

relationship with the recipient and how the donor perceived donation and the oocyte.

**Results:** The age distribution was as follows: <30 years, 40%; 30–35 years, 46%; >35 years, 14%. The professions of donors were: employees, 62%; upper class, 11%; intermediate profession, 5%; workers, 10%; unemployed, 12%. Concerning the opinion of their partners, 68% of donors had the approval of their partner, while 39% thought their partner should not be involved in the process. In all, 83% of the women had a good memory of this experience: 60% were ready to repeat the procedure while 40% were not. The bonds between the donor and the recipient were: family bond, 32%; friendship bond, 55%; professional bond, 9%; no specific bond, 4%. The evolution of the bond was the same in 44% of cases, stronger in 37% of cases, worse in 3% of cases and broken in 6% of cases. Different images of donation and the oocyte were observed: like blood or organs, 25%; like the potential for life, 55%; like a potential child, 25%. Of the donors, 60% donated because they thought that 'to have a child is the most important thing in life', and 40% because 'it is a very precious material which would be lost otherwise'.

**Conclusion:** These women donated their oocytes by identification to infertile women. It gave the donors a very good image of themselves (altruistic). This attitude is very different to that held a few years ago. These days, to donate is part of a moral and ethical debate. Most women who donate decide to do so very easily and rapidly. More and more women say that they would have donated before if they had known about oocyte donation. The idea of oocyte donation and the potential birth of a child is the '20th century creation story'.

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## Psychology and counselling

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### P-190. Should patients be given feedback about the progress of IVF?

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**Introduction:** Clinic staff determine the progress of IVF by evaluating various markers of biological response to treatment interventions (e.g. serum oestradiol concentration, number of oocytes retrieved, etc.). Information derived from these markers is often used, either implicitly or explicitly, to provide patients with positive or negative feedback about the progress of their IVF cycle. It is not known to what extent such feedback impacts on the intensity of emotional reactions when treatment fails. It has been suggested that telling women that treatment is not going well (negative feedback) may help them prepare mentally and emotionally for the worse case scenario, thereby reducing the intensity of their reactions when treatment fails. In contrast, it has been suggested that telling women that treatment is going well (positive feedback) would increase

patients' optimism about pregnancy and lead to greater distress when treatment fails. The purpose of this study was to examine the effect of both positive and negative feedback received during IVF on emotional reactions 3 days after treatment failure.

**Materials and methods:** The sample consisted of 30 women about to begin an IVF cycle. The mean  $\pm$  SD age of these women was  $32.0 \pm 2.9$  years and mean  $\pm$  SD duration of infertility was  $\sim 6.9 \pm 3.0$  years. At 1–2 months prior to IVF, women were interviewed and completed the Beck Depression Inventory (BDI). During IVF, women completed the Daily Record Keeping (DRK) form from day 1 of down-regulation to day 3 after the pregnancy test result was known. Using the DRK, women rated the extent to which they experienced 16 negative emotional reactions (i.e. distress) during each day of the cycle. The DRK was modified so that women could also indicate, on a daily basis, the type of feedback (i.e. positive, negative) they received from clinic staff about the progress of treatment. At 3 days after the pregnancy test, women completed the BDI again.

**Results:** Women reported about the same number of days of positive (mean 3.89 days) and negative (mean 2.61 days) feedback during the IVF cycle ( $t = 1.43$ ,  $P > 0.10$ ). However, more treatment distress was reported on days when patients reported negative feedback (mean 1.11 days) than on days of positive feedback (mean 0.37 days) ( $t = 2.04$ ,  $P < 0.10$ ). As expected, depression was significantly higher at the time of IVF failure (mean 12.51 days) than before IVF (mean 7.23 days). A multiple regression analysis was computed examining the unique contribution of both positive and negative feedback received during IVF on depression scores 3 days after the pregnancy test. Overall, these two variables represented 38% of variance in depression scores with positive and negative feedback, accounting for 15.2 and 16.0% of variance respectively ( $F = 3.62$ ,  $P < 0.05$ ). Correlations showed that greater depression after treatment failure was associated with significantly more negative feedback ( $r = 0.43$ ) and significantly less positive feedback ( $r = -0.46$ ) during the actual IVF cycle. The number of positive feedback days reported was unrelated to the number of negative feedback days reported ( $r = 0.07$ ).

**Conclusions:** Contrary to expectations, preparing women for a potential treatment failure by letting them know that IVF was not progressing well did not reduce their distress when treatment actually failed. It may be that because negative feedback cannot predict IVF failure with complete accuracy, especially when based on hormone concentrations or number of oocytes retrieved, it serves only to increase distress during the actual treatment cycle without substantially affecting the intensity of reactions after the pregnancy test results are known.

### P-191. Psychosocial counselling in reproductive medicine

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**Introduction:** The rising number of couples in emotional and psychological difficulties convinced us to act in a preventive manner by defining a concept of psychosocial counselling. From the first medical visits onwards we offered an interview as an integral part of the medical investigation. The four main objectives were: (i) to evaluate the couple's capacity to bear stress and failure; (ii) to help the couple in a realistic manner without sanctioning medical treatment by psychiatric diagnosis; (iii) to enhance the liberty of the partners through an individualized therapeutic approach; and (iv) to promote access to humanization of the technicalities in a specialized unit.

**Materials and methods:** A total of 60 couples were interviewed between October 1995 and January 1996. Follow-up was performed after 12 months by an interview and a semi-structured questionnaire.

**Results:** In all, 100% of couples were reached by telephone, 83% of questionnaires were returned, 66% of couples were interviewed and 17% refused to collaborate.

**Conclusions:** Counselling is felt to be reassuring by the majority of couples. The global approach is appreciated by the patients, who feel valued and thus more able to feel themselves as partners of the team. Despite the offer of counselling, several couples were still in great difficulties but had not asked for help. These results show the importance of fixing another appointment after 6–12 months of treatment.

#### **P-192. Results of a qualitative study of psychological treatment within a fertility unit**

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**Introduction:** We conducted an interdisciplinary study within the context of a collaboration between the Department of Adult Psychiatry and the Fertility Unit of the CHUV. The aim was to assess the emotional reality of couples considering assisted reproduction treatment in the specific context of a fertility unit.

**Materials and methods:** A total of 40 couples participated in a semi-structured videotaped interview (~2 h). Three internationally validated questionnaires were transmitted to the couples to evaluate the marital relationship, parental bonding and the affective atmosphere in the family of origin. We did not wish to confine ourselves to a psychopathological evaluation, and opted for an analysis of the discourse of the couples. We evaluated 'narrative mobility', meaning the manner in which the couples transmitted their individual and familial history to the interviewer, using an evaluation grid.

**Results:** From the narrative analysis of the interviews, we distinguished three major groups of couples: (i) couples who, in the transmission of their story, left themselves and the interviewer space for elaboration (co-construction); (ii) couples who limited themselves to the transmission of requested information, without narrative co-construction with the inter-

viewer; and (iii) couples who transmitted disorganized information concerning their history, without links, or like a succession of facts, without leaving the interviewer space for elaboration. From this distinction of groups, we were able to propose different therapeutic attitudes.

**Conclusion:** The results obtained allow us to refine the concept of psychological treatment within our Fertility Unit, where modalities of collaboration between gynaecological and psychological teams are at the forefront.

#### **P-193. Alternative solutions for donor anonymity**

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**Introduction:** In Belgium the identity of the sperm donor is kept from the recipient couples or women as well as from the children. Over the years, the use of anonymous donor material has become the subject of public debate. The opposed parties are entrenched in fixed positions which block attempts at finding a flexible solution adapted to the needs of the people involved.

**Results:** An examination of international legislation immediately reveals two 'camps'. In France, the principle of anonymity is explicitly inserted into the new law on bioethics. In Belgium, anonymity of the sperm donor is guaranteed by all fertility centres and is based partly on secrecy of the medical professional and partly on the right to privacy of the donor and of the parents. In Germany and Switzerland, on the other hand, the right of the child to know his or her genetic origin, a right which is of fairly recent date, is recognized as a basic right. Dutch jurisprudence has recently adopted this right for every child, not only for the child born by donor insemination. As a compromise between the different parties, we suggest the 'multiple counter' approach, where parents can choose between a known and an anonymous donor and where donors can decide whether they want to be known. Another alternative would be that the donor's dossier contains a minimal amount of information concerning medical, social and possibly psychological characteristics which should be made available to the child whatever the opinion of the donor. In this way the needs and rights of all parties are weighted against each other.

**Conclusion:** With the presentation of these alternative solutions we wish to promote breakdown of the frozen and inflexible positions currently adopted in most legislations.

#### **P-194. Special aspects of the desire for a child among emigrated Turkish couples**

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