that there is ‘not yet a baby’.

When there is a child, , the unattached position becomes trickier to take up. For example, one donor constructs eggs as having ‘the potential to always be a part of you’ which shifts the construction away from a present-focused (just an egg) to a future focus (will be part of you), in which the shared genetics are given meaning and the genetic discourse appears to be reasserted. This contradicts constructions of eggs from an unattached position, by suggesting an ongoing relationship/connection as bestowed *through* genetics. Further, an embryo, although also still ‘not yet a baby’, aligning with constructions of eggs, is described as harder to give away. Embryos were also seen as equivalent to a ‘full child’, with ‘full’ implying greater connection, while eggs were described as ‘not yet anything’, and held at arms-length confirming previous research (Kirkman, 2003; Kirkman et al., 2014).

The extent of shared genetics, and the way in which genetic material is to be used may be more or less meaningful to donors. When a genetic discourse is resisted, an ‘unattached’ position may be enabled. When the genetic discourse is taken up, the distance becomes more difficult. For example, donors suggest that transferring eggs as ‘property’ can be difficult, suggesting a tension between remaining unattached but still wanting some involvement. This is reflected in the experience of donors wanting to be kept informed in relation to their eggs, their use, and the outcome of donation. The conflicting positions suggest there are tensions in the attachment donors hold for their eggs. Therefore, egg donation may be associated with conflicting emotions. Taking up an ‘unattached’ position was considered an attempt to avoid more difficult emotions, therefore, enabling donation. However the ‘unattached’ position was often unsuccessful in avoiding conflict/distress for the women in this study – who generally desired some form of acknowledgement and connection. This is an important finding

in that some discourses that encourage women to donate eggs may not be associated with women donor's health and wellbeing.

Negotiating connection to DCCs and families

The genetic discourse constructs shared genetics as bestowing immutable biological and/or social relations between the DCC and the donors' own children. Donors both drew on and resisted the genetic discourse, in both instances, as a means to ensure safe boundaries between their own children and the DCC, but also to maintain their own relevance and connection to the DCC

The donors' naturally conceived children were emphasized as their 'own' as donor's had played a part in mothering them through genetic ties, gestation, birthing, and social practices involved in child-rearing. Therefore, their mothering role was seen as more concrete with their own children (social as well as genetic) than with the DCC. Labelling their children as their 'own' emphasized that their responsibility was for their 'own children' and not the DCC (as in Kirkman, 2003).

Donors also resist the maternal/genetic discourse, however, which positions them as 'mothers'. Instead, they draw on a law/legal and property/ownership discourse, positioning the DCC as 'belonging' to the recipient. The property discourse can be seen as the lowest level of involvement, where the donor is essentially removed from the ED picture. Here, gestational practices are brought to the fore to construct recipients as the 'only' family for the DCC. This relates to the construction of motherhood as 'gestational' (more below).

In contrast, construction of the DCC as a 'niece/nephew' or as 'special' positions the donor closer to the 'involved' end of the spectrum. Through using family constructs or friendship terms, interest and possible involvement in the DCC's lives is enabled, but with particular boundaries and circumscribed responsibilities. This role enables donors to have a role/interest in nurturing and caring for the DCC. From this position, donors are responsible for considering the welfare of the child and remaining available for potential contact. Donors also acknowledge the child's right to know their conception story and the damage non-disclosure can cause, bringing genetics to the fore. Here, social forces can be seen operating to define the 'good mother' as one

that takes some responsibility for the DCC and focuses on the child's needs instead of their own. This relates to the construction of motherhood as a collective.

When donors position themselves here, as selfless and responsible, a 'good mother' label is rewarded by society, as a badge of honour. Curtis (2010) states when a woman holds an attachment for her eggs and a concern with who they are donated to, they are consequently constructed as "a good woman" (p. 95). These social constructs complicate any straightforward decision to donate, as there are wider implications for women to consider.

These various levels of involvement confirm previous research where donors' expectations and experiences of contact with the DCC ranged from none to a close relationship (Bracewell-Milnes et al., 2016; Kirkman, 2003; Kirkman, 2014). When donors construct the DCC as an extended relative they implicate genetics may have a role in defining their relationship with the DCC (as in Kirkman, 2003; 2008; & 2014; Indekeu et al., 2014). Significant tension can be seen where donors position the DCC as 'not mine', 'not attached', but they 'care' and would be 'devastated' if anything happened to the DCC. Therefore, donors suggest a difficulty in making sense of constructions that draw the DCC near and distance themselves as a result. This suggests a constant to-and-froing where women try to stay unattached, but still require a level of involvement, which indicates the positions available for woman egg donors may not be productive.

One action possibility enabled through the genetic discourse for donors was concerns for the safety and welfare of the child, confirming previous research (Graham et al., 2016; Isaksson et al., 2014; Kirkman, 2003; Kirkman et al., 2014). Since donors construct the DCC as connected to them, as a 'niece/nephew' and 'special', they position themselves as 'guardians' or 'extended relatives', with an interest in and responsibility for the child's welfare. Concern for the welfare of the child is one form of mothering available to women donors, and has been reported in previous studies (Graham et al., 2016; Isaksson et al. 2014; Kirkman, 2003; Kirkman et al. 2014). Similar findings have also been cited in embryo donation research (Goedeke, 2014).

Donors demonstrate their sense of responsibility for the child's welfare in various ways. First, through choosing suitable participants that would provide a 'secure

environment' for the DCC. Donors felt responsible for ensuring the child would not be 'ill-treated' but loved by their recipient families. Donors also felt responsible for ensuring the DCC has a positive upbringing. They position themselves as responsible in the event of difficult upbringings, and should the child begin having psychological difficulties in the future.

A concern for the welfare of the DCC also positioned donors as open to contact in the future. Contact however, was for a purpose, where donors chose not to emphasize the purpose of building a relationship with the DCC but to fill in missing knowledge and inform the child of their genetic heritage and genealogy. A genetic discourse was drawn on to construct disclosure with the child as 'the child's right' and as pivotal for enhancing the child's sense of self and wellbeing. This confirms findings in previous studies (e.g. Baccino, Salvadores & Hernandez, 2014; Kelly & Dempsey, 2016; Nordqvist, 2014). However, for some donors with minimal involvement, where direct contact with the DCC was not available, donors expressed the hope that the recipient parents would disclose to the child (Bracewell-Milnes et al. 2016). While disclosure of donor conception is recommended in New Zealand, this is not enforceable and rests on a perceived moral obligation of the recipients to disclose. Therefore, donors experience a lack of control to meet their responsibilities for the child's welfare. Enabling this responsibility rests on if and when the DCC makes contact in the future (e.g. at sixteen-to-eighteen years of age).

Counselling was seen as a platform where disclosure and expectations around information sharing and contact arrangements could be discussed. For some donors, recipients that wanted no contact were turned down immediately. Donors therefore, demonstrate they are driven to protect the child from the detrimental effects non-disclosure may cause, confirming research by Freeman (2015). Instead, donors favoured disclosure arrangements where the child's conception story was introduced from an early age and expanded upon according to the child's level of development (as in Van Berkel, Candido & Pijffers, 2007; Yee et al., 2011). By drawing on a genetic discourse and taking responsibility for the DCC's welfare, donors can be seen as drawing closer to the DCC, positioning themselves as 'partly mothers'. However, this is a limited form of mothering/care available to women when considering other

forms of motherhood, such as stepmothers and adoptive mothers, where genetic relatedness is not possible, but a mothering role is still taken up.

Defining and Negotiating Motherhood

Indekeu et al. (2014) suggest that reproductive technologies may challenge cultural norms of what constitutes motherhood and concepts such as ‘maternity’ can take on new meanings through these technologies. They highlight that although the construction of family as defined by genetics “appears to be a biological truth set in stone, biology is never just a given; it is also socially constructed” (Indekeu & Hens, 2019, p. 18). The section provides a discussion of the various constructions of motherhood that were drawn on by donors to reinforce and challenge traditional understandings of kinship (Indekeu & Hens, 2019; Indekeu et al., 2014). Motherhood constructed as ‘shared parenting’, a ‘collective’ role, offered donors a level of involvement in the DCC’s life, where they were able to demonstrate their care for the DCC. A competing construction of motherhood as based on gestation and birthing provided a narrow view of motherhood, where recipients assumed full responsibility for the child, positioning donors as ‘not mothers’.

Motherhood as genetic – Donors as ‘partly mothers’ and the concept of ‘shared parenting’

Donors drew on the genetic discourse which positioned donors as having a role, reinforcing “previously held cultural constructions of kinship” where kinships ties are constructed as based on genetic ties (Taylor, 2005, p. 189). A genetic discourse would imply that only those who are genetically related assume positions as mothers. Donors positioned themselves and were positioned as ‘partly mothers’ because of the shared genetics. From this position, donors took up some responsibility for the DCC’s welfare but did not assume full responsibility for mothering the DCC because they identified as only ‘partly’ mothers. This construction suggests the concept of parenting does not need to be exclusive to one woman or a couple, instead it can be seen as a shared responsibility. Here, ED can be seen as resulting in a ‘shared parenting’ arrangement also found in embryo donation research, where the genetic discourse brings the recipient parents and the donor together due to the genetic ties the donor and offspring share (e.g. Goedeke & Payne, 2009; Goedeke, 2014).

Goedeke & Payne (2009) suggest this shared parenting arrangement where the donor has some involvement, may cause recipient mothers to feel the child is theirs, but not entirely, as they share genetics with the donor. However, this construction of motherhood enabled donors to negotiate a role in the DCC's life. This may cause donors to feel more comfortable with their lack of legal rights to the DCC by drawing on a discourse that reinforces immutable social relations as bestowed by genetics. This 'shared parenting' arrangement allowed woman donors to 'mother/care', in a limited way and enabled earlier connection with the child. Donors contributed to nurturing the child by carefully considering the welfare of the child. Stevenson (1998) suggests 'collective' or 'shared' parenting can enhance wellbeing during adolescence. This is particularly relevant to ED, as recent research indicates adolescence can be a challenging period for the DCC in forming their identity (Indekeu & Hens, 2019), confirming previous research (Golombok, Blake, Casey, Roman & Jadva, 2013; Nordqvist, 2014). Therefore, this 'shared' parenting arrangement may be beneficial, as it provides wider family networks and support. This may enable more support for the DCC, but also an opportunity for the donor and recipient to support each other (e.g. through pregnancy, parenting decisions). However, shared parenting could also undermine the recipient mothers authority and position the donor as a threat which could have an adverse effect on the donor/recipient relationship (Goedeke & Payne, 2009).

Where mothering was constructed as a shared responsibility, the role of genetics is brought to the fore. This position offered donors more involvement than the gestational discourse, where a narrower view of motherhood is adopted. Here, the naturalness of human life and the sustainability of the population were prioritised by donors, which contradicts constructions of ED as 'unnatural' that are present in society. This construction confirms Kirkman's (2003) findings that donation is not incompatible with motherhood.

Here, a new model of kinship is considered, to challenge traditional norms of what constitutes parenthood (Indekeu et al., 2014). From this construction donors are not expected to 'give the gift of motherhood' away, with nothing in return. Instead, they are enabled to negotiate the gift by constructing ED as a form of reciprocal exchange, where responsibilities are shared (Shaw, 2007). In this shared parenting construction,

the donor could be acknowledged and enabled a level of involvement within certain boundaries. The gestational, social and genetic aspects of parenting are held together by both parties and integrated, as opposed to defining parenthood as one or the other (e.g. gestational versus genetic). This enabled donors and recipients to appreciate the importance of genealogy, as is prioritised by policy around ED in NZ (e.g. HART Act 2004), without allowing the genetic relationship to cross boundaries and destabilise family relationships. This is a modern, more productive position available for donors (Grace & Daniels, 2007). Wallbank (2002, as cited in Grace & Daniels, 2007) suggests this modern construction, which can hold various elements of reproduction and build families in relationship with each other, has the potential to strengthen and lengthen connections among parties involved in ED, and enable them to operate alongside one another. It is important to note, however, this is a new, and uncommon practice, which may work for some donors and not for others.

Motherhood based on gestation and birth – A narrow view

A biological discourse was drawn on by donors to construct the biological connection the recipient mother and DCC shared as significant for defining attachment (as in Kirkman, 2003, 2008). This construction is also identified in embryo donation research (e.g. Goedeke, 2014). The lack of this gestational connection between the donor and donor-conceived offspring, was constructed as distancing the donor from the child. Placing importance on the biological connection made between mother and child during gestation draws the DCC into the recipient family, whilst separating them from the donor. The lack of a biological connection to the child makes donation easier than relinquishing a child that developed during gestation and was birthed by the donor. This gestation period and the experience of birthing the child were considered key aspects where a strong maternal connection was developed. Research indicates that some recipients frame gestation as having the ability to affect genetic expression (e.g. characteristics of the child) (Indekeu, 2015). Indekeu (2015) found that this not only helped recipients to achieve legitimization of the donor-conceived family, but also played a role in creating family bonds and kinship. This construction minimized the meaning of genetics in defining motherhood and alternatively brought the physical practices of gestation and birthing to the fore, positioning the recipient as the one true mother. In NZ, laws around legal parenthood also reinforce a gestational

discourse, where the woman who births the child is legally recognised as the mother and her partner is the other parent, regardless of whether donor gametes were used. This consequently minimized the role of the donor, who was less likely to request ongoing relationships with the DCC and recipient family in the future.

The construction of motherhood as gestational is also reinforced by legal discourses of ownership involved in ED, where donors must sign away their legal rights to any resulting offspring. Therefore, donors had to position themselves as ‘not mothers’ in order to donate. Assuming this position as ‘not the mother’ was challenging for donors that wanted to contribute to mothering the child in some way. This can be seen in the frustration donors expressed where clinic staff minimized their role in donation to ‘purely parts’. Donors describe feeling ‘just like a number’, ‘part of a factory’ and dehumanized as a result of this treatment. Clinic practices actively encourage a degree of contact between donors and the DCC (ANZICA, 2018). This may be in part what makes it more difficult when donors are treated ‘just like a number’ and are ‘cut-off’ following donation, as policy and counselling practices have emphasized that there are longer term implications. Also, the law is inherently contradictory. Legally, the birth mother is the parent, drawing on the discourse of motherhood as gestational. However, the Human Assisted Reproductive Technology (HART) Act 2004, explicitly asserts the significance of genetic ties. Tensions can be seen where these legislative guidelines emphasize genetics, but there is no birth certificate annotation, as there is in Victoria, Australia (VARTA, 2019).

Indekeu et al. (2014) suggests there is a stigma surrounding ED as an ‘alternative practice’ to achieving parenthood in comparison to the social norm where the man, woman and child share a genetic connection. The construction of motherhood as defined by the gestation and birth period of the DCC works against constructions of ED as abnormal. Donors who take up the ‘advocate’ position aim to normalize and encourage egg donation, to contribute to recruitment numbers. The ‘advocates’ draw on this discourse to place importance on the biological connection with the child in defining motherhood. Therefore, the gestational discourse can be seen as contributing to normalizing ED practice. Indekeu et al. (2014) highlights that this construction of motherhood is also taken up by recipients, where they position donors as a means to an end following the birth of the child, which enabled them to fully embody the

position of a mother. Recipients who had received donor sperm also drew on mothering as based on social practices, in order to emphasize their role as parents and minimize the role of the donor (as in Indekeu et al. 2014). Kirkman (2008) suggests feelings of discomfort were present for recipient mothers of donated eggs. This suggests donors position themselves as ‘not mothers’ to enable recipients to feel confident in assuming the position of the DCC’s ‘real’ mother. Positioning donors as ‘not mothers’ protects the recipients from feeling threatened by donors positioned as ‘mothers’. This speaks to the protected and defended construction of ‘mother as child owner’ by NZ law which assigns recipients as the legal parents. This suggests donors must assume a restricted position in the context of this gestational discourse. Therefore, social mothering may have more flexibility/options.

This construction of motherhood is ‘narrow’ when considering that in some contexts, genetics (e.g. DNA) confers parenting status (Indekeu & Hens, 2019; Leve, 2013; Taylor, 2005), and that in other methods of becoming a parent, such as adoption, mothering is defined not by genetics, not by the gestation period and birthing, but by social practices involved in child-rearing.

Mothering defined by social practices involved in child-rearing

Indekeu and Hens (2019) emphasize that although family defined by genetics is the most dominant societal norm at present, other forms of ‘mothering’ exist. For example, those based on social practices. A discourse of motherhood defined by the social practices involved in child-rearing was also identified and drawn on by donors, confirming previous research (e.g. Goedeke, 2014; Kirkman, 2003). However, this was a much less dominant discourse. This discourse constructs mothering as having a personal investment and commitment to the child in their everyday life ‘for eighteen plus years’. This construction challenges dominant cultural constructions of kinship as defined by genetics (Taylor, 2005). This construction differentiates the role of recipients as mothers from the donor’s role as a ‘helping hand’. Recipients suggest the experience of parenting donor offspring also contradicts the construction of ED as ‘unnatural’, where following the birth of the child recipients experienced feelings of normalization, by being acknowledged and recognized as parents (Indekeu et al., 2014). This construction works to normalize recipient parents’ role after birthing their

child, where they take up social practices involved in bringing up a child. This construction of motherhood differs to the construction of gestation and birth, as it makes room for adoptive mothers and stepmothers, where genetic ties, gestation and birthing are not possible. This is a wider construction which is much more inclusive in comparison to the previous discourse, which suggests a narrow view of motherhood. When importance was placed on social ties and the biological connection is minimized, this positively affected the likelihood recipient parents would disclose the donor conception information with the DCC (Indekeu et al. 2014; van den Akker, 2001). Therefore, placing importance on social ties to define motherhood may positively influence disclosure decisions and consequently normalize parenting as a result of ARTs. When recipients choose to disclose, the possibility of future contact becomes available to donors. Future contact may enable them to negotiate a role in the DCC's life, similarly to the genetic discourse. Those that already have contact with the DCC may draw on this construction of mothering, positioning themselves as contributing to child-rearing practices in interactions with the child. Therefore, social motherhood may offer more possibilities for women donors than gestational motherhood.

Strathern (1992) argues that ARTs blur the binary essence of nature/culture by separating social from biological parenting, making a distinction between the two, through the assistance of third parties. Motherhood as gestational gives the recipient mother ownership of this position, with no room for the donor, constraining donors from having any input or involvement in the DCC's life. This narrow view can be challenging for women, who express a desire to mother/care for the child, but have to position themselves as 'not the mother' to donate because of the strength of biomedical and legal discourses, which assign parenthood to recipients. However, there is seldom just one discourse in operation. The construction of mothering as a collective highlights how normative kinship models "prioritize 'genetic' or 'blood' relationships, which highlights that even in the context of donor gametes" (Becker, Butler & Nachtigall, 2005, p. 282), these norms are difficult to disrupt (Leve, 2013). However, where women grapple with their position as 'not mothers' due to a desire to mother/care for the DCC in some way, they suggest motherhood cannot be simplified, as the gestational, genetic, and social aspects of parenting all play some role in defining the role of the mother.

Carsten (2004) and Strathern (2005) locate motherhood as a 'process' in the ARTs context, which is flexible, fluid, and under construction as opposed to an essentialist given (Leve, 2013). Therefore, more expansive definitions of mothering that benefit women donors need to be made available (Neyer & Bernardi, 2011). The findings suggest motherhood involves a relationship that is organic, can shift/change and may require more support, or not. This is also found in embryo donation research (Goedeke, 2014).

Most clinics will say they do offer ongoing support after donation but experiences from donors and recipients seem to suggest this is not easy to access. Therefore, ongoing support for donors needs to be implemented where needed, to enable women to navigate this relationship in a way that benefits their health and wellbeing, by enabling them to construct terms of engagement that work for them. The psychologist may have a role here, in opening up further opportunities for women (more below).

Motherhood as imperative/vortex

These constructions of motherhood contradict and challenge one another, making available a fourth construction of motherhood as a biological imperative/vortex you can get drawn into against your will. This discourse constructs motherhood as an 'all-or-nothing' concept. This construction stems from the 'mother' but 'not mother' position identified, which is made available in the construction where women resist and take up the 'sibling' title. From this position, donors have an interest in and possible need to for involvement to mother/care for the DCC but struggle with the reductive constructions of what mothering is (e.g. as gestational, social or genetic). While the 'not mother' position enables donors to avoid maternal feelings and facilitates donation, donors' own needs cannot be met, as they are unable to negotiate their role in the donation process through such constructions. Consequently, they are required to come up with new positions (e.g. genetic responsibility or the 'special auntie'). This enabled the donor involvement and some 'family rights' (e.g. concern for the welfare of the child) and to show an interest in the DCC by staying on the periphery. However, their rights are constrained by an 'involvement ideal' which

serves to protect the recipient mother's position as 'the mother', whilst keeping the donor a safe distance from the DCC.

This 'involvement ideal' discourse is drawn on by donors to construct what it means to be a 'good donor', which involves taking up a 'bystander' position. From the bystander position, the donor follows strict boundaries to ensure they do not jeopardise the recipient's role as a mother or their ability to have some contact. Overstepping boundaries was seen as threatening the recipient's 'mother' role which could then lead her to limit levels of contact between the donor and DCC (Stuart-Smith, Smith & Scott, 2012). Following these boundaries involves monitoring the child's progress from a distance through their recipient mother. This positions recipients as 'gatekeepers' where they are able to control the level of contact, positioning the donor 'at the mercy' of recipients. Following these boundaries enables the donor to remain a safe distance from the DCC and avoid becoming attached. However, their own needs are possibly consequently constrained from being met. This may be because they clearly still care, as indicated by the construction of motherhood as a 'shared responsibility', where this care enables them to have involvement in the DCC's life. By following discourses that encourage them to stay in their lane, conflicting feelings arise of possibly wanting to mother, in a way that makes sense to them, but being unable to. Therefore, motherhood as an imperative/vortex does not allow women to take up certain aspects of mothering and not others, as this does not align with social constructions of the 'good mother' (Curtis, 2010). Therefore, donors are constrained to choose. They are either 'mothers' or 'not mothers'.

Implications

From the constructions of ED identified in the current inquiry, several implications for policy and practice arise. These are discussed below.

Assessment/selection of recipients

This study highlights how women are trying to find ways to care for/relate to children and families, in the context of some restrictive constraints that need not be such barriers. The genetic discourse enables donors to express an ongoing concern for the welfare of the DCC. Donors discussed child abuse to emphasize the importance of choosing recipients wisely to ensure they were placed in a loving, safe and secure home to enhance the DCC's wellbeing and sense of self. Donors' motivation to 'prevent child abuse' is employed to enable women donors to connect with the families in an ongoing and meaningful way, by caring for the DCC. However, no thorough assessments of the recipients (apart from police checks) or observations of their homes are required by ED policy in New Zealand. How successful this construction of their role in relation to donor families is likely to be in establishing ongoing connection is questionable and likely to be limited.

Choosing recipients is based on donors' instinctual feelings towards potential recipients, navigated in a mandatory pre-treatment counselling session. Donors highlight the barriers to choosing recipients. For example, recipient profiles provided by the clinic include limited information. Pronatalism and commercialisation of ART are also potential barriers for donors where they fear the recipient and clinic may tell them what they want to hear in exchange for their eggs. The New Zealand government declined a recommendation by the Law Commission (2005) to introduce mandatory screening for recipient parents to have a child through embryo donation (New Zealand Ministry of Justice, 2006). Angus (2012) suggests emphasis is currently placed on balancing the rights of the DCC and the rights of the individual (adult/recipient/donor) and these need to be considered before assessments are made mandatory. De Lacey et al. (2010) highlights that assessment can be seen as discriminatory, undermining reproductive rights and individual choice of the recipient. The researchers also suggest assessment may be unnecessary, as there is 'not yet' a child. Research further indicates that evidence suggests that parenting assessments are not necessarily effective (Anderson, 2006; de Lacey et al., 2010). Findings in the current study suggest that the need being articulated for women is

about negotiating some kind of ongoing connection with DCCs and families, and not necessarily child protection primarily.

Policy around Disclosure

In the current study, when the genetic discourse was drawn on, then the child's conception story and access to genetic information were constructed as pivotal. In New Zealand, an educative stance has been adopted as opposed to enforceable legislation, where recipients are encouraged in counselling to disclose this information with the DCC, however, this is not mandatory (Angus, 2012; Bracewell-Milnes et al. 2016; Sutherland & Postlewaigh, 2011). Therefore, these decisions are ultimately left in the recipients' hands. Donors express some anxiety around this and a fear that once their donation is complete, there is no policy to keep donors informed of the whereabouts of the child, which could be problematic for the donors 'own' children. Although donor's nonidentifying information are on the register, the DCC may not know to look if they do not know they are donor-conceived. Donor perspectives highlight the importance of negotiating connection and a relationship with the DCC. To enable donors to have this opportunity, recipients must disclose, which is not always the case. Therefore, a desire for involvement with the DCC causes them to discuss the importance of disclosure in a way that is emotionally charged. Donors' perspectives and research indicates that non-disclosure may be detrimental to the DCC, highlighting the importance to disclose their conception story to enhance psychological wellbeing and a sense of identity (Balcino, Salvadores & Hernandez, 2014; Kelly & Dempsey, 2016; Nordqvist, 2014).

In Victoria Australia, birth certificate annotation is one way genetic information is made available to the DCC from a young age. This recommendation was made for ED in New Zealand by the Law Commission (2005). However, the government declined implementing such legislation (New Zealand Ministry of Justice, 2006). Therefore, emphasizing the importance of the child's right to their genetic information and genealogy is contradictory where no mechanisms to ensure this information is given to/can be accessed by the child are in place (Allan, 2010). Falling short of such practices does not respect the best interests of the DCC, enables acts of deception, and constrains donors from negotiating connection and a

relationship with the child (Blyth et al., 2009). Although donors position themselves as ‘extended relatives’ to become more involved in the DCC’s life, legislation around ED does not as the egg donor holds no legal rights or responsibilities for the child. Therefore, disclosure arrangements are the recipients’ decision. Revisiting the current legislation in place around disclosure and a reconsideration of birth certificate annotations is therefore suggested. This may also be a direction for future research, to explore donors’ views of how disclosure could be enforced, whether through legislative changes or by implementing other methods.

Training for medical staff – a relationships-focussed approach

Donors express discomfort around their treatment by clinical staff, which they experience as dehumanizing, causing them to feel ‘just like a number’ and ‘part of a factory’. This contributed to their experience of ED as challenging. Their lack of control over the ED process and being ‘cut off’ by the clinic after egg retrieval invokes uncomfortable feelings for donors. Despite policy and counselling practice in ED which encourages contact between the donor and the DCC. Donors, nonetheless, appear to feel dehumanized in the medical process. These negative aspects of donation reported by donors could negatively impact recruitment numbers of donors. This brings forward one implication for ED practice. Perhaps clinic staff need to take a more relationship-focussed approach, fostering client-centered practice (Farrell, 2013; Hill, 2004; Stanley, 2013), where importance is placed on the donor/client so clinic staff can fully explore relational possibilities with donors and between donors and recipients. This could ensure donors feel like a valued part of the ED process. Without their input, ED would not be possible. Currently, medical and psychological practise remain distant disciplines. This can be problematic as both professions specialise in working with people. Therefore, professional development opportunities where staff can be trained to adopt a relationships-focussed approach to working with donors is suggested.

Counselling

Consent processes

Donors expressed that the pre-treatment mandatory counselling phase of donation lacks depth. However, the list of what is recommended by the Australia and New Zealand Infertility Counsellors Association (ANZICA, 2018) is extensive (e.g. where motivation, social situation, legal issues, procedural issues, and issues related to the donor-conceived person are covered). The findings suggest that perhaps practice is not matching up to policy. The lack of depth reported by donors is around considering the ongoing consequences of ED, and how this will affect them in their lifetime, which is confirmed in previous research (Kalfoglou & Geller, 2000). Therefore, ongoing counselling should focus on setting donors and recipients up for a relationship that is organic, can shift and change and may require further support but may not. ED is a complex process and the donors' and recipients' needs may change as the relationship does. Therefore, supporting donors to navigate this could improve both donors' and recipients' experiences of ED.

Fertility clinics are financial enterprises. As such, they offer services where they can meet perceived demand, without necessarily addressing the psychosocial implications for women donors (Goedeke, 2014). This implication may open up a role for counselling psychologists. Counselling psychologists may provide donors with non-biased support/counselling to consider the ongoing consequences involved in ED fully and accurately. Counselling psychologists are trained in both the scientist-practitioner model and the humanistic therapeutic relationship model (Farrell, 2013; Stanley, 2013). "These models seek: to engage with subjectivity and intersubjectivity, values and beliefs; to know empathically and to respect first person account as valid in their own terms... and to recognise social contexts and discrimination and to work always in ways that empower rather than control" (Farrel, 2013, p. 12). Given that donors experience counselling in ED as lacking depth, counselling psychologists may provide a more in-depth contextual exploration of how ED may be experienced, as applied to each donor's individual, multi-layered context. Counselling psychologists may be more suitable for exploring the implications of donating eggs, as fertility clinic employed counsellors have to operate within the constraints of clinic practices.

Promoting a critical awareness of the multiple meanings of ED in women's lives

Donors expressed ambiguity in how to position themselves within available discourses of motherhood. While they felt a need to protect themselves, they also expressed a desire for more involvement with the recipient and DCC following donation. Therefore, counselling should focus on promoting a critical awareness of the multiple meanings that ED can have in women's' lives (van den Akker, 2001; Indekeu et al., Kirkman, 2004). This may make room for donors to experience the full extent of ED and the conflicting emotions that arise, with a space provided to process these (ongoing counselling).

The different constructions of motherhood donors drew on and the constant tension identified in how women positioned themselves suggests a new focus for counselling. Exploring how donors construct motherhood and what it means to be a mother may be an important new direction. The 'shared parenting' model of kinship, where women were positioned as 'partly mothers', which challenged traditional held norms of what constitutes a family (Taylor, 2005) could be explored. Here, biological, genetic, and social parenting were combined and separated to serve individual and different roles. This may support women to engage productively with discourses of motherhood rather than police/idealise or banish/resist/demonise them and promote creativity. This may enable women who donate and receive eggs to be supported to create the terms of engagement that actually work for them. Currently, many donors follow the 'involvement ideal' which distances them from the donor or they position themselves as 'related' to take responsibility. We do not have to rely on or assume the traditional/normative ideas about what a mother is or 'ownership' of the child (Grace & Daniels, 2007; Goedeke, 2014). Exploring this could decrease some of the incongruency and conflicting feelings of possibly wanting to mother, in a way that makes sense to them, but being unable to. This opens another opportunity suitable for the counselling psychology scope. Counselling psychologists place importance on understanding the client's values and beliefs in their entirety (Farrell, 2013; Stanley, 2013).

Exploration of these may facilitate the uncovering or creation of more expansive definitions of mothering that benefit women donors (Neyer & Bernardi, 2011). This could be navigated throughout mandatory pre-treatment and ongoing counselling, as

donors emphasize ambiguity around their role in relation to the child does not only exist prior to their donation, but may become more significant once the baby is born. This may improve donors' experience, where they suggest they felt the counselling procedure made ED 'all about the recipients' and suggest ongoing support would be beneficial.

Study challenges and recommendations for future research

Various challenges arose during the completion of this research. Given the complexity of ED, I implemented a discourse analysis as my method, while simultaneously adopting a poststructural feminist lens to analyse the data holistically. Being a novice in the complex research area of ED and given the time restrictions given to complete this Master's Practice Research Project, the quality of the data gathered could be improved. In-depth interviews are needed to identify new discourses, as opposed to reifying existing discourses. Although a novice position was implemented in a way to encourage donors to share to enhance my learning, certain aspects could have been explored in more depth. More time to read and research the existing research on this area of ED prior to conducting interviews may have facilitated the collection of more in-depth data. For example, if my knowledge around what is involved in the pre-treatment counselling stage of ED was stronger, I could have asked more questions about how donors found certain aspects of the counselling session. Also, where they suggested inconsistencies between counselling guidelines (ANZICA, 2018) and the counselling received, I could have explored aspects that were lacking in their experience.

Participants were recruited from various stages of the ED process. Some donated many years ago which caused issues with memory and validity to arise. One donor did not reach the egg retrieval phase of donation and for some, the DCC was recently born. For these donors, their experience of navigating the ongoing consequences of donation was from a hypothetical perspective according to their expectations as opposed to their lived experience. Therefore, a recommendation could be made to complete a similar study with donors that donated three-to-five years to the commencement of interviews. This would ensure more in-depth findings. Donors touched on the impact ED had on their families by referring to a 'ripple effect'.

Future research could explore constructions of ED from donors' extended family members. Future research could also expand on the donors' own children and the of impact having a 'genetically linked' person or 'half-sibling', comparing their experiences between those that have contact with the DCC and those that do not. Another direction for future research could be to understand potential new constructions of the modern family in the New Zealand context, by facilitating the exploration of women donors 'ideal' roles in egg donation, which may help to facilitate future policy and practice.

Conclusion

This study highlights the challenges encountered in ED for woman egg donors. Challenges arose when women grappled with contesting discourses to assume a comfortable position in the ED process. The altruism discourse is critiqued by feminist scholars as constraining for women donors, and reinforcing historically problematic gendered norms of womanhood, motherhood and femininity (Curtis, 2010; Almeling, 2006; Almeling, 2011). When donors took up this discourse, they were positioned as having no role or a severely limited role in ED following their donation. The contesting genetic discourse alternatively offered women a position to negotiate some involvement in the donation process. The constant to-and-froing identified suggests positioning themselves was a difficult task, as women were concerned with ensuring their position did not disrupt the recipient's position or the family relations within the recipient family. This led women to take up constraining discourses of normative kinship to describe motherhood, such as the 'motherhood as gestational' discourse, where they were constrained from involvement with the DCC. One new construction of motherhood was identified which challenges the traditionally held norms of what constitutes a family and provides an interesting avenue for future research. This 'shared parenting' construction suggests a more binary form of motherhood, which combines and separates the social, biological and parenting roles, to provide a wider range of support for the DCC and enables the donor to have a role. Facilitating the exploration of other potential forms of kinship to construct new 'novel' ways of defining the family and exploring extended family members constructions of ED could help to form new arrangements between the recipient family and the donor. This could help to inform policy and practice.

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APPENDIX A - Consent form

Consent Form

Project title: Egg donation: The motivations and experiences of egg donors

Project Supervisor: **Dr. Sonja Goedeke**

Researchers: **Dr. Sonja Goedeke, Heather Gamble, Beckie Thurlow**

- I have read and understood the information provided about this research project in the Information Sheet dated May 2019.
- I have had an opportunity to ask questions and to have them answered.
- I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.
- I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without being disadvantaged in any way.
- I understand that if I withdraw from the study then I will be offered the choice between having any data that is identifiable as belonging to me removed or allowing it to continue to be used. However, once the findings have been produced, the removal of my data may not be possible.
- I agree to take part in this research.
- I wish to receive a summary of the research findings (please tick one): Yes No

Participant's signature:

.....
.....

Participant's name:

.....
.....

Participant's Contact Details (if appropriate):

.....
.....
.....
.....

Date:

***Approved by the Auckland University of Technology Ethics Committee on
08/05/2019, AUTEK Reference number 19/148***

Note: The Participant should retain a copy of this form.

APPENDIX B- Participant Information Sheet

Participant Information Sheet

01.05.2019

Project Title

Egg donation: Motivations and experiences of egg donors

An Invitation

Kia ora! I am Dr. Sonja Goedeke, a Senior Lecturer in Psychology at AUT, and along with postgraduate students, including Beckie Thurlow (Master of Health Science in Psychology) and Heather Gamble (Bachelor of Health Science Honours student) we are interested in exploring the motivations and experiences of egg donors in New Zealand. If you have donated your eggs to another individual (either known or previously unknown to you) in New Zealand, we would like to invite you to participate in this research.

What is the purpose of this research?

The purpose of this research is to better understand the reasons for which women may donate their eggs in New Zealand and to explore their experiences of donation. Findings may help inform practice around donor recruitment and appropriate support for donors. The research findings will be published in academic journals and will be presented at national and international conferences to inform understanding of donor motivations and experiences. The research will also form part of students' research and dissertation requirements which are part of the AUT Master of Health Science/Bachelor of Health Science qualifications.

How was I identified and why am I being invited to participate in this research?

You have responded to an advert posted on webpages and social media sites which asked women who had donated their eggs in New Zealand and were interested in participating to make direct contact with us. We are aiming to interview approximately 20 women who have donated their eggs in New Zealand, either to someone known to them previously e.g. a family member or friend, or to someone they did not previously know e.g. recruited online or via a fertility clinic. Participants must be fluent in English and have donated their eggs in New Zealand. Once we have a sufficient number of participants, we will close the recruitment.

How do I agree to participate in this research?

Women interested in participating are invited to make direct contact with Sonja Goedeke, as the Project Supervisor, via phone or email (see below), who will address any questions you may have about the research, and if you agree, will arrange an interview with one of the research team at a time and place convenient to you. Only the researchers will have access to your contact details. We will ask you to complete a Consent Form immediately before beginning the interview. Your participation in this research is voluntary (it is your choice) and whether or not you choose to participate will neither advantage nor disadvantage you. You are able to withdraw from the study at any time. If you choose to withdraw from the study, then you will be offered the choice between having any data that is identifiable as belonging to you removed or

allowing it to continue to be used. However, once the findings have been produced, the removal of your data may not be possible.

What will happen in this research?

If you agree to participate, the research will involve an interview at a time and place convenient to you. Where this is outside of Auckland, you have the option of being interviewed via Skype or similar media, or via phone. The interview is anticipated to take approximately 1 – 1 ½ hour.

What are the discomforts and risks and how will these be alleviated?

Talking about your personal experiences may involve some discomfort, however, we aim to ensure a comfortable and safe environment for you to talk. You can choose to stop the interview at any time or choose to stop talking about any issue about which you feel uncomfortable. Further information and support for people affected by infertility challenges may be available through Fertility NZ, who can be contacted on 0800333306 or email: support@fertilitynz.org.nz

What are the benefits?

You will have an opportunity to share your experiences of being an egg donor. This research may be useful to other women who are considering or have undertaken egg donation and may contribute to policy development and guide practice in this area. The research will also contribute to postgraduate students' Master of Health Science and Bachelor of Health Science Honours qualifications.

How will my privacy be protected?

You will be asked to provide a pseudonym by which you will be known in the study, or we can choose a pseudonym for you. All references made during the interviews to names of other people (e.g. practitioners), place names and organisations, or any other details that could compromise confidentiality will either be deleted or altered to protect confidentiality as much as possible. Only the researchers will have access to data during the data collection and analysis stage. Only the project supervisor, Sonja, will have access to the data after the final reports are produced. Audio-recordings of interviews will be destroyed following transcription. Consent forms and transcripts will be kept for six years in a locked filing cabinet in the Psychology Department on AUT premises.

What are the costs of participating in this research?

There are no costs to you other than your time. We anticipate that the interviews will be approximately 1 – 1 1/2 hours in duration and that you may spend approximately a further hour in reviewing your transcript should you wish to do so.

What opportunity do I have to consider this invitation?

The advert on websites and social media pages will ask those interested in participating to make direct contact with Sonja, the Project Supervisor, within a two-week time period. If insufficient participants have been recruited, the posting will be made again.

Will I receive feedback on the results of this research?

All participants who would like a copy of the results will receive a summary report via email at the end of the study.

A summary of results will also be made available to the organisations who posted the advert on their websites and social media pages.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Dr. Sonja Goedeke, Email:

sonja.goedeke@aut.ac.nz, 09 9219999 ext. 7186

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEK, Kate O'Connor, ethics@aut.ac.nz, 921 9999 ext 6038.

Whom do I contact for further information about this research?

Please keep this Information Sheet and a copy of the Consent Form for your future reference. You are also able to contact the research team as follows:

Researcher and Project Supervisor Contact Details

Sonja Goedeke, Email: sonja.goedeke@aut.ac.nz, 09 9219999 ext. 7186

Approved by the Auckland University of Technology Ethics Committee on 08/05/2019, AUTEK Reference 19/148

Appendix C – Interview Schedule – Indicative Questions

Sample questions - Interview Schedule

Sample question areas for donors are:

- Reason/motivations for donation, including how the decision was made to donate and factors influencing the decision, thoughts around the choice of recipient, thoughts around recruitment and recognition of donors, and the value and meaning behind egg donation.
- Experiences of the donation process, including preparation for donation, clinic and consent processes, the physical process, practical aspects, required counselling, and storage of eggs.
- Expectations and experiences on an ongoing basis, including: role of the donor, information-exchange, disclosure and contact arrangements, relationships with offspring and recipient family (prior, where a known donor, during and subsequent to donation), contact desires/needs with the donor-conceived offspring, their expectations and reality and support needs (e.g. ongoing counselling through the process of contact).
- Experiences of disclosure of donation with own family members and friends (e.g. donor's partner, own children, parents, friends, etc), the relationship between the donor-conceived offspring and the donor's own children.
- Donor's reflection on donation.
- Advice to others?