

## The Stork in the Lab: Biological, Psychological, Ethical, Social and Legal Aspects of Third Party Conceptions

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**Abstract:** None available.

**Full Text:** Headnote ABSTRACT: The proliferation of third party conceptions has answered the prayers of some infertile couples for a child. At the same time it has created a variety of profound biological, ethical, legal, social and psychological problems. In this paper an attempt is made to explore specifically the psychological issues consequent to the use of AI, IVF and surrogate motherhood. INTRODUCTION Society has traditionally supported procreation within the family unit, i.e., a man legally married to a woman. Children born out of wedlock as well as their parents were strongly discriminated against in the past. Today the family is still the principle focus for childbearing and childrearing. But many people who are single or practice alternative lifestyles want to have children. Scientific advances in reproductive technology now allow for these people to have a child in an almost infinite variety of ways in many cases without sexual intercourse. I would like to discuss some of the psychological issues that arise when procedures such as in-vitro fertilization (IVF) better known as test tube babies, surrogate motherhood and artificial insemination by husband (AIH) or by donor (AID\*) are used. I refer to these procedures as "third-party conceptions" because conception is achieved with the assistance of one or more persons other than the two people in the primary relationship. The oldest and best known of these procedures is AI. Unlike test tube babies and surrogate motherhood AI has been studied for many years. I propose to examine the major psychological aspects consequent to AI and then those that follow the more recent reproductive techniques. ARTIFICIAL INSEMINATION BY DONOR (AI) Introduction Where there is a powerful desire to bear a child rather than to just rear a child and where the parents want to be biologically linked to their child, the use of AI appears to be a reasonable course of action. Psychology and Fertility We know that psychological factors can influence the function of all our bodily systems including the reproductive system. In order for AI to be successful the woman needs to have a functioning ovary, oviduct and uterus. There are reports in the literature<sup>1</sup> of women ceasing to ovulate once they commence treatment and of men becoming impotent. Judging by the much higher rate of success in veterinary medicine one must conclude again that in humans psychological factors may hinder pregnancy. Furthermore, the considerable stress inherent in the AI procedure and the preceding often long period of investigations for infertility may adversely affect the reproductive system of either or both partners. Indications for AI The accepted indications for AI are male sterility due to lack of viable sperm, hereditary disease in the husband and RH factor incompatibility. About 10,000 children are born yearly by way of AI, 1/4 million have been born over the past 20 years. Depending on how one measures pregnancy rates they vary from 60 to 85%. Pregnancy rate drops with increased age of women. AI has been regarded as an alternative to adoption and as a procedure to be used predominantly by a married woman. It has been seen as a therapy for infertility and therefore, administered by medical doctors. Comparison with Adoption - AI implies sterility by husband, adoption carries no such implication. - AI child is genetically related to mother but not social father, adopted child is not related genetically to either social parent. - Adoptive parents are screened at length by adoption agencies, AI parents receive no such screening or counseling. - Adoptive parents can usually inspect the child they wish to adopt, AI parents cannot. - AI couples experience a normal pregnancy and delivery, adoptive parents do not. No comparative studies between AI and adoption outcomes have ever been done. The evidence is generally favorable to AI and studies indicate remarkably good psychological outcomes.<sup>2</sup> Selection of AI Couples Selection is made difficult by several factors. 1. Fertile couples are not required to subject themselves to assessment. To require infertile

couples to do so smacks of prejudice. It may also be unconstitutional. 2. There is a lack of agreed upon criteria. 3. The idea of selecting suitable-for-AI couples raises the specter of Nazi eugenics and social engineering. Realistically speaking every AI practitioner sets his or her own standard which covers the spectrum from total laissez-faire to stringent rules. In my opinion a psychological assessment should exclude couples in whom AI might exacerbate or generate severe emotional problems, unstable relationships where there is a strong likelihood of marital strife or separation and couples in which one or both partners may cause the AI child physical or mental harm. In a large study conducted in England<sup>3</sup> seven couples were refused because one was a heroin addict, one couple was blind, one woman was unmarried and there were no suitable donors for two Nigerian and two Chinese couples. Having children for neurotic reasons is probably less common amongst AI couples than "normal" couples. Yet, in AI couples it could be avoided or at least decreased with proper psychological screening. The following is an example of a case that will most likely lead to the growth of an emotionally scarred child and/or the break up of a marriage. The wife was 25 years of age and the husband was 45 years old, divorced and father of three girls by previous marriage before becoming sterile as the result of an accident. The wife wanted a child in order to be like the first wife; she was sure that if she had a son her husband would be so delighted that "there would be no further problems." The child was a girl. During the interview the husband spoke only twice: "I put up with the AI," and, when the subject of the wife's prenatal fear of having a malformed baby was being discussed, "Her malformation is her horrible character."<sup>4</sup> Walters and Sousa-Posa<sup>5</sup> recommend that the AI practitioner should request consultation with a dynamically oriented psychiatrist in every case in order to determine the couple's suitability. They express concern with regard to the couples who have "neurotic, maladaptive or regressive trends." Obstetricians<sup>6</sup> at one AI center in England analyzed the variables that promote success with AI. These were listed as: - residence close to clinic - husband of social class I or II (upper & middle) - wife employed - lack of stress - total devotion to AI by couple. Several investigators<sup>7</sup> have made the point that conception frequently occurred after some external distracting influence. Thus, the wife's working or a change in the family's situation or even the birth of a child may allow subsequent conception to occur. It is interesting to note that one study<sup>8</sup> conducted in Holland on 56 couples found that four initially infertile husbands underwent a spontaneous remission of their infertility after their wives had conceived children by AI. Each of these men begot a child after six, eleven (two men) and thirteen years of a childless marriage respectively. Each of them was diagnosed by specialists as sterile. Similar occurrences have been observed with adoptions. AI Procedure To summarize the procedure: the physician who will administer AI will select a donor either from a group of donors known to him or from a sperm bank according to certain personality traits requested by the recipients, e.g., race, religion, color of hair, general body build, etc. Apart from this, the selection of a donor involves minimal medical or psychological precautions. Specifically, each prospective donor is required to take tests to detect sexually transmitted diseases and to complete application forms which if answered honestly will help to exclude donors with major hereditary diseases such as Huntington's Chorea. The husband of the requesting couple is usually asked to sign a consent form for the procedure. Two days prior to ovulation and on the day of ovulation the semen specimen is introduced into the recipient woman's vagina near her cervix. Throughout this period the AI practitioner takes every precaution to conceal the donor's identity from this patients and vice versa. The artificially inseminated couple usually keep the origins of the pregnancy secret from their obstetrician if he or she is a person other than the AI practitioner. This marks the beginning of a life-long struggle to conceal the true paternity of the AI child. The frequency of pregnancies using frozen spermatozoa is approximately two thirds of that obtained with fresh spermatozoa. The advantages to the use of fresh over frozen spermatozoa are that the pregnancy rate is about 30% higher and that the AI practitioner usually knows the donor and can therefore better match up his physical characteristics with that of the future father. On the other hand the freezing of sperm may eliminate the danger of transmitting AIDS, gonorrhea and other infections to the AI child. We shall postpone the discussion of sperm banks until a later date. Pregnancy Rates In a representative sample of 619 couples<sup>3</sup> who were referred for AI

over a 12 year period 381 were eventually treated. The attrition rate was close to 30% and divided itself as follows: - 141 decided not to proceed after the initial interview - 48 failed to attend the initial interview - 2 women who were grossly obese refused to lose weight and were rejected - 2 women refused medical investigations and were rejected. - 193 = 30% dropped out A further 7% were referred, had a child or were refused by the clinic: - 14 became pregnant after elementary sex education - 21 were referred elsewhere - 3 obtained adoption - 7 were refused for reasons previously stated - 45 = 7% On average six inseminations were required for each pregnancy and this seems to be representative of most studies. A few women underwent a large number of inseminations, e.g.: A. -25/18 months B. -22/22 months C. -9/10 months D. -62/4 years! (This lady had a daughter and conceived again after only 10 inseminations.) 117 patients (17%) withdrew from treatment after they started on the program. Of these, according to the author<sup>3</sup> of the study 38% discontinued for domestic or financial reasons (which were not defined). An unspecified number of women discontinued the program because of a miscarriage. Consequently, the total attrition rate is 54%. In other words, only one woman out of two completed the program. Now how many of the couples dropped out of the program for predominantly psychological reasons can only be guessed at from this study but the number is obviously very significant. It would be of great interest to know what the psychological causes for not pursuing the AI program were but this will have to await further investigation. The AI Practitioner Usually physicians act as brokers between the infertile couple and the donor. From reading the literature they emerge, as a group, very much concerned with secrecy about the identity of the parties involved in the AI triad and as fairly ambivalent about the morality of the procedure. For example Gerstel<sup>9</sup> in a review article in 1963 writes: "... once conception has occurred, it is recommended that the physician who has attended the patient up to this point withdraw from the case, in order that the obstetrician may be unaware of the irregular (*italics mine*) conditions under which conception occurred." A Dutch physician<sup>10</sup> says the following about his research on AI couples: It must be admitted that I had to overcome some hesitation before starting this investigation. It is my opinion that, as a rule, every contact with the couple should be broken off as soon as results are attained, in view of a quite understandable but undesirable emotional tie with the doctor who inseminated. But considering, on the one hand that this fairly impersonal inquiry was by mail and for once only, and on the other hand, that such an investigation was felt to be necessary, I decided to overcome my scruples and carry on. Another point to consider was professional discretion concerning the nature of the treatment. I had therefore to use a rather cryptic text, understandable only to the people concerned in case the forms and the added introductory letter should fall into the wrong hands. To ensure the absolute reliability of this inquiry (and to serve as possible evidence against false accusations) I invoked the aid of a notary public (in Europe a more official authority than in the United States). The forms were numbered and stamped by him and put into pre-addressed envelopes in his presence. We posted those letters together. From the returned questionnaires, bearing no names or addresses but only the mark of the notary, I obtained the data and arranged them for this report. The forms were then deposited with the notary, who verified the data presented in this paper against the answers on the forms. I think it would be difficult for a couple to feel morally good about the AI procedure if they had a doctor who was this uptight about it. I wonder whether the AI practitioners who recommend that the AI couple have sexual relations after each insemination or who mix the husband's semen with the donor's do not unconsciously imply that the husband is too weak to face the truth about his sterility and that by using these little tricks he can pretend that the child is really his. The attitude exemplified by strict adherence to secrecy and denial of the true paternity of the child seems to be an expression of the AI practitioner's belief that AI is abnormal and somehow dirty. In my readings I came across one gynecologist who told all his patients after AI "to go home and to forget it." In the absence of any research either proving or disproving the beneficial effects of these stratagems one can only question how a man who has tried to father a child for three or six or more years could believe even for a moment that intercourse after AI administration suddenly and miraculously succeeded when a previous five hundred or thousand attempts did not. However, it seems to me that there would be much value in the couple making love

after completing AI if the act was perceived by them as signifying their acceptance of the new life in their midst. In other words, as a celebration, a symbolic spiritual conception so that the resulting child becomes suffused with their love and their positive energies. If there is one conclusion to be drawn from all this, it is, that not all professionals working in the fertility field are either psychologically minded or trained. Obviously they should be. The Donor An Australian study<sup>11</sup> divided the men who donated sperm into two categories: married men with children who wished to help infertile couples or single men who needed money; many of the latter were medical students. Donating semen has been compared by some AI practitioners to donating blood. However, the two are really not analogous. Semen is given for the purpose of creating a new human being whereas blood is given to assist a person already in existence. The issues of personal and social responsibility are very different in these two cases. Legally the position of the donor is far from clear at the present time. If the AI mother or child wanted to, they could sue the donor for child maintenance payments. By the same token if a donor were to discover the identity of his child he could attempt to ask the court for visiting privileges. The Couple Most authorities agree that the couple seeking AI must successfully traverse two stages<sup>12</sup>: 1. coming to terms with the infertility; 2. confronting the problem of donor insemination itself. It has been observed that couples that rushed into AI encountered more difficulties with the procedure than did couples that delayed their decision. Consequently, most investigators recommend a cooling off period of several months before a final decision about AI is made. Only after the inability to have a child together has been resolved can the couple avail themselves of the options which include remaining childless, adopting, becoming foster parents, using AI or other third party conceptions. A commonly observed reaction of couples is an unexpressed fear that the other partner will become upset. According to psychoanalytic investigators<sup>13</sup> because semen is from an unknown donor it triggers repressed infantile incestuous strivings in both partners. They feel that exaggerated concern by the AI couple over the health of the baby, expectations of ill effects to family and society, fear of consanguinity, etc. are a function of unresolved Oedipal feelings. In the case of consanguinity, for example it has been calculated that even if AI increased by 20 times in England this would result in one consanguineous marriage every 50 to 100 years.<sup>14</sup> Yet the danger of incestuous marriage is repeatedly noted, with many safeguards devised to control the number of times a donor is used. A dearth of knowledge about the donor provides a fertile ground for the couple's fantasies. One way in which these fantasies find expression is in the fear that the physician has made a terrible mistake resulting in a deformed child, or the child of another race, or that he or she will be so different that everyone will speculate about the wife's infidelity. Research in the area of AI is made difficult by the tendency of couples to sever all link with the AI clinic as soon as they become pregnant. An interesting finding among successful AI couples is that very few of them separate or divorce. Behrman<sup>15</sup> reports that after a follow-up of seven years only 1 in 800 marriages of such couples ended in divorce. This may be due to the fact that a couple that engages in AI has probably spent a great deal of time and energy talking to each other about their feelings and that they had learned to be supportive of each other. It would be interesting to examine analogous statistics in adoptive parents. Presumably marriage break-down amongst adoptive parents would also be quite rare for similar reasons. The Husband Four out of five husbands studied by Gerstel<sup>16</sup> seemed to react to their infertility by becoming workaholics. If they could not "produce" a child then they at least would "produce" money and prestige. The husband's greater earning may also be seen as serving to atone for his unconscious guilty feelings towards his wife. The unconscious message is: I have failed you in a most important way but I will make it up to you in another way. Because of the husband's total involvement in his work one or more of the following may occur: 1. sooner or later he starts resenting having to work so hard, 2. his wife resents him for never being home, 3. he misses out on parenting his child, 4. child becomes increasingly attached to mother, 5. under the circumstances a female child will fare better than a male child. Temporary impotence is not uncommon during the period following the diagnosis of male infertility. This problem may again surface after AI. Men have reported feeling as if their wives had been violated and they had been cuckolded. The initial reaction on the knowledge of male infertility was especially pronounced among men

who thought that their wives were responsible for their childless state.<sup>17</sup> In a study of 16 AI couples Berger<sup>18</sup> found that 11 husbands experienced a period of impotency and depression after receiving a diagnosis of lack of sperm (azoospermia, oligospermia). The birth of an AI child may not relieve the psychological problems associated with the husband's sterility, indeed the child may serve as a constant reminder of the husband's incapacity and intensify his feelings of inadequacy, guilt and resentment of the child. The man must come to terms with the fact that his family lineage will not be continued with the AI child. This may pose a problem for men who are proud of their family heritage. As we have already mentioned, some physicians encourage couples to have sexual relations around the time of the AI procedure and a few will even mix the husband's and the donor's semen so the couple will never know for sure who the father of the child was. From a medical standpoint mixing the husband's and the donor's semen is counter-productive: it only dilutes the donor's spermatozoa and thus decreases the chances for impregnation. From a psychological perspective this kind of attitude only helps to cover up a reality situation, i.e., the husband's sterility which he will have to come to terms with sooner or later. The Wife Typically the wife's first thought after finding out the cause of the couples' childlessness is that she has been cheated. This leads in many if not all women to transitory feelings of hostility towards their husbands. In the study by Berger which I referred to before, 14 of 16 women experienced anger towards the husband, developed psychiatric symptoms and/or had dreams that revealed a wish to be rid of the husband and guilt over this wish. The woman may express feelings of selfishness that her genetic heritage will continue while her husband's will not. Barbara Eck Menning<sup>19</sup> writes: "I have seen women grieve as fully as their men over the loss of their husband's genetic continuity, expressing poignantly the physical details and mental characteristics which are beloved and lost to future generations." In the group of couples studied by Gerstel<sup>20</sup> the conscious fear of revealing their "secret" became so strong that four of the five women refused an anesthetic during delivery. Psychological repercussions following the birth of an AI child may include the development of a fantasy by the wife of affection for the donor, the focusing of her love exclusively on the child, or even resentment of the child for alienating her husband from her. Rubin<sup>21</sup> in his study of 85 women all of whom had been artificially inseminated found that they did not differ significantly from a group of mothers who had children through natural insemination in terms of childhood development, attitudes about femininity, and in their pregnancies and subsequent care of children. The Child Jackson<sup>22</sup> in her study of 127 AI cases reported that the children so conceived were rather above average physically and mentally. An Australian study<sup>23</sup> on 50 AI couples shows 14 parents complained that their children were hyperactive. 37 children reached their physical milestone early. The higher than average rate of hyperactivity could be due to over stimulation of the baby or over anxiety of the couples who waited many years before the pregnancy. The finding that these children were physically advanced would also fit in with more than average stimulation. Marik<sup>24</sup> at the Tyler Medical Clinic in Los Angeles investigated the effect of the use of frozen sperm in AI and found that the children born to 74 couples scored higher than normal on most IQ tests. A Japanese study<sup>25</sup> of 54 children born after AI obtained the same results. A study<sup>26</sup> based on a survey of the outcomes of all AI's ever carried out until 1980 in six eastern Canadian fertility centers found that the children conceived by AI may have trisomie and trisomy abnormalities (i.e., trisomy 21 - Down's syndrome, trisomy 18 - Edward's syndrome and trisomy 13 - Patau's syndrome) four to seven times as often as normally conceived children. This is the first large scale study which has detected any negative physical effects of AI on children. Because of the difficulty of obtaining data on the subject the results should simply alert us to the possibility of increased teratogenic risks in AI. The AI child is almost always raised as if she were a natural child of her parents.<sup>18'</sup><sup>20</sup> However the child senses that something very important is being hidden from her and this family secret usually leads the child to believe that there is something very much wrong with her. Obviously this sort of ideation is not beneficial to healthy ego development. Secrecy About AI Without a doubt, one of the most difficult areas which AI couples confront is the concern over confidentiality. Most physicians recommend keeping the procedure a confidence, protect the couple by coding their records carefully, and refer them for delivery to an obstetrician who has no knowledge of

the case. The records of the donor are also very carefully coded, and many physicians destroy them after a period of time. Therefore, there is no possibility of a child searching for his or her genetic father. Such fears were present only a few decades ago with respect to adoption. Where once adoption agencies advised parents to conceal the adoption they now counsel to tell the child as early as possible about his adoption. AI couples naturally worry over confidentiality. It all boils down to "what other people will say." In my experience "others" will not be critical unless the couple itself harbors strong negative feelings of guilt or disapproval about AI. It is incumbent upon professionals working with AI couples to impress upon them that infertility is a medical issue not a moral one. Consequently, they need not be ashamed for resorting to a medical solution to their medical problem. Although the secrecy surrounding AI has been shown to be virtually ignored by the researchers, a review of the data provides evidence that the secrecy itself may be psychologically harmful.<sup>18-20</sup> Furthermore, those studies which attempt to consider psychological suitability for AI and the psychological consequences of AI are severely hampered by concealment. This state of affairs is further buttressed by legal uncertainties, which both foster and are fostered by the secrecy. Should it be concealed from the individual? Researchers are divided on the question. The fact is, we lack scientifically valid studies about secrecy. In the absence of these the best that we can do is to raise all aspects of this problem with the couple and then support whatever course they decide to follow.

**Moral & Religious Issues** The Roman Catholic Church and most fundamentalist Protestant Churches still consider AI as adultery and a child so conceived illegitimate. **Legal Issues** Statutory and case law have established that AI by husband (AIH) and by donor (AI) within marriage with the husband's consent are legal and that the child so conceived most likely will be considered the legitimate issue of the husband and wife. Only one statute, and one court decision and one legal article<sup>27</sup> consider the subject at any length. All court decisions have been based on the premise that a child's best interests can only be realized by giving or finding the child a father. There have been cases seeking to recover damages from physicians for "wrongful life." These actions have been filed on behalf of children born with negligently undiagnosed defects. Parents have sued the physician in their own right for "wrongful birth," alleging damages resulting from faulty sterilization or prenatal testing. Courts have recognized a cause of action in these wrongful birth cases. The courts have refused to recognize suits for wrongful life, saying that being born is not a compensable injury and, in the case of a deformed infant, that one cannot measure the difference between having been born with birth defects and the "utter void of nonexistence."<sup>28</sup> I find it interesting that while every woman has a constitutional right to bear a child, she has none to adopt one. With respect to rights of donors: if a man donated his sperm with the understanding that he would be treated as the child's father just as if conception had been through intercourse, his paternal rights should be protected. If the mother, however, accepted sperm from a man because he had waived all interests in serving as a parent, as is commonly done, he should not be permitted to claim parental rights at any point after the birth of "his" child.

**Benefits of AI as an Alternative** At a time when adoption of a healthy white infant can take five years or more, couples using AI will usually achieve pregnancy within six months on average. Since the AI parents can control the pre-natal environment, they can be sure the growing baby is receiving proper nutrition and is protected from harmful drugs or toxins. They have a chance to learn together about prepared childbirth and to participate together in labor and delivery. They can enjoy a breast feeding relationship with the baby. They will be able to parent, nurture and bond with their baby before his birth. Finally, the baby will be the mother's genetic child and will resemble the father, often remarkably! The AI couple have lost only the husband's genetic input. From the moment of conception they can be full participants and recipients in the childbirth and parenting adventure. One of the most important benefits of the AI procedure is the fact that the child is planned and wanted. We know that such children do better than unplanned and unwanted ones.

**UNANSWERED QUESTIONS** General Is there a difference between the way males and females react to sterility in themselves or in their partners? What is the effect of prior knowledge of sterility in one partner on the success of a committed relationship? The Child \* Does a child have a right to know about his origins?<sup>29</sup> \* Are there dangers inherent in telling a child about her origins? \* Are there dangers in keeping a

child's origins a secret? \* Should there be legal changes in order to make the AI child legitimate? \* What information about the donor should be available to the AI child? \* To what extent would AI children wish to trace their genetic paternity? Recipients \* Should there be criteria for selection? \* What should be the criteria for selection? \* Who is responsible for selection? \* What is the effect of AI on the marital relationship? \* Is having a baby a fundamental right of every woman? of every person? \* Should the husband of the AI wife be deemed to be the legal father of the child with consent? without written consent? \* What information about the donor should be available to the recipient couple? \* Is the couple allowed to choose a donor known to them? \* What characteristics of a donor are significant to the recipient couple? Recipient's Kin \* Should the relatives of the AI recipient couple be told of the AI child's origins? \* Do they have a right to know? \* If the AI couple keeps the origins of their child a secret will this harm their relationship with their families? The Donor \* Should there be criteria for selection? \* What should be the criteria for selection? \* Should the donor be required to give written consent? \* Should donors receive payment? \* How frequently should the same donor be used? \* Should the donor have any legal liabilities in respect of his progeny? \* Does every man have the right to do with his semen as he sees fit? \* After the semen has been donated or sold who does it belong to? Can this person or institution do with it as they see fit? \* Should there be a national register for all donors? The Donor's Family \* Do the relatives of the donor have a right to know of the donor's participation? \* If the donor is married should his wife be required to give written consent? \* Does the donor's participation have an effect upon his own marriage and family relationships? The AI Practitioner \* Who should provide an AI service? \* What skills are required in the provision of AI \* Should psychological assessment and counseling be mandatory? \* What requests for donor characteristics should be honored by the AI practitioner Sperm Banks \* Should sperm banks be only permitted to exist as part of a medical institution? \* Should commercial sperm banks be permitted? IVF - TEST TUBE BABIES IVF Procedure In vitro fertilization (IVF) more popularly referred to as "test-tube" fertilization consists of removing a ripened egg from a woman, mixing it with freshly obtained semen (usually her husband's) in a flat laboratory dish (Petri dish), incubating the dividing cells and then at a specific time returning the product of conception (sometimes called a conceptus, sometimes an embryo) back to her uterus. Since the birth of the first IVF baby in England in 1978, the success and availability of this procedure has raised hopes of many infertile couples who, up until now, have not been able to conceive because of the wife's blocked or absent ovarian (Fallopian) tubes. According to a report presented at the Third World Congress of In Vitro Fertilization and Embryo Transfer held in Helsinki in 1984 a baby was born by this technique every day and by the end of the year it was predicted that 1,000 successful pregnancies will have been achieved. IVF can be the answer to the anguished prayers of an infertile couple. It can also give rise to serious psychological, ethical, social, legal, and medical dilemmas. Many of these have been addressed by various experts while others, such as what is the effect of the procedure on the emotional adjustment of the IVF child, mother and father have not. The IVF procedure may also be used to transfer fresh or frozen embryos for incubation into the womb of a surrogate mother. A further innovation related to IVF is uterine lavage by which a normally conceived or an AI conceived child after spending 28 days in its mother's womb is washed out of her uterus and implanted in another woman's uterus. In the U.S. about 490,000 infertile women have tubal problems.<sup>30</sup> They could all theoretically be helped by in vitro fertilization. IVF can also help couples where the husband has a low sperm count. Since the sperm is placed close to the egg in the glass receptacle, fertilization can occur much more easily. Most American programs cost about \$5,000 per attempt. Some IVF centers require the couple to contract for at least four separate fertilizations raising the minimum cost of the program to \$20,000. In 1984 there were 55 IVF clinics in the U.S. Healthy couples who engage in sexual relations have a one in three chance of becoming pregnant. The expected live birth rate with IVF is 10%.<sup>31</sup> This low rate may be due to a variety of reasons such as improperly timed transfer, inadequate buildup of uterine lining, irritation of the uterine muscles by the transfer procedure itself causing uterine contractions, improperly placed oocyte, or disturbance of the mucus plug, resulting in a higher risk of infection. These are the areas where most in vitro research is focusing in order to

improve the success rate of the transfers.<sup>32</sup> One of the commonly voiced oppositions to IVF is that it is destructive of the family. There is the concern that IVF turns procreation from a loving, personal experience into a laboratory process. But the couples using IVF are not deliberately foregoing natural conception; they believe that they have no other choice. "In vitro fertilization is the most profamily thing I can think of," maintains Ellen Casey. "No one has tried harder to get a baby than someone in an innovator program. There has been so much pain and heartache and searching for someone who has turned to in vitro fertilization. There's no more wanted baby in the world than an invitro baby."<sup>32</sup> Opponents of IVF voice the same fears as opponents of AI did and continue to do. They worry that acceptance of IVF will lead to diminished respect for human life, and that scientists performing IVF will become dehumanized in attempts at eugenics.

Scenarios for IVF

1. Members of an established heterosexual couple provide ova and sperm, conceptus transferred to biological mother.
2. Donated ova plus sperm of husband of established heterosexual couple - conceptus transferred to husband's wife for gestation. This combination is closely analogous to AI. Suggested reasons: inability of the would be mother to produce fertilizable ova (without ovaries or severe and incurable infection of ovaries) or the knowledge that she carries a dominant or x-linked recessive genetic defect.
3. Transfer of conceptus to the uterus of a surrogate mother for gestation and delivery. Medical contraindications or obstacles to the ovum donor becoming pregnant might include: - cardiac disorders - partial paralysis - repeated miscarriages - hysterectomy - psychological fears re: pregnancy and delivery Social reasons: - career plans - desire to avoid discomforts of pregnancy - concerns about one's looks especially important to one's career, e.g., modeling

The Couple As in AI, different clinics differ in their criteria for administering IVF. At the Toronto General Hospital<sup>33</sup> candidates are selected as follows: \* Husband must be sperm donor and his wife the recipient; \* Wife must be less than forty years of age; \* Preference given to couples with no natural children; \* Fallopian tubes are absent or blocked and not amenable to surgery; \* Presence of normal uterus and at least one normal and laproscopically accessible ovary; and \* no evidence of untreatable ovulation disorders.

The Wife In the only psychological study of IVF pregnancies that I know of Duval<sup>34</sup> in France has made several interesting observations. One of these is that most of the time it isn't just simply a case of a mechanical occlusion of the tubes without psychological factors. On the contrary, there is a particular psychological context with which one or more mechanical factors combine, thus giving complex infertilities, so that the treatment of in vitro fertilization appears as a "miracle" solution. The other point that Duval makes is that the procedure of IVF with all its scientific razzmatazz confirms to the couple the biologic nature of infertility and thus indirectly contributes to the denial in the infertile couple as well as IVF practitioners to co-existent psychological problems that may have contributed to the infertility. I would like to present two case histories from Duval's paper. From these, one can easily see that the same psychological factors which influence conception, pregnancy, labor, etc. in normal couples play an even more significant role in infertile couples.

Mrs. A., a secretary of 36 years, took medical advice for the first time in September 1982. Married for 11 years, she has been wanting a child for 8 years. Without noticeable antecedents, this unexplained primary infertility has been the object of tubo plastic surgery in 1977 and a laparoscopy in 1981 demonstrating patency of the tubes bilaterally. However, Mrs. A. had irregular periods with unpredictable ovulation. Everything was medically all right on the husband's side. A first attempt of in vitro fertilization was performed in December 1982. During her hospitalization no problems were observed. We barely saw her and she spent a lot of time with her companions, especially talking about her work. Everything was simple and nothing was a problem. The first attempt, after a difficult embryo transfer, was followed by a pregnancy. Because of her age, an amniocentesis was advised but this was rejected. No problems rose until Mrs. A. reaching her 41 weeks gestation, arrived at the hospital with a child dead in utero. We had seen her in the department a week before, and she did not worry when 2 days later she noticed a slowing down and then cessation of fetal movements. She did not ring up, neither did she go to the department, but only took medical advice from her general practitioner who reassured her. She came 3 days after fetal movements had stopped, when she delivered a dead child weighing 4 kg. with no apparent abnormality, nor any anatomo-pathological



abnormality. I was brought in to see them. The husband was very depressed, Mrs. A. was comforting him and said she herself could not be depressed, because she had to help her husband. Following this she made holiday plans to take his mind off his depression. Always pleasant, always active, talking about positive things and preparing to return to a normal life, she would not reveal anything of herself. I then found out that she had been abandoned at birth and did not know anything about her parents. She constantly talked about her role in supporting her husband and his family. Mrs. C., a secretary whom I got to know better during the hospitalization, was a 33 year old woman, feminine and open. A definite primary infertility had been known for 12 years, discovered during her first marriage. The IVF attempt proceeded in a relaxed atmosphere and with unusual ease. Mrs. C. went back home to live normally "to avoid any family disappointment." Mrs. C was expecting twins. The pregnancy progressed normally, followed up by another clinic visit, and we only saw Mrs. C. at the end of her pregnancy because she delivered at Antoine Beclere. Even prettier with her bulging triumphant tummy, she used her Parisien stay to the full with visits to exhibitions and to IVF candidates. Mrs. C. asked me to assist at the delivery and it was in a very relaxed and welcoming atmosphere that two little boys were born by normal delivery. I will add that when Mr. C. went up to shave, in order to welcome the children looking his best, Mrs. C. told me: "my first husband left because I was infertile, my present husband has accepted me without children and I can give him two." Needless to say the relationship between Mr. and Mrs. and their children established itself straight away and their subsequent development did not preoccupy us at all. The Child Australia has about one half of the world's test tube babies. It is therefore not surprising that one of the first research studies on psychological aspects of IVF was conducted by an Australian, Dr. Diane Bretheron.<sup>35</sup> According to her, grade school children regard the idea of IVF as "yucky." Asked how they would react if they discovered they had been conceived by IVF methods, the children said "awful," "alien," and "like a Martian." Older students have already dubbed products of the IVF program as "test kids" and "the glass-heads." But according to Bretheron, a psychologist at the institute, the more children know about real life IVF children the less negative their attitudes. Preliminary results from the Australia National Registry of In Vitro Pregnancies<sup>36</sup> show there were no congenital abnormalities among the more than 100 IVF births. Possible Medical Hazards to the Unborn IVF Child 1. The effect of ultrasound on the genes - ultrasound is used to monitor the production of ova before laparoscopy and again later to check on the growth of the fetus; 2. the influence of hormone injections to the mother before ovulation and to prepare her endometrium for implantation; 3. it is known that freezing destroys one half of the fertilized ova but what does it do to the ones that survive? 4. IVF programs face high multiple pregnancy rates because more than one embryo is transferred at any one time; 5. IVF pregnancies face a higher than average ectopic pregnancy rate. Laboratory IVF Research Research effort is directed toward the development of a knowledge base that will one day contribute to the achievement of such goals as: - the promotion of fertility - the provision of better contraceptive measures - the prevention or repair of genetic and chromosomal abnormalities. The American Fertility Society (AFS) has issued ethical guidelines and minimal standards for IVF programs. They hold that all gametes and zygotes - concepti - belong to donors. Donors can agree to scientific examination of nontransferred concepti, which is ethical, says the society, if carried out within 14 days after insemination, the period during which implantation normally occurs. Alternatively, donors may choose cryopreservation of excess concepti with the intent of future impregnation of a specific recipient. But, the Society stipulates in its guidelines, concepti should be cryopreserved for no longer than the recipient's reproductive life. In addition, donating extra concepti to another infertile couple is acceptable, says the AFS, provided that the donors waive any claim to resulting offspring and that anonymity between donors and recipients is maintained.<sup>37</sup> IVF research has brought the day closer when three reproductive options, which I find personally repugnant, may become reality. 1. Scientists working with IVF have discovered that human ova under certain biochemical conditions can be prodded to divide and develop into an embryo. If this procedure were to be perfected it could drastically alter the family, separate sex from procreation, make men redundant sexually and produce children with no fathers at all. (Immaculate conception). 2. Test tube

technology if taken to its ultimate limit could lead to babies spending their entire nine months from conception to birth in an artificial womb. What a horrible prospect! 3. A slight variation on the above procedure would be to implant human embryos in animals. Frozen Embryos - Life on Ice In 1981, a childless California couple, Mario and Eisa Rios came to Melbourne's Queen Victoria Hospital in Australia where several of the woman's eggs were removed and fertilized with her husband's sperm in the laboratory. One or more were implanted in her uterus and two were frozen for later use. The Rios' left Australia, intending to return if the initial IVF failed. It did, but the couple were killed in a plane crash in 1983, leaving an estate of about \$1 million. In the absence of a will the question arose whether their "orphaned" frozen embryos were entitled to a portion of the inheritance? The news set legal experts, researchers and ethicists around the world abuzz and forced the Australian government to eventually enact a law governing the disposition of frozen embryos. There are a number of medical centers all over the world now where one can find large stainless steel containers of liquid nitrogen chilled to a crisp - 320OF with up to 200 glass tubes each holding a microscopic embryo. Just two to eight cells in size, waiting in suspended animation for thawing and transfer. Their existence raises some fundamental questions about laboratory reproduction. To whom do the frozen embryos belong, and who has jurisdiction over their fate? Do they have any rights of inheritance? Most basic of all, are they human beings? Once the embryos are implanted in a "adoptive mother," could the donor claim them as their own in the future? Should experiments be allowed on fetal tissue, including the possible production of embryos for "spare parts" that could be used for transplants? Should IVF be used to create human beings physically and mentally suited for particular tasks such as space travel?

### SURROGATE MOTHERHOOD Introduction

A surrogate mother is any woman who contracts to bear a child for another person. Usually, she is artificially inseminated by a man married to a woman unable to have a child. Often the surrogate mother is paid a fee for her services, which has added another controversy to this already emotionally loaded procedure. The advantage to the parental couple include having a biologic child of the husband and being able to choose the biologic mother of the child. What is the psychological profile of women who become surrogates? What guidelines should one follow in selecting a surrogate, how should one relate to her during pregnancy and after birth? What will be the effects of this reproductive arrangement of the child, on preexisting children of the surrogate or of the commissioning couple and on the mate of the surrogate?

### Motivation of Surrogate Mothers

As of this date very few medical or psychological studies have been published on surrogate mothers. The person who has done most of the work in this area is Philip Parker, a psychiatrist who has so far evaluated 350 women. They were referred to him by Michigan lawyer Noel Keane who runs the largest surrogate mother program in the US. In a review of the first 125 women who applied to be surrogates Parker<sup>38</sup> found that these women were motivated by the following factors: - desire for financial reward - wanting to be pregnant - satisfaction in "giving" a baby to another woman - need to resolve previously unresolved loss by voluntary adoption or abortion In a later paper<sup>39</sup> Parker elaborated on his previous data and reported on 30 successful pregnancies. Of these 30 surrogate mothers, 28 received a fee. They looked at it as a fee for services. The fee became less important as the pregnancy developed and as the relationship grew with "the couple." Surrogates felt that the pregnancy increased their self-esteem. One third of the women had a prior loss of a child - abortion or adoption - surrogating helped them to master their prior traumatic experience. The surrogates often idealized their relationship with "the couple"; the relationship varied from very close to no contact. Following the relinquishment various degrees of grief reaction occurred which lasted up to five months after delivery, aggravated by loss of contact with "the couple." Three surrogates told their friends that the baby had died. Surrogates had some feelings of envy towards adoptive couples. Some wanted to maintain a relationship with "the couple" - this was left up to them. No measures of personality correlate with outcome. There is no evidence that single women make any better surrogates than married ones. Surrogates seem to have a need for a relationship with the parental couple. About one third have continued to relate to "the couple." Parker feels that surrogate mothers should be paid during pregnancy instead of after birth. One surrogate mother had a child for a single man. In a study on 41 pregnancies of surrogate mothers Nancy Reame<sup>40</sup> who is

a co-worker of Parker's discovered that 45% of these women smoked at least one half a package of cigarettes a day in spite of advice to the contrary. Reame also mentions the reluctance of surrogates to involve their husbands in their pregnancies, e.g., one woman said: "My husband is normally my labor coach but I don't feel right to ask him to be my coach with this baby." One researcher has raised the question: what effect does the surrogate's pregnancy have on her children? These children see their parents giving away a baby. This must trigger latent fears of abandonment which are present in all children. It can also lead to other reactions as it did in the boy who said to his mother: "Why don't you give away my sister and keep the baby?" Other bizarre problems arise such as the account of a single man who wanted a surrogate to carry his child. As soon as she became pregnant he planned to have a sex operation and was going to raise the child as his or her mother.

Problems with Surrogate Motherhood - the refusal of the contracting couple to accept the child - decision by the surrogate mother to abort - refusal by the surrogate mother to relinquish the child after birth - diminished prenatal bonding - interruption of post-natal bonding - "adoption syndrome" for surrogate child

The Effect of Money on the Surrogate Mother Process Short-term and long-term effects of a payment on the psychological functioning of the husband and wife (parental couple) toward each other, other children, and the newborn child, need to be studied. Will payment lead to feelings of guilt? What will a child feel knowing money has played a role in his/her existence? Does a child who is commissioned for and paid for become a commodity, an object to be traded rather than a baby to be cherished as a miracle of creation? Summary The proliferation of third party conceptions has answered the prayers of some infertile couples for a child. At the same time it has created a variety of profound biological, ethical, legal, social and psychological problems. In this paper an attempt is made to explore specifically, the psychological issues consequent to the use of AI, IVF and surrogate motherhood.

Footnote \* In order to avoid mistaking artificial insemination by donor (AID) with the autoimmune disease (AID) we shall refer to both AID and AIH singly as AI in the rest of the text.

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