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ARTICLE

Refining Methodological Reflection: Exploring the Interviewing Experience of Oocyte Donors

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ABSTRACT

The article reflects on the collaborative experience between a practicing psychologist actively involved in the oocyte donation protocol (participating in guide development, conducting interviews, and drawing conclusions for the clinic) and a philologist who interprets the interview transcripts using narrative and communicative situation analyses. The article begins by describing the interviewing process, the structure of the oocyte-donor guide, and the profile of a "stable donor," drawing from Russian-language materials. Through narrative analysis of 21 transcripts, the roles of the interviewer and informant at each stage of the interview process are identified, along with their contributions to the discussion and testing of the communicative situation. The paper investigates both the instances of cooperation and discrepancies observed among the participants as they strive to construct a credible and value-consistent autobiographical narrative that comprehensively encompasses their donation experience. The article analyzes both explicit and hidden narrative motives placed by informants in a conversation unfolding from the respondent's past into a projected future. The authors aim to situate this experience within a broader personal value context, which includes compensatory aspects related to the pressing concerns of potential donors.

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KEYWORDS
interview, guide, qualitative analysis, reproduction, infertility, oocyte donor, narrative analysis, autobiography, self-description, self-representation

Introduction

As the field of reproductive donation and oocyte donation in particular continues to grow, more individuals are being involved in reproductive medicine practices. This has led to the growing awareness of the need for qualitative changes in the approaches to selecting and preparing egg donors. According to international research, the use of donor oocytes is one of the most effective reproductive technologies that help infertile people become parents (Barri et al., 2014; Hogan et al., 2020). Nevertheless, the use of donor material in human reproduction is riddled with contradictions (Beeson et al., 2015) and undoubtedly requires further study.

There is no universal approach to how reproductive donation should be legally regulated. In several European countries, such as Germany, Austria, and Switzerland, oocyte donation is prohibited by law. In other countries, like Denmark and Sweden, a procedure is considered dangerous to donors' health and is subject to significant legislative restrictions (Lima et al., 2019). Among global trends, a movement towards open gamete donation is evident (Blyth & Frith, 2009). An increasing number of countries are adopting legislation requiring disclosure of the donor's identity. Such legislation acts in the interest of children born from donor materials, granting them the possibility, if desired and upon reaching a certain age, to connect with their biological parents. While most countries allow compensation for donor expenses, monetary remuneration is not typically permitted.

Russian legislation in this area is quite accommodating and regulated by the Order of the Ministry of Health of the Russian Federation dated July 31, 2020, No. 803n *O poriadke ispol'zovaniia vspomogatel'nykh reproduktivnykh tekhnologii, protivopokazaniiakh i ogranicheniiakh k ikh primeneniiu* [On the Procedure of the Use of Assisted Reproduction Technologies, Contraindications and Limitations of Their Application]. According to this Order, oocyte donors can be both non-anonymous and anonymous. This Order does not provide for financial compensation or for its absence (O poriadke ispol'zovaniia, 2020).

In contrast to other countries, active social advertising of reproductive donation is absent in Russia. The most effective advertising strategy among experts is considered to be the "word of mouth," where information is passed on by interested individuals who have experience with donation or those in need of donor material. Other forms of advertising are considered less effective or even detrimental (Bashmakova et al., 2023, p. 43). Moreover, an essential channel for transmitting information is from doctor to patient.

The research project *Sotsial'no-psikhologicheskoe blagopoluchie donorov ootsitov: Sotsiokul'turnye faktory i osobennosti motivatsii* [Socio-Psychological Well-Being of Oocyte Donors: Sociocultural Factors and Motivation Factors], which was

conducted from January 10, 2022 to March 31, 2022, included 21 semi-structured 1.5-hour interviews with women who expressed a desire to become oocyte donors and met health requirements. The formal outcome of the interview should be the psychologist's conclusion about the donor's readiness and motivation for the donation procedure. The psychologist also evaluates the potential risks of further cooperation with this or that donor for the fertility clinic. However, the narratives obtained during the conversation between the donor candidate and the psychologist also allow for several research questions to be raised: the first question concerns the structure of the guide and the second question involves the possibility of interpreting women's statements not only as "feedback", but also as a means of gaining new knowledge about the driving motives of donation and their connection with the donor's life situation. These two questions will be our focus of attention in this article.

Goals of Interviewing, Guide Structure, and Methodology of Analysis

Given the high health risks involved in oocyte donation, it is important to ensure the donor's psychological and physical well-being not only during but also after the donation procedure. In other words, a young egg donor after the end of the stimulation cycle should maintain fertility, stable relationships with her loved ones, and be at peace with their moral and ethical beliefs. Certainly, reproduction centers need mentally and physically healthy donors who are ready for repeated procedures and are capable of weighing the benefits and risks for their mental and physical health.

Thus, the current tasks of interviewing can be formulated as follows:

- Identify external and internal sociocultural factors that influence the motivation for oocyte donation depending on the absence/presence of prior donation experience, candidate's age, and their social and economic status;
- Identify significant socio-psychological indicators correlating with motives for donating oocytes;
- Identify and systematize social and ethical-psychological problems (barriers) of oocyte donation as well as the ways donors deal with them;
- Build a socio-psychological profile of a "stable donor".

It should be noted that the clinic invests resources in donors before the donation procedure. This includes legally required medical examinations and treatment of some minor conditions that are discovered during the process, the costs of which are covered by the fertility clinics. In some large reproductive centers in Russia, there are staff psychologists whose main task is to diagnose women whose character traits or symptoms of personality disorders make them unsuitable for the clinic. The psychologist also evaluates the punctuality, communicative competence, and overall adequacy of the applicants.

Unfortunately, as far as we know, at this stage, the activity of a diagnostic psychologist remains strictly pragmatic in nature. A review of Russian academic publications gives grounds to believe that no research has been conducted in this field. As for international research, several examples of similar qualitative studies can be provided. For instance, in 2014, a team of British researchers conducted

11 semi-structured interviews with egg donors. In addition to studying the participants' own "reproductive history," that is, their experience of going through the procedures of selection, counseling, and becoming an oocyte donor, the interviews included questions about the reasons for their participation in egg donation programs, how they first learned about egg donation, and whether they discussed this procedure with other people. During the interviews, a special emphasis was made on the thoughts and feelings of the participants regarding the recipient person or couple, the resulting child, and the possibilities for future information exchange (Graham et al., 2016). A research team from Australia conducted 18 semi-structured interviews with oocyte donors. Their findings were used to devise a guide, which included questions about the experience of egg donation, the quality of medical care, and "feedback" regarding the degree of satisfaction of the donors' expectations of donation. All questions were open-ended and formulated as an invitation for the participants to describe their experience in their own words (Hogan et al., 2022).

Our methodology is most akin to the one employed by Canadian researchers (Winter & Daniluk, 2004). Their attention was focused on the interviews with egg donors. The analysis was based on the authors' acknowledgment of a respectful attitude towards egg donation as a phenomenon, and trust that individuals are the best sources of information about themselves. This is the ethical platform on which the methodological part of the article is based (Winter & Daniluk, 2004, p. 486). Our Russian colleagues, sociologists and anthropologists, also highlight the fact that the consideration of reproductive matters inherently involves value judgments (Zdravomyslova & Temkina, 2009b, p. 8). Introducing Russian-language materials into scholarly discussion becomes even more important, especially considering their significant differences from foreign practices, which will be further considered.

The material of this article consists of the transcripts of interviews with oocyte donors. There were 21 donors aged between 19 and 34. Six of them had already experienced at least one donation. The multifaceted and sensitive nature of the topic requires an interdisciplinary comprehensive approach. Initially, based on the analysis of international literature, a semi-structured interview guide was developed by giving due regard to the Russian context and in accordance with the goals of interviewing. The guide included five main sets of questions: prior donation experience, motivation, sociocultural factors that influence or determine motivation, donation barriers, and socio-demographic characteristics. The guide was developed by a professional sociologist and implemented in interviews by a professional psychologist with the help of a psychological toolkit.

After conducting the first three pilot interviews, the guide was revised because the donors had difficulty engaging in conversation and preferred to give brief answers. The decision was made to consolidate and formulate the following sets of questions: the client's family history (parental family and childhood), the current family situation, and egg donation and all its components. This allowed us to obtain the necessary narrative for analysis. In this article, the examination of the narratives resulting from the psychologist's interaction with the prospective donor is conducted in collaboration with a philologist. Together, they redirect their attention to the text, the structure of the communicative situation, the essence of the narrative, and other relevant factors for a comprehensive analysis.

Several key theoretical provisions underpin the methodological framework applied in this article. We rely on the approach to qualitative research interviewing formulated by S. Kvale (1996), which postulates openness and trust in a new type of knowledge that is not "acquired" as a result of processing "tons of verbal ore" for the sake of a psychological conclusion at the end of the interview, but rather emerges in the answers of egg donors as they attempt to articulate the pivotal moments that led them to participate in an oocyte donation protocol.

It is important to take into account the fact that women perceive their participation in the interview as part of the selection procedure, which undoubtedly affects the nature of their responses (the interview is not purely sociological; the power dynamic between the interviewer and the informant is unequal). In most cases, it is obvious to the psychologist that women want to find the "right answer" and, thus, not be "rejected," losing the opportunity to participate in the project and the expected financial reward. In this study, we do not delve into the evaluation of the "authenticity" or social acceptability of the motivations voiced by the donors, as it falls outside the scope of our material and ethical framework. From the hour-long conversation with each informant, we can provide a description of how they represent their autobiography as they enter into a new sphere of relationships for Russian society, the discourse tools they are prepared to use, and where they lay down their "individual paths." Prospective egg donors often restrict their statements to the bare minimum when they are in a stressful situation of having to undergo yet another test. From a philological standpoint, the aforementioned factors enhance the significance of discursive elements. For psychologists, socially acceptable motives for donation take center stage and are reiterated during interviews, while developed narrative fragments gain greater importance. However, during the interview, the psychologist–donor tandem constructs a specific autobiographical narrative, in which it is possible to distinguish between the layers of "routine," of what is "eventful" and "hidden" (Golofast, 1995). The peculiar nature of the situation, standing apart from everyday practices, and its formalization in the form of a conversation is what allows us to interpret such texts as self-descriptions. In his monograph, N. Luhmann defined the possibilities and limits of self-description of social systems, revealing the relativity and, at the same time, the critical importance of distinguishing between subject and object. He also pointed out the inevitability of self-simplifications in such self-descriptions (Luhmann, 1997/2009).

For research purposes, with certain reservations, we can identify three thematic areas of the guide: the situation in the donor's parental family, the woman's current family situation, and some possible future scenarios. Each area corresponds to one of the three temporal modalities: the past (childhood experience), the present ("myself now, myself today"), and the future. The sphere of "projected future" is where the traces of the collision of "scenarios" are the most pronounced: the psychologist suggests considering several situations that are modelled based on global practices in the field of reproductive technologies and the psychologist's own counseling experience; the woman's task is to react to them and perhaps oppose them with her own vision. More and more countries are enacting legislation that permits only known (non-anonymous) donors, indicating a worldwide shift towards open gamete (sperm and egg) donation

(Blyth & Frith, 2009). In this case, lawmakers act in the interests of the resulting children, giving them the opportunity, if desired and upon reaching a certain age, to meet their biological parents (Golombok et al., 2006; McWhinnie, 2001). Considering this, the main goal of the final segment of the interview is to enable the women to imagine meeting their prospective biological offspring in different circumstances and to fantasize about their emotions and sentiments in this situation.

To structure our article, we will use the "biographical illusion" of moving from the past to the future, despite the fact that in the interviews themselves, the thematic areas of "past–present–future" do not always follow a direct chronological order and often form one or two cycles that clarify (or refute) previous answers.

In our opinion, the anthropological perspective is highly relevant to our research material. Since the focus of our research is on reproduction, which is directly linked to the fundamental aspects of human existence such as life, death, and the meaning of life, the relevance of the anthropological perspective cannot be overstated. This applies regardless of whether the context is medical or domestic. Perhaps, this stage of data accumulation in the sphere of reproduction can be seen as a "panoramic dimension" of this social sphere (Golofast, 2000, p. 132). Regarding the relationship between individual texts and their potential for sociology and anthropology, V. Golofast wrote the following:

> Personal texts condense the sociocultural fabric of everyday life. *It no longer makes sense to view them only as signs of individual psychology or as a psychoanalytic space. They become a window into the sociocultural world* [emphasis added], the properties of which are much better known than the world of the soul and the unconscious. (Golofast, 2000, p. 133; trans. by N. Gramatchikova & I. Polyakova [N. G. & I. P.])

"An Open Door to the Past": The Informant's Childhood in the Parental Family

Using the informant's family history to connect their past and present can be a successful strategy for initiating the conversation with a prospective donor. This approach can establish a more comfortable psychological atmosphere and provide insight into the donor's communicative behavior.[1]

It should be noted that the women themselves focus entirely on the present. After deciding to donate their oocytes, they are generally not very interested in elaborating on the context of this decision. Perhaps, most of them are not accustomed to the role of storytellers. Most women are heavily involved in family matters, which means that even when they are focused on passing the "entrance psychological test," their own family history can evoke an emotional response in them.

At this stage, the psychologist's ultimate goal is to "do no harm": when encountering unprocessed traumatic experiences from the past, the specialist tries to "mirror" their presence for the woman herself and discuss them if the patient is ready and willing to engage in dialogue:

[1] The guide provides options depending on the donor's previous donation experience or lack thereof, but we will consider the situation in general without focusing on these differences.

Question (Q): Could you tell me about your childhood, please?
Answer (A): I was the only child in my family. Child of the 90s. I can't say that I had an ideal childhood like those who were more well-off. But my mother tried to do everything she could. It was an ordinary childhood …
Q: But were you subjected to physical punishment in your childhood?
A: Yes, you know, at certain moments, it was probably very hurtful for me. I didn't understand why, but now, analyzing my past life, I understand. She worked from nine to nine. Basically, it was my granny who brought me up. That is, she was always emotionally exhausted. Dad, so to speak, was a bit of a slacker. My father was absent most of my childhood, so my mother took it all upon herself and carried the load. At the moment I can't change anything anyway. I do realize that she was wrong, yes, but … I don't want to accept that she was wrong. Why would I accumulate this negativity towards my mother? I wouldn't be picking at her faults now.
Q: Do you remember which word you used to describe your childhood?
A: Not now, no.
Q: Ordinary.
A: Well, yes, it was quite ordinary.
Q: No, not all children, especially girls, are beaten by their parents, let alone their mothers. This is not an ordinary thing. (Donor 21)

The donor refrains from discussing the traumatic situation and seeks ways to evade such discussions:

Q: Do your parents know?
A: No, my mother died. I didn't tell my dad.
Q: And why?
A: I don't consider it necessary.
Q: And your brother?
A: My brother's dead.
Q: What happened to your relatives?
A: I don't want to talk about it. (Donor 17)

The constant shifts between the past and present function as "hyperlinks," established by the psychologist, frequently resulting in surprising revelations for the woman herself, as she often remains disconnected from her negative past experiences.

Childhood experiences are most often attributed by the informant to the sphere of the everyday, familiar, and shared with the majority. Sometimes the psychologist's and donor's understanding coincide:

Q: What was your childhood like?
A: It was wonderful. That is, I was loved, dressed, fed. In other words, it was a good and fulfilling childhood. I had an older sister whom we played with … Childhood … with family outings, with homemade pies, with books. Yes, yes. With picnics outdoors, yes. (Donor 12)

Another example:

> Q: How can you describe your childhood? What was it like?
> A: I don't know, it was ordinary, Soviet, obviously there were some moments when we experienced a lack of something, there were some good moments, but nothing negative. Nothing particularly spectacular as well. Everything was quite ordinary, normal.
> Q: In other words, you can't describe your childhood as happy?
> A: We lived, yes, in a small town, and there we didn't have everything we wanted. But in terms of family relationships, everything was fine, there were no negative situations. (Donor 14)

This dialogue demonstrates that the researcher and respondent view the woman's family history from fundamentally different perspectives: the expert seeks to identify the factors of family well-being/unwellness as an important part of the motivational complex, as well as to clarify the woman's typical problem-solving strategies and tactics. Meanwhile, the woman finds herself in a position of a person who needs to recreate a normalized picture of her parental family and/or of her current family relationships within a limited period of time.

There are, however, no clearly defined criteria for family well-being or maladjustment, not only in the common understanding but also in the Russian academic literature. As a result, researchers use several types of classifications of family dysfunction based on different sets of criteria or risk factors: medical-biological, sociocultural, psychological, socio-economic, and others (Kuragina, 2019).[2]

Thus, it can be suggested that a significant proportion of women assess the situation of their childhood in the parental family as normal, avoiding its evaluation from the position of other social strata. This may happen not only due to their internal psychological defenses but also because the concept of "family well-being" is not thoroughly defined, leading to uncertainty about what constitutes a healthy family environment:

> A: It was difficult when I was a teenager, in childhood; childhood was ordinary like everybody else's, normal, good, active childhood, wonderful friends, and wonderful parents.
> Q: So, you had a mom and dad?
> A: I had a mom and dad, but when I was about 11, my dad started drinking, had alcoholism, and basically, he fell out of my life, so I only had my mom. (Donor 18)

The interviewer's questions and clarifications compel some women to look at things differently, and what is more difficult *to articulate* the circumstances of their past that they were not accustomed to reflecting upon. Then the donor's statement "can't complain, everything was fine" (Donor 20) in the language of another social stratum reveals a long-

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[2] "Families at risk" include low-income families, families in stressful and crisis situations, families where one of the parents is a minor, families who have shifted the care of their family members to relatives, and others (Obstoiatel'stva, n.d.).

standing experience of domestic violence from her stepfather; constant cohabitation with a grandmother with dementia in the same room, which exhausted the informant, is normalized by the mother but identified by the psychologist as a real problematic situation (Donor 4); the informant habitually hides the beginning of her sexual life at age 12 from gynecologists in an attempt to avoid being judged: "Now, every time gynecologists ask me about when I started my sexual life, I sometimes give them an older age, because they start asking unnecessary questions. I don't like it, I'm against it, but I can't change it now" (Donor 6). The psychologist's clarifying questions move the donor to the legal field which considers sexual activity with minors to be illegal:

> Q: Was it a boy? Not an adult man?
> A: No, it was an adult man, but at that moment I didn't think that, he was 19.
> Q: So, he was *liable, actually, and could be charged with corrupting minors* [emphasis added].
> A: Yep.
> Q: But it was consensual?
> A: Yes. (Donor 6)

Starting with the perfunctory statement, "[Childhood] was good, we always went out of town with parents, together and united," the speaker then goes on to describe the deteriorating relationship with her father: "It's not painful or sad or fun, I just don't care" (Donor 4).

Another example: Donor 6 has been suffering from a long-standing acute feeling of guilt over her mother's suicide; this feeling was compounded by her mother's alcoholism, her parents' divorce, and her younger brother's troubled life. According to the psychologist, even though donors may have developed effective coping mechanisms, such as starting a family, having children, and learning multiple in-demand professions, unresolved "questions about the past" persist, preventing them from accurately evaluating their childhood and overall past:

> Q: How can you describe your childhood?
> A: I am not sure, really … I don't know … It's hard to describe my childhood.
> Q: What do you think, as a grown-up woman and mother of two children, why your mother chose this path?
> A: For me this is probably the biggest mystery. Most of all, perhaps … now I often find myself thinking that she was not suited for such a lifestyle, pondering about why she would do something like this … how could she have abandoned her children … And I still don't understand, I can't justify it at all, for me it's incomprehensible how she could have done something like that. (Donor 6)

The repressed past resurfaces in different forms: the eating behavior of the donor's younger brother, who was left in her care by her mother, is replicated in her son: "It's strange, he hardly ate anything, by the way, my son is behaving the same way now. He only ate bread with mayonnaise" (Donor 6); difficulties in the patient's sex life, conveyed through silence and pause in decoding:

Q: You tried and so?
A: Sex?
Q: Yes.
A: I still have difficulties with sex. In terms of psychological understanding. So, I don't know what to say.
Q: You mean you didn't enjoy it?
A: [silence]. (Donor 6)

A woman with a positive childhood background and strong communication skills is able to effectively engage in dialogue by blending persuasive transparency, advantageous self-presentation, and a well-defined sense of personal limits:

Q: What was your childhood like?
A: *I had a happy childhood*. I had a mom, dad. I did ballroom dancing; I went to an arts center. *I also studied hard*. *Because my Mum is a teacher*. I had an elder brother. I played volleyball, for a short while, because it was too far from home and interfered with my studies, neither of my parents could take me there, so *I just threw myself into studies*. After the 9th grade, I went to college, *following in the footsteps of my older brother*. Yes, he was *an authority figure for me*. Well, first, our mother influenced him, and then I followed my brother. *When I was a child, I spent a lot of quality time with my dad. He would always take me to the slides, if this is what you were asking about* [emphasis added], I have clear memories of my Christmas parties and I remember spending a lot of time with relatives as well. (Donor 17)

The answers about relationships, both past and current ones, are marked in a similar manner:

Well, it started with getting acquainted, then courting, that is, *the candy-bouquet period, it was obligatory for me.* Basically, I started dating young men when I reached adulthood. *That is, before I was 18, I didn't think much about it, I was too busy.* Generally speaking, I didn't have boyfriends as such, and after 18, when I started dating a guy, I lost my virginity, so if you need to ask me this question, it happened at the age of 18. *I haven't had many sexual partners. If you need the exact number, I can tell you, but if I can keep that secret, I'd rather not tell you* [emphasis added]. Then there were some boyfriends and that was it. (Donor 17)

In such cases, we can speak of a favorable narrative picture that the donor candidate is capable of clearly presenting in the testing situation.

In the thematic area related to the donor's past, an autobiographical narrative is formed, where what seems "routine," belonging to the sphere of daily life, prevails on the surface (Golofast, 1995). The psychologist's clarifying questions and their focus on certain aspects turn a number of practices into "eventful" ones: caring for a younger brother, early onset of sexual life, long-term cohabitation with a mentally ill

relative, parental incompetence of the mother or father, etc. This happens when self-built "defenses" against unprocessed past experiences fail and a woman finds herself face to face with her previous problems and emotions. However, there are cases when the woman is able to steer the conversation away from unwanted topics using her communication skills, as in the example of Donor 17 above. In such cases, the issue of donation may be marked as "hidden," and the specialist may note that the woman's hierarchy of concerns and problems appears to be stable since she manages to maintain privacy in the areas she does not wish to discuss during the intake testing.

In this sense, the reactions of the interlocutor (a specialist conducting the conversation) in all modes other than calm acceptance, including persistent clarifications, surprise, detachment, incomprehension, etc., mark the limits of routine and "everyday life" for the informant, opening up an exit beyond the boundaries of the social stratum into the realm of individual or group space of uncertainty, thus revealing "the prospect of stratification of determining forces, their subordination and connection" (Golofast, 1995; trans. by N. G. & I. P.) on the next step. Here, along with the understandable pain, there arises a "window of opportunities"[3] that ultimately leads to the transformation or discovery of the "biographical illusion," but these reflections go beyond the scope of this article.

The informants' discussion of their past is mostly discursive, covering two aspects of the context: as the background and condition of producing a particular text, and as an arsenal of expressive means. Discourse can highlight the normative institutions that organize the conversation.

Why the statements of informants, presented as texts, are important for the present? Sociologists observe that in personal texts people's actions are recorded and imbued with meaning:

> Personal texts are not just a parallel reality where the world of actions and behavior is doubled or imitated, reflected or retold, it is an integral part of the actions as such, the condition necessary for their repetition and comprehension, in many cases they constitute the reality that is more important and durable than the actual physical actions performed and reproduced by people. The reason why these physical actions are what they are is because they are culturally shaped and it is in this capacity that they are perceived, normalized, controlled and simply make sense. (Golofast, 2000, p. 137; trans. by N. G. & I. P.)

"Myself Today": Donors' Self-descriptions of Present

Women tend to feel more confident while answering the questions about their present. In this part, the psychologist's questions are related to the donor's current family situation, intra-family relationships, and distribution of roles (including the financial burden on spouses), place of work, desired number of children, and organization of leisure time.

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[3] As our material is limited to interview transcripts, we do not have data on how women will use it, or whether they will use it at all. However, some donors may decide to follow the interviewer's recommendations and seek individual counseling sessions with a psychologist (Donor 6, for example).

Women's decision to participate in the donation procedure is usually related to their perception of the resources that they can use to improve their overall life situation in the broadest sense. Thus, women may be more willing to accept potential risks to their fertility from donation procedures because they may perceive these risks as hypothetical or not yet existing, and may be less concerned about future threats compared to their current problems.[4] According to some donors, doctors' assurances that the donation procedure is safe if done "two or three times in a lifetime" (as reported by Donor 17) and "as long as it is not overdone, it does not appear to carry any risks" (as reported by Donor 5) are usually enough to satisfy women's concerns. Moreover, none of the prospective donors had any serious health problems and, therefore, had no experience of overcoming or encountering such problems.

An important factor that directly affects a woman's willingness to take part in a donation program is the conditions she will be offered by the clinic, including a full medical examination during the preliminary stage. It is highly uncommon for patients to receive this level of service and medical care for free in today's context. Therefore, donors mark this part of the program as a contribution to their health and a kind of step up the social ladder, especially since it is beneficial and does not involve any interaction with the bureaucratic state healthcare system (for more on the relationship between attitudes towards medical care and values and norms regarding health and illness, see Aronson, 2009, p. 159). What is worth noting at this point is that, on the one hand, people with a lower social status tend to have an instrumental attitude to their health and, on the other hand, our respondents show a strong inclination towards self-care expressed through their verbalized intention to find a "good doctor" and the "right clinic," which is made possible by their participation in the donation program.[5]

As was mentioned above, an interview with a psychologist can also be considered as a self-description text. N. Luhmann (1997/2009) highlights the paradoxical nature of such self-descriptions, as the systems themselves are part of what they describe, generating the integration of differences in order to recreate their own unity.

It can be seen that during the interview with a psychologist, some of the "puzzle pieces", i.e., elements of the patient's self-description of their present, are reproduced by the woman herself, while others arise as responses to the psychologist's questions. As a result, the formation of a specific "profile" of self-description occurs, that is a "reproductive history of a woman" (Instruktsiia i putevoditel', 2009).

All elements/themes that are included in the analysis are value-laden, which means that they are significant to prospective donors themselves: me and my child/children, me and my partner, me and my job, me and my nuclear/extended family

[4] Studies by Canadian colleagues confirm women's optimistic (sometimes excessively so) view on the process of donation (Winter & Daniluk, 2004, p. 487).

[5] For more on such practices in the context of reproductive medicine in Russia, see Zdravomyslova & Temkina (2009a). An important difference in the procedures for preparing for donation is that while international researchers discuss psychological counseling for couples before a consensus is reached (Winter & Daniluk, 2004, p. 485), in the Russian context, the burden of explaining and coordinating the decision-making process with all interested parties falls entirely on the female initiator. In general, this fits well into a gender scheme that is typical of Russia, when "the resources available to women and their beliefs about health largely determine the treatment strategies of the whole family" (Aronson, 2009, p. 166).

(relatives), me and my environment (friends, colleagues), and even me and "my God" (the latter was always prompted by the psychologist).

Young single and married women with children divide their time between part-time work and education,[6] which leaves little time for leisure activities. The latter are not well developed and easily monetized, for example, women take up creative side jobs (e.g., doing manicures). Starting their own business is often expressed as a dream (Donor 4). For young mothers with two children, family responsibilities take up all their time.

At the same time, an unclear picture of the family history correlates with the lack of clarity about the informant's current desires including those related to the choice of profession. This can be illustrated by the case of Donor 6, who adores the maternity hospital and who worked as an operating room nurse while being aware of the fact that for her, this activity "holds no opportunity for development or career growth," she also does part-time studies in veterinary medicine while being afraid of animals, especially dogs, etc.

The social environment is described as friendly and is not viewed as an issue:

> A: Most of my free time is occupied and sometimes I am on the go all day and I don't have time to think why I am not in a relationship. It means it doesn't bother me that much.
> Q: What is your friendly circle like?
> A: My friendly circle consists mainly of people I study with because we spend most of our time together. Additionally, there are friends from school, and I used to train and do sports, so I still have some very good friends from there as well. (Donor 12)

Few of the interviews we studied described situations of clear relationship distress (e.g., when a partner is completely indifferent to the woman's decision to donate, "invests little" in the relationship and in organizing joint life in general). In such cases, the woman's desire to use her fertility potential to improve her financial situation is understandable but it is not primary.

A third of the donors (7 out of 21) have experienced divorce and are now in their second marriage or "in a relationship." They tend to describe the decision to initiate divorce as their own, and attribute it to practical reasons related to their domestic situation:

> No, actually there was no some major, dramatic reason, just some daily things I faced when I was on maternity leave, that is, I had been working a lot before I went on leave and later, when I was on maternity leave, I started to realize who I was living with and I was not happy about it, so this decision was taken and we divorced, but we maintained a good relationship for the sake of our child, we have preserved a good healthy relationship … It was mostly the financial situation that I was unhappy with when I was on leave and somehow it seemed to me at that moment that it would be easier and better for me if I was on my own. (Donor 12)

[6] Among the activities that the informants remembered practicing in their childhood and youth, the most frequently mentioned were choreography, gymnastics, track and field, cheerleading, and playing the guitar. With caution, it can be assumed that in the past, most of them had experience of active interaction with their own body.

On the other pole, there is a picture of a stable family life with the spouses sharing similar values:

> We had *very similar ideas about family, that it should be a conscious decision,* and we discussed having children. I mean, we didn't discuss having children in terms of what we would name them, but rather the fact that, *well, this is the right age, there is already some understanding, there's work, there's some stability, and both of us want children, both of us want a family. We wanted a family in the traditional sense, so that we would have some rules at home*. Well, if we go into detail, if it's interesting, then *I can tell you that even before we had sex, we took some medical tests, I told him: "Dear ..., so this is what we are going to do." I won't give any names, I just said: "I want to be completely open with you, that our safety is very important to me." And we planned both of our children...* For both pregnancies, I had pregnancy supervision being done at the same clinic, all the way through. I had some difficult time during childbirth, they didn't give me enough time to dilate when I was having my second baby, that is, *we are feeling pretty serious about children and especially their health, yes* [emphasis added]. (Donor 17)

The question of whether the donor's participation in the project is a right decision by God, i.e., higher powers and values, is raised in all the cases by the psychologist. The respondents themselves frequently resort to this category in their discussions of women's infertility problems ("the Lord does not give you children," "the Lord will give you children later"). Some of them selectively adhere to domestic religious practices: "I believe that if you get baptized, you will have a guardian angel. I believe in holy water, when babies cry, you should wash them with it. However, for instance, I don't go and light candles for good health" (Donor 5).

The function of current behavior regulation is carried out not by God but by authoritative adults:

> A: I am not a believer to the extent of considering how the Lord views it.
> Q: So, does your God, the one inside you, agree with this action?
> A: Yes.
> Q: So, you are totally comfortable with this decision?
> A: Yes, because I'm not doing anything wrong. If I was doing something bad … I analyze my actions a lot, sometimes it even becomes my limitation and I don't really like it. This is why if it was something bad, I wouldn't be doing this in the first place.
> Q: What do you compare it with? You've mentioned that you analyzed it, but how do you understand whether an action is good or bad? What is your reference point?
> A: Probably, my reference point is my mother. I'm constantly with the children now, for example, if a child approaches me and I say something to him, later I think, "But if my mother … my mother never spoke to me like that when I was a child, so I must be doing something wrong". (Donor 5)

When asked directly about the attitude of their God towards the process of oocyte donation, women responded by defining their relationship with God as an equal relationship, describing it in tones similar to the way they would use when talking of distant relatives:

> Q: Does your God approve of this activity?
> A: I didn't ask Him about it; it is me who gets to decide, not Him. I never even thought about asking.
> Q: Why?
> A: Because I have my own opinion. (Donor 17)

Astrological interests and "ancestology" ("reinforcing one's bloodline that is getting weaker") can occupy the place of higher values (Donor 17). The idea of the "boomerang" is popular: "Because I want to help people to have children. I want them to have the same happiness as me" (Donor 17).

At the value level, setting the discursive frameworks (and, as a result, achieving deeper understanding) requires time and resources that exceed the capacity of counseling within the program. And then the psychologist, on the one hand, conveys the acceptance of the motives voiced by the woman ("there are no rules" to become an oocyte donor), trying to ease the tension, and, on the other hand, tries to assess to what extent the decision to donate "fits into a balanced, deliberate, informed mindset." In their turn, the women react to the interviewer's attempts to "get to the heart of the matter" with counter-questions: "What's the catch? I don't get it" (Donor 17).

What do women's narratives tell us about their present? We see how the conflicting frameworks of self-description and (auto) ethnography intersect in the texts produced by women and in the research perspective on them. In the most internally consistent system of conclusions, which is also evident in the composition of this section, we can see the influence of an ethnographic framework, which organizes, simplifies, and to some extent, imposes traditionally archaizing perspectives on the observed tendencies. The specialist is primarily interested in the candidate's social experience, coping strategies and problem-solving skills, and the nature of their immediate environment. In our view, the task of philologists is to evaluate the contribution of each party to the communicative situation, to identify moments of simplification or temptation to do so, especially given that, as we return to Luhmann, not only are self-descriptions not free of them but also are often directly inclined towards them.

The value-driven, supra-pragmatic level of motivation is not extensively discussed in the interview: aside from socially acceptable motives such as "helping people," "helping a desired child to be born," "passing on one's genes," etc., the rest requires clarification and is often not entirely obvious to the woman herself. Nevertheless, it is at this point that we approach the most generalized and comprehensive image of the "self," which emerges from autobiographical narratives that

> project consciousness and thinking onto a special temporal horizon—the macro-scale of human life. Here arises an ambiguous, perhaps unexpected, or even frightening meaning of such words as life, fate, happiness, life path, event, chance … Part of these words are used daily, but when they are applied to oneself, the conversation moves to a special level. (Golofast, 1995, p. 73; trans. by N. G. & I. P.)

“Projected Future” and Motives of Donation: “Right vs Wrong”

In countries where oocyte donation is highly regulated, there is a complex screening process involving a comprehensive social, medical, and psychological assessment of candidates for donation (Practice Committee, 2008). Research has shown (Gorrill et al., 2001) that out of 315 telephone inquiries from potential donors, only 38 women (12%) become part of the active donor pool. Another research team (Levy et al., 2007) believe that the most common reason why certain donors are rejected is their mental health problems (24%).

In our case, the outcome of the interviews conducted for the clinic is the psychologist’s assessment of the woman’s readiness for the donation protocol, the presence of a clear and consistent motivation, and the overall adequacy and communicative ability of the patient. Therefore, in the second part of the interview, the psychologist moves on to the questions about the motives for donation, seeking primarily to assess the probability of the prospective donor’s long-term successful cooperation with the clinic based on her psychological and value orientations.

There is evidence that egg donors pursue diverse motivations (Practice Committee, 2008), with altruistic motives coexisting alongside financial ones. This multifaceted motivation facilitates the implementation of reproductive programs in countries where monetary rewards for oocyte donors are legally prohibited.

For fields that are introducing new medical and social technologies and practices, such as organ transplantation, adoption, euthanasia, and others, there are some positions that already have a general public consensus, while others are still under debate. In the latter cases, progress is being made through the direct involvement of the stakeholders in the process, such as donors and recipients in our case. As their numbers grow, the social landscape is inevitably changing. Are donors ready to openly act as drivers of this change? Generally, no.

Despite the fact that most donors read literature on methods of reproduction and/or received initial information about such technologies from acquaintances who were higher in social/age status, they themselves do not share the attitude of “social promotion” of their activities in the field of reproduction. Although most of them have not encountered negative assessments of their donation or reproductive donation in general from the people in their social circle, women probably assume low societal awareness and low tolerance in principle. In this situation, even if neutral/positive reviews prevail, even few negative ones can be significant, especially in the sphere directly related to the notions of femininity, motherhood, and similar, which can be extremely painful and have a “long-playing” effect. Therefore, women are not willing to risk a situation of vulnerability, engage in “defensive” behavior, or spend time

justifying themselves, they are not ready to pay such a price for participating in a reproduction program. This partially explains why anonymity in donation is crucial for some women.

By the time of the psychological testing, the decision to donate had already been made by the women and agreed upon with their significant inner circle (the gynecologist and the husband). In some cases, the prospective donors' close ones had been informed and had no expressed opinion on this matter, being satisfied with the donor's explanations regarding the safety of the procedure for her health. The donors themselves, for the most part, perceive this project as depending solely on their decision and not negatively affecting their significant others. Viewing their own fertility as a resource, women consider their decision within the "my body, my choice" paradigm. However, these interviews indicate that preserving intra-family consent is essential for those donors who are married (14 out of 21 women in our sample).

In some cases, women who view donation as part of a broader project of self-sacrifice or a practice of "testing oneself" may face initial resistance from their environment, but this does not deter them. For these women, donation represents a significant altruistic step towards entering adulthood, among other motivations.[7] This is more characteristic of young unmarried women who live with their parents and want to finally separate (Donor 4); or those who want to "repay a debt to the past," heal a situation of guilt, etc. (Donor 6).

For some donors the concept of "secret benefactor" is quite significant: they express their disapproval of letting others know about the donation. In their eyes, it "eliminates" the meaning of this act:

> If a person does something good, roughly speaking, I think they should never trumpet their good deeds. When they do something good, it should come from their heart, it should be done for the greater good, and if it is done like this: "Have you heard? Let me tell you about it!" You can't just flaunt it, it's not right. For me, it is simply unfathomable. (Donor 17)

In the donor' eyes, this practice of keeping silent about one's good deeds is not strictly limited to donation: "We go to orphanages, we help orphanages, we do not make a show of it" (Donor 18); "basically, I don't like showing such things or talking about them. Well, you've done something good, so, you are a good person. No need to shout about it" (Donor 19).

Thus, in all cases, the donation is inscribed in a broader projective context that women articulate to some extent in the interview. All participants tend to minimize their fears of the possible negative consequences of their donation: they read articles about donation, talk to doctors, inform their loved ones, and they are hesitant to disclose their decision to others. The interviews show that some contexts of donation are better

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[7] One of the cases in our materials involves a donor (Donor 12) who also expressed a desire become an organ donor after death, although she admitted that this desire has not yet been legally formalized. This represents the most extreme position on this issue that we have encountered in our research.

understood by psychologists (for example, financial compensation[8]), while others lead to additional questions–“checks”:[9]

> All this “I want to help everyone in the world without expecting anything in return” … To be honest, I don’t believe in it. You may think differently, and it is quite possible that your belief gives you a lot, too. (Donor 14)

The final part of the interview comprises a series of thought experiments with elements of psychodrama: the psychologist describes situations of a “possible future,” sometimes taking on the roles of significant relatives (for example, the respondent’s parents) and observes their reactions. The technique appears to be quite effective if by effectiveness we mean the ability to elicit an emotional and verbal response in a short amount of time (approximately 15 minutes).

While at the first stage, the researcher takes a neutral position, as determined by the discursive structure of the narrative about the past and the representation of the present, in this part of the interview, the specialist’s position contains elements of agonalism, sometimes reaching provocativeness (“We only have an hour and a half, and we need to spend half an hour on diagnosis, so I’m pushing it a bit here,” warns the specialist in Interview 4).

Therefore, the psychologist offers to the woman a “mental experiment,” prompting an emotional reaction, specifically, she is asked to describe her feelings in the event of a possible future meeting with a child born as a result of donation: “great,” “but he’s not really my child, he doesn’t live with me, I didn’t give birth to him” (Donor 18). The next hypothetical situation is a meeting with the recipient parents and it is suggested that they might be unpleasant to the donor in appearance or behavior. The psychologist also suggests playing out a meeting with an adult child who has been given the opportunity to learn personal information about their biological mother. Each of these situations reflects the global trends of the human right to full and accurate information about their origins, and in this sense, such projective situations are completely justified as part of the donor preparation program. Another important point is that this task addresses the goal of assessing the donor’s overall emotional lability and sensitivity. This explains the active leading role of the psychologist at this stage of the interview.

[8] “Q: This means you see some advantages of donation for yourself? A: Yes. Q: Once again, which ones? Let us go through them so that we could end on a positive note. A: Self-assertion to some extent, proving something to myself. Second, I will get rewarded for the job I will do. Q: That’s it? A: Yes, I guess so. The key things. Q: I think it is an *honest answer* [emphasis added]” (Interview with Donor 4).

[9] When time is limited, this approach proves to be effective. An illustrative example from the interview: “Q: Based on what you’re telling me, you simply don’t need it. There’s just no real motive that … A: I was just thinking about what you said. Q: You see, the motive is that ‘I didn’t think it through, I read something that assured me that it’s safe and that it will be helpful to someone,’ and then I decided to proceed. I see the goal, I don’t see obstacles. Why such a goal? A: After today’s conversation, I started thinking about it” (Donor 19). Then the informant asks a series of questions about the conditions for refusing to participate in the project and admits that she has given little thought to the risks and adverse scenarios for herself personally if “something goes wrong”, for example, “I just never thought that there would be any risks on my part, that something would go wrong” (Donor 19).

Women perceive these situations as distant, only hypothetically possible (not accidentally, their remarks about their possible feelings are often accompanied by laughter, marking the situation as unserious). They are quite actively defending their vision of the future in relation to the image of the recipient parents as loving.[10] Speaking of the cases of possible claims of children born from their egg, the women disassociate themselves from "parents": "Parents are those who raised you, who put their soul, strength, time, who put all their love, tenderness into you" (Donor 17).

Here, the psychologist does not smooth out but amplifies the observed contradictions, drawing the donor's attention to the inconsistencies in her answers. The free association method here is combined with closed-ended questions:

> Q: Do you consider yourself a happy person?
> A: Yes.
> Q: In what way? You've said yes and you're smiling, what does it mean?
> A: I don't know, I am fine, everything's really fine for me, I have a great job, great friends, I have a great man, health, I think, otherwise I wouldn't have come here.
> Q: You are an oocyte donor. You don't tell your wonderful friends about it, you conceal this fact. (Donor 19)

Thus, the narrative and the situation become quite intense, which works in favor of the psychologist, as the expressed emotional reactions, both smiles and tears, become landmark for formulating/clarifying the patient's emotional profile.

In the final part of the interview, the psychologist focuses on fostering a positive attitude in the woman who has decided to participate in the donation program.

Conclusion

To sum up, we have described a counseling methodology that is being tested within the framework of the oocyte donor preparation program. For the clinic, the main outcome of the consultation is the psychologist's conclusion regarding the possibility of repeated effective cooperation with the woman and her personal characteristics.[11] Given the time constraints (one-hour consultation plus time for testing), the psychologist needs to solve a multifaceted task that includes establishing contact with the patient, engaging her in a dialogue to obtain possibly more detailed answers regarding her current situation and motives for donation, as well as offering her several thought experiments to assess the degree of her emotional stability. Without significant practical experience, the task of selecting donors cannot be accomplished by a psychologist.

[10] Typically, donors perceive recipient parents as responsible and mature individuals who prioritize values beyond monetary considerations: "They already have a completely different understanding of life and when they carry the child for nine months, they invest themselves in the process, the husband cherishes his wife, and she takes great care of herself, she wouldn't be going to the gym to do pole dancing and she wouldn't engage in an immoral lifestyle, smoke, drink, and so on. She has made a commitment. This is what I think it will be like. People who ask for children have already learned their life lesson" (Donor 17).

[11] For example, if the donor is afraid of injections, it is preferable to suggest a long-acting medication and assess whether the woman has accurate information about the preparation process for donation, etc.

Out of all the interviewees, six were recommended to seek personal psychological therapy. Two of them eventually decided not to participate in the donation program.

After analyzing the interview data, we have attempted to describe the hypothetical "stable donor" in Russia as follows: typically, it is a person aged 28–30 (which means that this person has accumulated certain life experience), with a complete family and two children. The donor has no desire for additional biological children (this decision is supported by her partner and she has no fertility concerns). The donor has an "open position" towards recipient parents and potential offspring, expressing willingness to meet them if necessary and having no fear of exposure. The donor is also willing to meet the resulting children and tell her own children about their biological siblings. It is important that the donor does not demonstrate potential dependence on relationships with recipients, leaving the initiative for contact solely to their side, and focusing on her own family and children. The donor has a clear pragmatic motivation, including a conscious understanding of donation as a socially acceptable activity. The donor has formed a structure of life attitudes and values that allows for the separation and acceptance of responsibility: "My child is the one I carried and gave birth to." She displays no accentuation of personality traits or tendencies towards dramatization and shows a disposition towards a positive result.

The main barriers to donation, as indicated by the informants, include the following: fear of adverse effects on their health, concerns about the future of the children, and the informational aspect (uncertainty about the openness/anonymity of the program, primarily within their close circles but also in society as a whole).

According to psychologists' observations, the emotional profile of oocyte donors is often "smoothed out," they are constrained at the beginning of the conversation and, as a result, provide little information. In this regard, questions about the family, both the parental family and the donor's own family, allow the psychologist to elicit more detailed and elaborate responses and prepare the woman for a more extensive dialogue, rather than just fill out a questionnaire verbally. The second part of the interview is aimed at clarifying the donor's current life situation, while the final part tests the possible emotional amplitude (taking into account its inevitable increase during hormonal stimulation).

What does narrative analysis and analysis of the communicative situation reveal? To start with, the contribution of *both* sides to how the conversation develops becomes apparent: during the initial stage, there is a process of revision of what the woman commonly regards as her "normal past"—her past experiences are analyzed from a distinct "expert perspective." Considering that for many, the decision to become a donor is motivated by financial factors stemming from the social and economic situation of the donor's parental family, the link between the woman's past and present becomes clearer, not only for the woman herself but also for an outside observer. It should be noted that this is not about "simulating well-being" for the sake of eliciting a positive assessment by the psychologist. Rather, a good sign is the closeness of the discursive frameworks of the donor and the psychologist in this case. Although she may have faced difficulties early in life, a woman can still come to terms with her complicated past, recognizing both its upsides and downsides.

In the present, women take a rather active position, and participation in donation only increases their subjectivity. The specialist's task at this stage is to make it clear that in some cases, young women pursue the goals of separation or compensation tasks that are only indirectly related to donation, and therefore the psychologist should suggest considering another option for implementing the intended goal.

Finally, the third stage of the interview should be filled with emotions and be indicative of the specialist's capacity to handle them. At the same time, we should note that women are often less preoccupied with their hypothetical future than with their present and past problems. We believe that the balance of subjectivity and objectivity towards a potential donor is the most challenging in this aspect, since the clinic is obviously concerned with the possibility of "looking into the future" and hence avoiding any problems. However, from the donors' perspective, this future should actually solve their current problems. While the ambition of reproductive clinics to follow global trends in open donation is both clear and feasible, it is important to note that most of the risks and challenges faced by oocyte donors lie outside this domain. Moreover, it may not be practical to address the areas that are truly painful for clients, given that the available resources of psychological support are limited. In this regard, the psychologist's concluding phrases are aimed at shaping a positive outlook on the overall outcome of the procedure for the potential donor.

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