Dr. Athan had also found that, despite a dire need for training in maternal and reproductive psychology, university-based curricula on these subjects were practically nonexistent. Instead, students and professionals were relying on post-graduate trainings, supervision, and books to gain specialized knowledge. But, why should they all wait until after graduation to learn about such important issues?

I was thrilled to teach the new course – and then found myself in a similar place to where I had been at the beginning of my dissertation research. There was no syllabus. I would have to build it from the ground up. I got to work creating the class that I wished had existed when I was in graduate school. I scanned my bookshelf, reached out to colleagues, and learned that the literature available was growing quickly. It was important to me that the course represented the rich, exciting nature of perinatal and reproductive psychology in today’s complex, modern, and diverse world. So, I incorporated some nontraditional media into the class, including television episodes, movies, memoirs, blogs, websites, podcasts, and social media. They provided a deep window into people’s subjective experiences, and they were almost overwhelmingly accessible. To further broaden students’ perspectives and bring the material to life, I also invited guest speakers.

It was time to begin. Students’ excitement and curiosity, as well as their diverse backgrounds, made the course a hit. They represented a variety of disciplines, including psychology, education, nutrition, and public health. Even if students were not planning to go into reproductive mental health professionally, they could relate on a personal level in some way. Others found a new interest. Students wrote papers, participated in class discussion, and completed final presentations. They found the material to be eye-opening. Most of them said that, other than media portrayals of postpartum depression and IVF, they hadn’t known much about reproductive psychology beforehand. The field was also changing. Family leave legislation was shifting so quickly across the country that I had to completely revise the syllabus the week before the class on that topic. At the end of the semester, I told the students how unique it was to have knowledge at such an early stage of their professional development. They were trailblazers. They should now feel ready to go out into the world to better support people and educate communities – no pressure.

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It was time to begin. Students’ excitement and curiosity, is riskier than in the past, when, for example, school children extrapolated family relations from eye color or blood type. The risks they outline below imply that non-disclosure to children may no longer be feasible.

The change identified by Harper et al. comes from so many people now centralizing their genetic and (often) contact information, in one of several large worldwide DNA databases. More than two million people have tested and stored their DNA at Ancestry’s database, AncestryDNA (DNA ancestry.com/#dnaFaqWrap), making it the largest direct-to-consumer (DTC) genetic database in the world. The database has existed since 2012, yet half the testing has happened in the last 18 months alone. This explosion in genetic testing is possible because it is available directly to any consumer with access to the web, a mailing address, their saliva, and $100-$200. This and other DTC genetic databases can assist individuals in obtaining ancestry and health information (e.g., disease markers) and in discovering genetic relatives. The continued growth in database membership also means that the likelihood of finding relatives is increasing.

For example, if you test your DNA at the DTC database, 23andme.com, you receive not only the names of ancestors, but also a map of others (often with their name) who tested at the database and a link to email them through the website. One of us (JES) discovered and contacted a former employer who was also a third cousin. More than four million third cousin and closer matches have occurred at AncestryDNA alone (corporate.ancestry.com/press/company-facts/). The
point is, without much effort or (especially) thought, people interested in their origins, whether they know they have a donor or not, can submit their DNA, choose their degree of identifiability (now required by some databases), and then, eight weeks later, learn of and connect with relatives. If a donor and/or their sibling, parent, or child does this, they become potentially identifiable to a recipient parent and/or offspring who does the same. Or vice versa. A donor-conceived person with an interest in their health, for example, can discover that their mother is not their genetic relative, and become identifiable to their donor’s sister, who also, for example, submitted her DNA for health interests.

Donor programs now have to consider the implications of the existence of these external, uncontrollable sources of genetic information available to recipients, donors, and their respective families. The reality is that offspring, now more than ever, may discover their donor origins, completely independently of parents and/or donor programs. In the US, fertility clinics are in a privileged position when they have a mental health professional who meets with recipients, and who can help inform and prepare them for the risks of identifiability. In contrast, donor insemination programs have a serious challenge because counseling of prospective parents is not a typical part of the process.

What about donors? As Harper, Borry and others (2014; ASRM 2014) have cautioned, programs can no longer guarantee anonymity to donors, and should include this in their legal documentation. In addition, the larger challenge is in adequately preparing donors, especially in programs that have primarily anonymous sperm or egg donors. Whereas anonymous donation can be appealing, the benefits to donation that is “no-guarantee” anonymous or open-identity (i.e., identifiable to adult offspring) are that they require donors to think longer-term, including considering that they may meet offspring. This may, in turn, inadvertently improve the quality of information they provide. Their motivation will have to go beyond the short-term financial gain, and include a better understanding of what it actually means to help others create families. In addition, where open-identity programs may already be preparing donors for the possibility of contact with adult offspring, implications counseling could also include the possibility that DNA database information may identify donors prematurely, to underage offspring who can have different expectations and needs than adults.

These new risks bolster the relevance of Visser et al’s (2016) findings on whether donors found counseling helpful or not. In interviews with 25 current and past open-identity Dutch sperm donors, 18 felt they would benefit greatly from counseling when adult offspring contact them, including how to manage expectations and boundaries with both offspring and families. Twelve of the 15 who had participated in counseling while in the program reported greatly appreciating the opportunity. Similarly, eight out of 10 who did not, regretted not receiving counseling, especially in how to talk to family and others about being a donor. In addition, these views became more evident once they learned that actual children had been born through their donations. This reveals how, even with counseling, and even among donors who know they will be identified, it is difficult for counselors to convey and donors to fully comprehend the long-term implications of gamete donation.

Whether or not the end of donor anonymity is near, it is interesting that the debate on banning anonymous programs may be resolved, not because of offspring rights and/or health and psychological identity development consequences, but because of something completely different. The stakes have changed with the growing popularity of DTC genetic products; there is now a substantial risk to all participants in gamete donation of unexpectedly being identified. Control of donor information is passively, unintentionally and, until now, quietly being transferred from gamete providers and parents to DNA database members.

References

The Mental Health Professional Group (MHPG) is a multidisciplinary group that formed in 1985 with the full support of the American Society for Reproductive Medicine (ASRM). Its mission is to promote scientific understanding of the psychological, social, and emotional perspectives of infertility patients.