Third-party reproduction

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ABSTRACT Infertility is a life crisis which may disrupt the stability of individuals, relationships and societies. During the last twenty-five years medical science has expanded and today there are nearly forty ways to have a baby without sexual intercourse. Nearly half of these ways involve third-party reproduction such as donated gametes, embryos and/or gestational carrier. Together with third-party reproduction infertility counseling has emerged as a recognized specialty within the mental health profession. The role of the infertility counsellor is to meet the psychological challenges of assisted reproduction and includes assessment, support, treatment, education, research and consultation. It has been suggested that all patients considering the use of donor gametes to achieve parenthood should be seen by a counsellor with the focus on preparation for parenting involving third-party reproduction. The major psychological tasks for couples considering the use of donated gametes include acknowledging the individual loss of reproductive capacity and what this means to them individually and as a couple. Grieving the hoped for genetically-shared pregnancy and examining the acceptability and suitability of gamete donation as a family-building alternative for them as individuals and as a couple.

Key words: Infertility, Reproduction, Assisted Reproductive Technologies.

Introduction

Infertility is a multifaceted, intergenerational developmental crisis that has an impact on religious beliefs, life plans, marital and sexual functioning, economic well-being, and social relationships. It is a life crisis of significant physical and emotional magnitude, requiring the attention and understanding of medical caregivers and mental health professionals. Infertility, or involuntary childlessness, is a crisis that can disrupt the stability of individuals, relationships and societies. Throughout history childlessness -and remedies for it- has been a fundamentally essential part of the public and private lives of infertile men and women. In a cross cultural study of childlessness Rosenblatt and colleagues (1973) found that infertility was considered a crisis across *all* cultures, although it was experienced differently and the ways of managing the crisis varied. These researchers found that solutions to infertility could be grouped into one of three categories: 1) medical interventions, 2) prayer or spiritual interventions, and 3) realignment of social relationships. They found that culture and religion had an impact on the solutions to infertility chosen or found acceptable. Across all cultures the realignment of social relationships was the *last* alternative: «[...] *It is "human" to be concerned about childlessness* [...]. *People pray, or take drugs, or cast spells* [...] *before they try to change social relationships by adding a spouse, ending a marital relationship or quasimarital relationship,*

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adopting or fostering» (p. 2). In modern societies it is increasingly common for infertile couples to pursue medical remedies that involve expensive, protracted treatments.

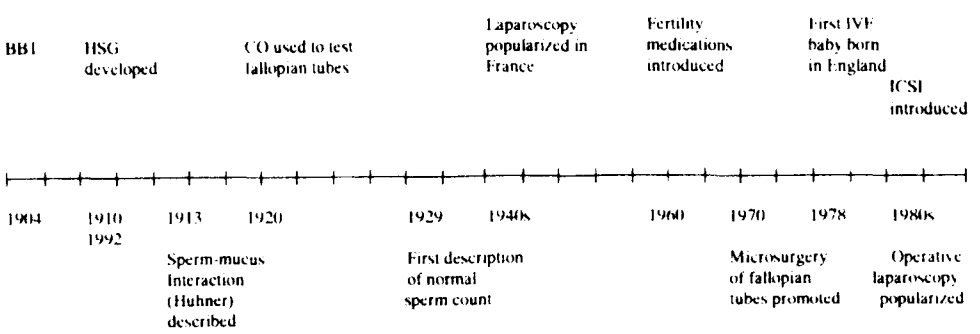
Over the past twenty-five years medical science has greatly expanded the reproductive choices and family-building opportunities for infertile couples and individuals (see Table 1). Today there are at least forty ways to have a baby that do not involve sexual intercourse (see Table 2). These medical treatments often involve assisted reproduction – conception aided by medical technology, medications and/or the contribution of a third-party in facilitating parenthood for an infertile couple. Of the forty ways to have a baby without sexual intercourse nearly half involve third-party reproduction, such as donated gametes or embryos and/or a gestational carrier (i.e., loaner uteri) (see Table 3). Third-party reproduction offers hope, treatment, and potential solutions for infertility for couples who, in the past, would have remained childlessness or been forced to consider the realignment of social relationships (e.g., adoption or taking an additional wife). However, third-party reproduction may not be completely beneficial for everyone and is not without expense – financial, emotional, physical, relational, even cultural.

Definition of terms

Assisted Reproductive Technologies (ART) refer to medical treatments that assist conception through the use of procedures (e.g., in vitro fertilization), surgeries (e.g., needle aspiration of oocytes, testicular biopsy), the use of donated gametes and medical technologies such as freezing of sperm and/or embryos and intrauterine insemination.

The term «third-party assisted reproduction» (also referred to as «third-party conception» or «third-party reproduction») refers to the contribution of a third person not normally expected to be involved directly in the on-going life of the resultant family or intended parents. Third-party conception includes: donated sperm (typically referred to as «*donor insemination*» – DI), *oocyte donation* (OD), *embryo donation* (ED), *gestational carrier* and *surrogacy*. In this paper «gestational carrier» (sometimes referred

Table 1
Time-line of major advances in the diagnosis and treatment of infertility over 20th century



Keye, W. R. (1999). Medical aspects of infertility for the counsellor. In L. H. Burns & S. N. Covington, *Infertility Counselling: A Comprehensive Handbook for Clinicians* (pp. 27-46). New York: Parthenon Publishing.

Table 2
Methods of reproduction without sexual intercourse

Intravaginal insemination

1. Intravaginal insemination with husband/partner
2. Intravaginal insemination with ovulation stimulation/ovulation induction medication (e.g., Clomid)
3. Intravaginal insemination with superovulation induction medication
4. Intravaginal insemination/donor sperm
5. Intravaginal insemination with ovulation induction medication/donor sperm
6. Intravaginal insemination with superovulation induction medication/donor sperm

Intracervical insemination

7. Intracervical insemination with husband/partner
8. Intracervical insemination with ovulation stimulation/ovulation induction medication (e.g., Clomid)
9. Intracervical insemination with superovulation induction medication
10. Intracervical insemination/donor sperm
11. Intracervical insemination with ovulation induction medication/donor sperm
12. Intracervical insemination with superovulation induction medication/donor sperm

Intrauterine insemination

13. Intrauterine insemination with husband/partner
14. Intrauterine insemination with ovulation induction medication (e.g., Clomid)
15. Intrauterine insemination with superovulation induction medication
16. Intrauterine insemination/donor sperm
17. Intrauterine insemination with ovulation induction (e.g., Clomid)/donor sperm
18. Intrauterine insemination with superovulation induction medication/donor sperm

In vitro fertilization

19. In vitro fertilization with superovulation medication
20. In vitro fertilization/natural cycle

In vitro fertilization male-factor related treatments

21. In vitro fertilization/intracytoplasmic sperm injection (ICSI)
22. In vitro fertilization/microscoptic epidimyal sperm aspiration (MESA)/ICSI
23. In vitro fertilization/percutaneous epididymal sperm aspiration (PESA)/ICSI
24. In vitro fertilization/testicular sperm extraction (TESE)/ICSI
25. In vitro fertilization/donor sperm

In vitro fertilization related procedures

26. Gamete intra-fallopian transfer (GIFT)
27. Tubal embryo transfer (TET)
28. Intrauterine embryo transfer (IVF/ET)
29. Frozen embryo transfer

Table 2

Methods of reproduction without sexual intercourse

30. In vitro fertilization/donor egg
31. Donor embryo
32. In vitro fertilization/pre-implantation genetic diagnosis
33. Assisted hatching

Gestational carrier/surrogacy

34. Surrogacy
35. Gestational carrier with husband/partner sperm
36. Gestational carrier/donor sperm
37. Gestational carrier/donor oocyte
38. Gestational carrier/donor embryo

Other

39. Gender selection
40. Cloning

Table 3

Methods of third-party reproduction

Intravaginal insemination

1. Intravaginal insemination/donor sperm
2. Intravaginal insemination with ovulation induction medication/donor sperm
3. Intravaginal insemination with superovulation induction medication/donor sperm

Intracervical insemination

4. Intracervical insemination/donor sperm
5. Intracervical insemination with ovulation induction medication/donor sperm
6. Intracervical insemination with superovulation induction medication/donor sperm

Intrauterine insemination

7. Intrauterine insemination/donor sperm
8. Intrauterine insemination with ovulation induction medication (e.g., Clomid)/donor sperm
9. Intrauterine insemination with superovulation induction medication/donor sperm

In vitro fertilization related treatments

10. In vitro fertilization/donor sperm
11. In vitro fertilization/donor egg
12. Donor embryo

Gestational carrier/surrogacy

13. Surrogacy
14. Gestational carrier with husband/partner sperm
15. Gestational carrier/donor sperm
16. Gestational carrier/donor oocyte
17. Gestational carrier/donor embryo

to as «gestational surrogacy») refers to a woman who carries an embryo to delivery. The embryo is derived from the oocyte and sperm of persons not related to the carrier – therefore, the carrier has no genetic relationship with the resulting offspring. Gestational carrier pregnancies may be genetically shared conceptus of the contracting parents or may be the result of donated gamete(s) or a donated embryo. By contrast, in traditional surrogacy a woman (surrogate) is inseminated with the sperm of a man who is not her partner, in order to conceive and carry a child to be reared by the genetic father and his partner. In this procedure the surrogate is genetically related to the child (Burns & Covington, 1999, p. 603).

Donated insemination or the use of donated sperm to facilitate conception for couples experiencing male-factor infertility has been mistakenly described as a «treatment» for male-factor infertility. This is inaccurate because, although donor insemination provides a family-building alternative to an infertile man, it does not provide medical treatment for male-factor infertility. Donor insemination allows a couple to share the experience of pregnancy and to control the prenatal environment, but the resulting pregnancy is not a genetically shared pregnancy. Donor insemination typically involves less medical technology, it is usually cheaper and less time-consuming and it involves less labor-intensive paperwork than traditional adoption. Donor sperm may be used in conjunction with other assisted reproductive technologies, such as in vitro fertilization and gestational carrier. The first births from DI were reported in the United States and France almost simultaneously in 1884, while the first use of donor sperm for insemination was reported in 1909 (Zoldbrod & Covington, 1999). It is estimated that at least 40,000 children a year are born in the USA as a result of donor sperm.

Donor oocyte conception allows an infertile woman to make a biological contribution to the birth of her child, although she is not genetically related to the child. Donor oocytes usually involve in vitro fertilization, but may also be used in conjunction with a gestational carrier. The child may or may not be genetically related to her partner (if she has one). Donor oocyte conception is currently more complicated than donor sperm, because the cycles of the oocyte donor and recipient must be synchronized, as the technology for freezing oocytes has not been perfected. By contrast, frozen (cryopreserved) sperm has been available over 50 years, making conception simpler, cheaper and more readily available to a wider range of individuals and couples (Zoldbrod & Covington, 1999). And, while the use of donated sperm is a legally and socially acceptable form of family building, the use of donated oocytes is not a widely acceptable family-building alternative, either legally or socially. The first oocyte donation was reported in 1984 in Australia (Lutjen et al., 1984), and about 10,000 children are born each year in the USA as a result of donated oocytes.

Daniels (2005) has suggested that the history of third-party reproduction is predominantly a history of donor insemination. In fact, there is a hundred years of science, tradition, social milieu, psychological theory and legal practice between the first donor insemination pregnancy, the first in vitro fertilization pregnancy and the first oocyte donation pregnancy. Couples using donor insemination as a family-building tool were told to keep the circumstances of their child's conception secret, for a variety of reasons. It was thought to be in the best interest of the child, protecting the child's legal status as a «legitimate» offspring and heir, as well as the child's and parents' emotional well-being. Third-party reproductive technologies, such as donor oocyte and gestational carrier, were technological by-products of the medical advances achieved via in vitro fertilization. With the onset of oocyte donation and gestational carrier arrangements, the tradition of secrecy came under question and received increasing scrutiny. There remains considerable variation between

(and even within) different countries, with many allowing donor insemination while banning oocyte donation. Recently, Blyth and Landau (2004) outlined the social, legal and ethical issues of third-party conception, noting that the movement from secrecy to disclosure has been a significant struggle and, to date, no country has attained a satisfactory position that respectfully balances the needs and interests of all parties (donors, parents and offspring).

Surrogacy and gestational carrier pregnancies are less prevalent than donor gamete third-party reproduction, but provide an important option, particularly for women who have lost their uterus to disease or injury, or were born without an uterus. Surrogacy is a complex family building alternative, that is not widely accepted either legally or socially, in large part because the surrogate is both the genetic and gestating «mother». For this reason, the genetic father and his partner typically must legally adopt the child after birth. By contrast, gestational carrier parenthood is less legally complex, because the gestational carrier is not genetically related to the child she carriers and delivers. As a result, it is an increasingly acceptable and widespread form of family building, even though it can be financially expensive, legally complex and psychologically demanding for all parties. The first contracted traditional surrogacy was reported in 1977 and the first gestational carrier pregnancy was reported in the 1987 (Hanafin, 1999).

Historical perspective

Infertility counselling as a profession emerged almost in tandem with the major medical advancements in the field of reproductive medicine, particularly with the advent of assisted and third-party reproduction. Although the psychological impact of infertility was addressed in the literature in the 1950s, it has only been within the last twenty-five years that infertility counselling has emerged as a recognized profession and speciality between the mental health professions (Covington, 1999). Historically, the role of the infertility counsellor was to cure the neurosis that was thought to cause the patient's infertility. This approach fell into disfavour in the 1970s, as mental health professionals working in infertility clinics began providing psychological support, crisis intervention and education to ameliorate the stress of infertility and enhance the patient's quality of life (Bresnick & Taymor, 1979). Today the role of the infertility counsellor has expanded to meet the psychosocial challenges of assisted reproduction and now includes assessment, support, treatment, education, research and consultation (Covington, 1995).

In Australia the Waller Report (1984) was followed by legislation regarding assisted reproduction (specifically in vitro fertilization) that required that all clinics providing assisted reproduction provide counselling by accredited counsellors under the Australian Infertility (Medical Procedures) Act of 1984. Further defining the role of infertility counselling, it was recommended that it should include: 1) education, 2) facilitation of decision-making, 3) personal and emotional counselling, and 4) therapeutic counselling. The Infertility Treatment Authority (also known as the Donor Treatment Procedure Information Register), established in 1995, provided for the availability of «donor-linking» counsellors especially trained to provided counselling regarding third-party reproduction for offspring, donors and parents of donor-gamete conceived offspring. In addition, the authority did not *require* counselling for any applicant to the Voluntary Register, but «retained the discretion to require counselling in those cases which it deems appropriate» (p. 6).

In Great Britain the Warnock Report of 1984 recommended that counselling be made available to all infertility patients, to contemplate the implications of assisted conception. Subsequently, the King's Fund Committee Report on infertility counselling (1991), which became the

foundation for and the precursor of the Human Fertilisation and Embryology Authority (HFEA), provided guidelines and recommendations specifying the parameters of counselling and training of infertility counsellors. The three distinct types of infertility counselling were defined as: 1) *implications counselling*, in which the implications of the proposed treatment for the individual, family and potential child be discussed, 2) *support counselling*, which provides emotional support regarding the stresses of infertility, and 3) *therapeutic counselling*, in which the goal is to help people cope with the consequences of infertility and reach resolution, regardless of the treatment outcome. It is important to note that, although the HFEA does not mandate that counselling be *provided*, it does mandate that it is *offered* and outlines the manner in which it is provided and by whom. The King's Fund Committee Report suggested that implications of counselling were particularly important to couples and individuals contemplating the use of donor gametes, because of the profound social and psychological implications for the couple and the child. The Human Fertilisation and Embryology Authority's latest code of practice explicitly emphasizes the positive contribution of counselling in the words «counselling is recognised as beneficial in relation to all licensed treatment» (2004, section 7: 3).

A precursor of legislation passed in Canada in 2004 was the 1989 Commission on New Reproductive Technologies, which investigated the current and potential developments in assisted reproduction and considered the social, ethical, health, research, legal and economic implications, as well as the public interest. *Proceed with Care* (1993), the two-volume final report of the Canadian commission, recommended that infertility counselling be an integral part of assisted conception services. The recommendations of this commission finally became legislation in 2004, under the Assisted Human Reproduction Act. It defined infertility counselling as an integral and required part of patient care, particularly for patients considering assisted reproduction. The 2004 legislation also established the Assisted Human Reproduction Agency of Canada, similar to the HFEA in the United Kingdom, to regulate assisted reproduction. This legislation also established a central donor registry, similar to the one in Australia.

While the United States and the majority of countries worldwide have lagged behind the commonwealth countries in establishing comprehensive legislation on third-party reproduction and counselling, professional organizations have established counselling standards in this regard. Two excellent examples are the Mental Health Professional Group of the American Society of Reproductive Medicine (MHPG/ASRM) and the Psychological Special Interest Group of the European Society of Human Reproduction and Embryology (PSIG/ESHRE), both of which established guidelines regarding qualifications for infertility counsellors and counselling in third-party reproduction. The 1995 MHPG «Qualifications guidelines for mental health professionals in reproductive medicine» suggest that the minimum qualifications and training of mental health professionals should include: 1) a graduate degree in a mental health profession, 2) a license to practice in the professional's mental health profession, 3) training in the medical and psychological aspects of infertility, 4) a minimum of one year clinical experience in providing infertility counselling, preferably under the supervision of or in consultation with a qualified infertility counsellor, and 5) continuing education in the field of infertility counselling (Burns & Covington, 1999, pp. 529-530). In 1994 MHPG instituted «Recommended guidelines for the screening and counselling of oocyte donors» (Burns & Covington, 1999, pp. 543-545) and in 1996 «Psychological guidelines for embryo donation» (Burns & Covington, 1999, pp. 546-547). Most recently the Ethics Committee of ASRM (2004)

supported the disclosure by parents of their use of donor gametes in their child's conception. PSIG/ESHRE published the «Guidelines for counselling infertility» in 2002, a comprehensive page document outlining qualifications in infertility (including who should counsel and who is likely to need counselling). This guide devotes a section to special topics in third-party reproduction, that includes donor insemination, oocyte donation, embryo donation and surrogacy, as well as reproductive services for lesbian couples and single women without partners (Boivin & Kentenich, 2002).

The guidelines established by these professional organizations, along with legislation in several countries and the work of professional organizations world-wide, have all contributed to the establishment of infertility counselling as a recognized mental health profession specialization and an integral part of the health team providing care and treatment of infertile men and women. Professional organizations further defined the field of infertility. Some of the original infertility counselling organizations were the British Infertility Counselling Association, the Australia/New Zealand Infertility Counselling Association and what is now known as the Mental Health Professional Group of the American Society of Reproductive Medicine. Similar organizations have emerged in Europe, Germany, Japan, and are on the horizon in Canada, the Middle East and Latin America. While in the past infertility counsellors had some difficulty having the importance of their work and role on the treatment team being recognized, the challenge now is providing clinics with trained and qualified infertility counsellors. Infertility counsellors offer advice, education, consultation, support and analysis, and they are more likely to be patient advocates with caregivers or healthcare providers than in more traditional psychotherapies (Burns & Covington, 1999). Infertility counsellors provide psychological assessment, screening and therapy; diagnose and treatment of mental disorders; psychometric testing; decision-making counselling; bereavement therapy; crisis intervention; marriage and family therapy; and sex therapy.

Counselling goals for intended parents using third-party reproduction

Therapeutic approaches that have been applied to infertility include: psychodynamic therapy, cognitive-behavioral treatment, marriage and family therapy, group therapy, strategic/solution-focused brief therapy, psychopharmacological treatment, sex therapy, crisis intervention and grief counselling (Applegarth, 1999). It is generally recognized that a variety of treatment modalities (individual, couple, family support and therapy groups) is the most commonly used therapeutic approach in infertility counselling. As such, infertility counsellors offer advice, education, consultation, support and analysis, and are more likely to be patient advocates with caregivers or healthcare providers than in more traditional psychotherapies (Burns & Covington, 1999). A useful tool in assessing couple's and individual's response to infertility is the Comprehensive Psychosocial History of Infertility (Burns & Greenfeld, 1999) (see Table 4).

It has been suggested that infertility can be divided into five distinct phases: Dawning, mobilization, immersion, resolution and legacy. During the *dawning* phase couples become increasingly aware that they are having a problem conceiving, and eventually seek medical assistance. *Mobilization* marks the first step into the medical arena, during which the couple begins diagnostic testing. If a definitive diagnosis is made, it can cause shock, disbelief and denial, particularly if it is secondary infertility. Problems may emerge in the relationship as the couple faces the first of what will probably be many losses. *Immersion* is the most complex and demanding phase, as the couple undergoes more and more testing and treatment. This stage

Table 4
Comprehensive psychosocial history of infertility

This is not a psychometric test. Instead, it is a comprehensive psychological and social history of infertility, designed to be used by a mental health or medical professional. It should provide the clinician with a global impression of the patient's history, stressors, functioning and current psychosocial status relevant to infertility. Although the history provides guidelines for potential disruptive responses, there are some areas that are red flags and indications for referral for more complete psychological evaluation and intervention. They include: 1) use or consideration of a donor/surrogate program, 2) prior psychiatric illness, 3) change in current mental status and/or exacerbation of prior psychiatric symptoms, 4) history of pregnancy loss, 5) history of cancer, 6) history of rape or sexual trauma, 7) ambisexual patterns, 8) current problems with substance abuse.

I. Reproductive history
  A. Infertility
    1. Current infertility: primary or secondary
    2. History of past infertility
  B. Pregnancy
    1. Living children (stepchildren, adopted, donor offspring, placed for adoption)
    2. Therapeutic abortion(s)
    3. Spontaneous abortion(s)
    4. Other perinatal loss: SIDS, death of child
    5. High-risk pregnancy
  C. History of genetic/chromosomal abnormalities
    1. Cancer of reproductive tract and/or chemotherapy
    2. DES exposure
    3. Congenital abnormalities of the reproductive tract
    4. Family history of genetic disorders
II. Mental status
  A. Psychiatric history
    1. Hospitalization for psychiatric illness
    2. Psychiatric treatment
    3. Treatment with psychotropic medication
    4. Substance abuse/addiction
  B. Current mental status
    1. Symptoms of depression
    2. Symptoms of anxiety/panic attacks
    3. Symptoms of obsessive/compulsive disorder
    4. Current use of psychotropic medications
    5. Current problem with substance abuse/addiction
  C. Changes in mental status
  D. Exacerbation of prior psychiatric symptoms
III. Sexual history
  A. Frequency and response
  B. Function/dysfunction

Table 4

Comprehensive psychosocial history of infertility

C. Religious or cultural influence on sexual patterns or procreation beliefs
D. Sexual history
    1. Function/dysfunction
    2. Sexually transmitted disease
    3. Prior sperm donor/surrogate mother/consideration of use of donor gametes
    4. Homosexual or ambisexual patterns
    5. History of rape or incest
E. Changes in any sexual patterns secondary to infertility or medical treatment

IV. Relationship status
A. Marital
    1. History of marriages/divorces
    2. History of marital discord/therapy
    3. Extramarital relationships
    4. Current satisfaction/dissatisfaction
    5. Ambivalence about medical treatment and reproductive technologies
B. Familial
    1. History of dysfunctional family of origin
    2. Recent deaths or births in family
    3. History of numerous familial losses
C. Social
    1. Available support systems
    2. Career disruptions or pressures
    3. History of current legal problems
    4. Criminal conduct

Burns, L. H., & Greenfeld, D. (1999). Appendix 2: Comprehensive psychosocial history of infertility. In L. H. Burns & S. N. Covington (Eds.), *Infertility Counselling: A Comprehensive Handbook for Clinicians.* New York: Parthenon Publishing.

is marked by feelings of being in «limbo» or «not yet parents», because they cannot move ahead to the next stage of the life cycle: parenting. Late in the *immersion* phase couples may face family-building alternatives they never thought they would have to consider: decisions about donor gametes, donor embryos or adoption. The *resolution* phase consists of three overlapping sub-phases: 1) ending medical treatment, 2) acknowledging and mourning the loss of not having a genetically shared (or related) child and 3) refocusing on other possibilities, such as prenatal adoption, traditional adoption or childlessness. The *legacy* phase encompasses the aftermath of the infertility experience, including the marital, sexual and paring problems that may emerge as a consequence of infertility, particularly when partners have not adequately handled the significant losses of it. Covington (1999) outlined the psychotherapeutic tasks for the infertility counsellor through an adaptation of these developmental stages of infertility (see Table 5).

Fundamental to coming to terms with infertility for each couple is defining their goal: reproduction or parenthood. Whether their personal goal is reproduction or parenthood, each partner, as well as the couple together,

Table 5
Phases of infertility treatment and counselling tasks

Phase

I. *Dawning:* Acknowledgment of fertility problem and seeking help
Counselling tasks:
- Support and education
- Providing information
- Identification of resources

II. *Mobilization*: Undergoing medical evaluation
Counselling tasks:
- Psychosocial assessment
- Support and education
- Preparation for treatment

III. *Immersion*: Treating infertility problems
Counselling tasks:
- Support and education
- Identifying coping mechanisms
- Stress management
- Emotional and therapeutic counselling
- Preparation for outcome

IV. *Immersion*: Further treatments – Investigating and treating additional diagnosis
Counselling tasks:
- Stress management and coping strategy
- Emotional and therapeutic counselling
- Exploring alternatives

V. *Immersion:* Attempting non-coital conception – Donor gametes and assisted reproduction
Counselling tasks:
- Emotional and therapeutic counselling
- Implications counselling
- Psychological assessment and support
- Facilitation of decision-making
- Exploring alternatives
- Preparation for outcome

VI. *Resolution*: Deciding to end treatment and redefine family – Adoption and childlessness
Counselling tasks:
- Grief and therapeutic counselling
- Pursuing alternative family-building
- Preparation for outcome

Table 5

Phases of infertility treatment and counselling tasks

Legacy (any stage): Adjustment to pregnancy and parenthood
Counselling tasks:
Support and education
Redefining self/couple as parent(s)
Emotional and therapeutic counselling

Covington, S. N. (1999). Integrating infertility counselling into clinical practice. In L. H. Burns & S. N. Covington (Eds.), Infertility Counselling: A Comprehensive Handbook for Clinicians (p. 481). New York: Parthenon Publishing.

must determine which alternatives are acceptable and the direction their future will take. If the goal is reproduction and they have reached the limits of treatments that will allow them to achieve a pregnancy and transmit their own genes, the couple must consider a childfree lifestyle. However, if parenthood is the goal family-building alternatives, such prenatal adoption (donor gametes), traditional adoption and/or surrogacy or gestational carrier must be considered.

Mahlstedt and Greenfeld (1989) suggest that all patients considering the use of donor gametes to achieve parenthood should be seen by a counsellor, with the focus on preparation for parenting involving third-party reproduction. The major psychological tasks for couples considering prenatal adoption (the use of donated gametes) include:

- Acknowledging the individual loss of reproductive capacity and what this means to them individually and as a couple.
- Grieving the assumed and hoped for genetically shared pregnancy.
- Examining the acceptability and suitability of gamete donation as a family-building alternative for them as individuals and as a couple.

According to the ASRM 2002 «Guidelines for gamete and embryo donation», recipients should receive counselling on the feelings relative to the medical conditions necessitating the use of donor gametes and the potential psychological implications donor gamete treatment and/or parenthood (S11-12). Recipients should be counselled about the impact of treatment termination, including the grieving process and developing alternatives for the future. Recipients should be informed about the screening and testing of the donor and, in case of identified donors, the recipients should be warned that a donor may be deemed unsuitable for donation. In cases where a recipient couple chooses to use a donor deemed unsuitable, additional counselling must involve risk management and an agreement that the recipient couple understands and assumes the risk.

Daniels & Thorn (2001) note that a prime goal of counselling in prenatal adoption is the acknowledgement and restoration of confidence diminished as a result of the infertility diagnosis and treatment. They suggest that couples need an opportunity to deal with the issues that emerge as they consider prenatal adoption, and these issues are addressed so that the couple can consider the implications for the family that they plan to build via gamete donation. It is suggested that counselling services be provided at pre-treatment, treatment and post-treatment (Thorn & Daniels, 2003). They further suggest that post-treatment counselling is particularly important, as an increasing number of donor-conception parents are now telling (or planning to tell) their offspring about the nature of his/her conception, and, therefore, they are seeking information and guidance on the issues that

emerge from this information sharing.

Klock and Maier (1991) suggested that the purpose of counselling in prenatal adoption includes consideration of the following:

- Insuring that the patient(s) can provide informed consent.
- Providing preparation, education and support.
- Assessing readiness for parenthood via gamete donation.
- Assessing marital stability and the mental stability of both potential parents.
- Consideration of legal issues.
- Religious and cultural considerations.
- Addressing potential parenting roles, including disclosure issues.
- Facilitating decision making, particularly regarding anonymous versus identified donors.

For the individual and/or couple considering intra-familial gamete donation, it is important that the infertility counsellor address issues concerning coercion and boundary violations, in order to prevent «psychological incest», as well as potential cultural and/or religious factors influencing their adjustment to infertility and decisions regarding third-party reproduction. Additionally, the social consequences of third-party reproduction must be addressed, including how parenthood achieved in this way will impact the couple's social network and the child's acceptance within the extended family.

Legal issues can be a major consideration for couples considering third-party reproduction. The infertility counsellor should address any relevant laws governing the use of donor gametes where the intended parent(s) reside, as well as where they are seeking treatment. Legal issues can be particularly relevant in oocyte donation, particularly if the oocyte donation is intra-familial, the couple is legally required to recruit their own donor or is considering egg sharing (donating their own oocytes or using the oocytes of another infertile patient). Baetens and colleagues (2000) suggested that in oocyte donation with a donor recruited by the patients (intended parents) the infertility counsellor should:

- Guide the decision-making process for known or anonymous donation, including discussions of the consequences of this choice for the recipients, donor and the child.
- Address the motivations of the donor, boundaries between the parties and issues of coercion.
- Evaluate the motivations of the recipients (intended parents).
- Address issues of secrecy/openness and the consequences of this decision to all parties.

Egg sharing is discouraged by MHPG/ASRM guidelines, because of the inherent qualities of coercion and lack of genetic (or even psychological) evaluation of potential donors for potential recipients. Baetens (2000) astutely suggests that when egg-sharing donations are based on «financial need, the woman's *freedom* to consent is restricted by this need». However, Baetens (2000) recommends that the infertility counsellor address the following issues with couples considering oocyte sharing:

- The consequences to their own treatment of their donation with potential oocyte-sharing donors.
- The consequences of donation with potential recipients, including how matching is done and the possibility of negative outcomes (e.g., donor not producing sufficient oocytes for sharing or oocytes being of poor quality).

Finally, according to the ASRM Ethics Committee, familial donors that would create consanguinity such as a sister donating to her brother's wife should be prohibited. Furthermore, «certain arrangements that create the impression of incest, like a brother donating sperm to his sister, who is also using donated eggs, need to be evaluated carefully, even though there is no consanguinity». The committee recommends counselling to patients and donors who are considering intra-familial gamete donation. «Patients from close families willing to help them overcome their infertility are very fortunate, but,

as the Ethics Committee points out, we need to take care to ensure that the plan is in the best interest of everyone involved: intended parents, donors or surrogates, and especially the children», remarked Owen Davis, MD, President of the Society for Assisted Reproductive Technology.

According to the ASRM 2002 «Guidelines for gamete and embryo donation», recipients of donated embryos (and their partners) should also receive counselling about the potential psychological implications of «prenatal adoption» (S13-14). Many of the issues of embryo donation are similar to the counselling tasks of gamete donation (e.g., feelings relative to the medical conditions necessitating the use of donated embryos). However, the guidelines recommend psychological assessment to evaluate the appropriateness of the potential recipient(s), in an attempt to rule out significant psychiatric illness, current substance abuse and the ability to cope with the stress of assisted reproduction. In addition, it is recommended that the recipient(s) be advised of screening and testing requirements and be prepared either to not use or to assume the risks related to the use of donated embryos the donors of which probably have not been screened and evaluated as thoroughly as gamete donors.

Counselling issues for couples considering the use of a surrogate or gestational carrier include most of the same issues as gamete donation recipients. Like couples and/or individuals considering other forms of third-party reproduction, counselling prior to treatment is recommended and some centers require psychological evaluation (e.g., MMPI-2). According to the ASRM «Gestational carrier guidelines» (2004 pending), this evaluation is recommended to ensure that the couple is capable of maintaining a warm and respectful relationship with the potential surrogate or gestational carrier and to provide a clear understanding of the potential psychological issues and risks associated with this form of parenthood. While clinical interview should include a history of the intended parent's infertility and methods of coping determining, it is ***not*** the purpose of the evaluation to assess the intended parents' ability to parent. It is recommended that the infertility counsellor conduct a group meeting with the intended parents, carrier and her partner. In addition, unique issues should be explored regarding amount of contact, privacy issues and potential for negative impact on the various relationships. If the carrier and the intended parents are being matched by a third party, the procedure for accepting or rejecting a match should be clearly stated in this meeting and they should understand that all parties always have the right to refuse a match. It is recommended that the carrier and intended parents have a legal contract that clearly defines the financial obligations, decision-making process regarding the pregnancy, issues of multiples and fetal reduction, delivery options and collaboration/contact during the pregnancy. Finally, it is recommended that the carrier and intended parents have separate legal counsel.

The consensus, although not necessarily the universal practice, is that all couples considering third-party reproduction (gamete donation, embryo donation, surrogacy or gestational carrier) should have a minimum of one session of pre-treatment counselling, and that counselling should be made available to them both during and after treatment. It should be performed by a mental health professional with special training in infertility counselling and reproductive medicine. Although these recommendations have been made by the various professional infertility counselling organizations, professional medical societies, government agencies and policy makers, this recommendation is not universally followed. Infertility clinics world-wide lack trained mental health professionals and/or the motivation to provide this service to their patients and consumers, who, typically uneducated about what counselling will involve, often reject the

idea. Infertile patients, feeling stigmatized by infertility and/or the diagnosis, feel further stigmatized by the suggestion that they require mental health care. Although these barriers have proven formidable, there has been considerable movement over the past twenty years – in large part, due to the efforts of professional infertility counsellors worldwide, their professional organizations and the research of mental health professionals working in the field of reproductive medicine.

Psychological issues: Potential gamete donors, gestational carriers and surrogates

The original (1993) ASRM «Guidelines for gamete donation» pointed out the difference between male and female gamete donors. The 1993 guidelines, along with subsequent guidelines from ASRM (2002) and those of PSIG/ESHRE, recommended psychological counselling for all parties involved in oocyte donation, but did not recommend counselling for sperm donation, unless it was identified, or intra-familial sperm donation. This is, in large part, because sperm donation is a non-invasive donation, that does not make physical demands on the donor in the same way that oocyte and/or embryo donation does.

Schover (1993) provided a comprehensive list of issues to be addressed in a thorough, structured clinical interview with oocyte donors. The interview should include: the donor's motivation; unrealistic expectations of the psychological benefits of donation; financial pressures; past history of reproductive losses, particularly if linked to the donor motivation and/or guilt for past elective abortion or adoption; risk for obsessing about unknown outcome for recipients; risk of grieving the loss of perceived potential offspring; general coping with emotional losses; realistic expectations about the medical procedure; history of somatization; history of involvement in a lawsuit related to her medical care or criminal behavior; significant pressure from family or friends; overall comfort with donation as a concept; assessment of sources of happiness and satisfaction; assessment of stresses and/or behaviors that could impact compliance; overall stability and goal-directedness; past history of abuse; ability to comply with abstinence from sex during treatment; past history or current evidence of major psychopathology and/or chemical dependency. In evaluating identified donors, Anderson and Alesi (1998) suggest that the additional issues which have to be considered for known donors include: future relationships with participants; future relationship with child(ren); emotional aspects of relationship with child(ren); telling the child(ren); confidentiality with other parties – a significant issue in intra-familial donations; number of planned donations; and implications of negative outcome of treatment and/or conflicts regarding treatment. Applegarth and Kingsberg (1999) provided an outline of the psychological indications for acceptance or rejection of a potential gamete donor. An ideal candidate can provide informed consent; is able and motivated to comply with treatment; and is an emotionally stable individual, who has a history of stable employment and relationships; there are no unusual life stressors in her life; and she uses adaptive coping mechanisms. In addition, standardized psychological testing is within normal range.

One recent study found that one third (35%) of oocyte donors were willing to donate again, while 37% would not, and 28% were unsure (Klock et al., 2003). The average donor was a 27-year old single, white, college-educated woman who had had at least one prior pregnancy. Fifty-eight percent were first time, anonymous donors and 42% had donated more than once. All of the donors (who were from the USA) felt that compensation was important, with only 11% stating that they would be willing to donate if they were not compensated. In an open-ended question about the best thing about being a

donor 88% of the women answered «being able to help someone». The worst part of the donor experience, according to 37% of the donors, was the daily injections. Willingness to donate again was related to lower ambivalence and less time taken to make the decision to be an egg donor. About half of the donors surveyed took approximately one month to make this important decision. Women who were willing to donate again also expressed greater satisfaction with the medical aspects of the process.

According to the ASRM «Gestational carrier guidelines» (2004 pending), the purpose of the pre-treatment counselling session is to provide the potential gestational carrier with a clear understanding of the potential risks of the process, including the emotional issues of the pregnancy and the risks of emotional stress. Additional issues to be addressed in the interview include:

1. Managing the relationship with the intended parents.
2. Coping appropriately with the pregnancy.
3. Risks of attaching to the baby and risk to the carrier's own children.
4. Impact on carrier's marriage.
5. Impact on carrier's employment.
6. The balance between the carriers' right to privacy and the intended parents' right to information about their baby.

As a general rule, childless women should not be considered as carrier candidates, primarily because, without having experienced pregnancy, birth and/or parenthood, it is probably impossible for the woman to provide informed consent. Reasons for rejection of a potential gestational carrier are provided in Table 6. Most carriers find a support group or the regular sessions with a therapist/counsellor an important aid during the pregnancy, particularly for addressing their emotional needs, which are often overlooked by the intended parents and/or medical caregivers.

It is generally accepted that education, preparation and screening of potential oocyte donors, gestational carriers and surrogates is the standard of care in third-party reproduction. Surrogacy is a fairly rare practice, although some couples choose to make their own arrangements, without the assistance of medical, mental health or legal professionals. However, donor oocyte and gestational carrier arrangements and evaluations are a frequent part of the infertility counsellor's work. More complicated are intra-familial and identified donor/carrier arrangements in which one or both parties bring a relationship history, personal expectations and even differing agendas to the arrangement. These arrangements can be conflictual and require the infertility counsellor's best conflict resolution skills, as well as an aptitude for tact and diplomacy. The most important therapeutic goal in working with these altruistic individuals is for the mental health professional (as well as other caregivers) to ensure a positive experience in which the donor or carrier feels they have been treated with warmth and respect and that their contribution has been a valuable one, that is appreciated.

Post-treatment issues

The pregnancy after infertility is typically fraught with a variety of anxieties and unique circumstances, including ambiguity, isolation, fear and technological bewilderment (Glazer, 1990). If the pregnancy is achieved as the result of third-party reproduction, the patient may have difficulty bonding and may experience significant feelings of ambiguity and ambivalence. Patients who have not had pre-treatment counselling may begin to have questions and concerns about the circumstances of the child's conception: Do they keep the issue private or opt for a more open approach? Are there educational materials that would be helpful? How will the child react to the information? How does the non-genetically related parent feel about the pregnancy or after the child is born?

Table 6
Suggested rejection criteria for potential gestational carriers

1.	Cognitive or emotional inability to comply or to understand
2.	Evidence of financial or emotional coercion
3.	Failure to evidence altruistic commitment to become a carrier
4.	Psychological testing not within normal limits
5.	Unresolved or untreated addiction, child abuse, sexual abuse, physical abuse, depression, eating disorders or traumatic pregnancy, labor and/or delivery
6.	History of major depression, bipolar disorder, psychosis or diagnosis of a personality disorder
7.	Insufficient emotional support from partner/spouse or support system
8.	Current marital or relationship instability
9.	Excessively stressful family demands, without sufficient support
10.	Chaotic lifestyle
11.	Inability to maintain respectful and caring relationship with intended parents
12.	Evidence of emotional inability to separate from/surrender the baby at birth
13.	History of conflict with authority
14.	Inability to perceive and understand the perspective of others
15.	Motivation to use compensation to solve own infertility
16.	Unresolved issues with a previous abortion

Multiple pregnancy is a significant risk in donor gamete pregnancies, but typically one that is minimized (even welcomed) by previously childless couples. Nevertheless, pregnancy complications and compromised health conditions remain significant risks in third-party reproduction – whether intended parents want to acknowledge it or not. Research indicates that multiple births have numerous effects on the quality of life, not the least of which is the «social stigma» of multiple parenthood (Ellison & Hall, 2003).

A major issue in third-party reproduction is whether or not to reveal to the child the circumstances of his/her birth. Australia (Szoke, 1999), New Zealand (Ministerial Committee on Assisted Reproductive Technology, 1994), the United Kingdom (Warnock, 1985), Canada (Royal Commission on New Reproductive Technologies, Canada, 1993), many European countries and, most recently, the ASRM Ethics Committee (2004) have recommended that children conceived via third-party reproduction deserve accurate information concerning their genetic/biological history. Nevertheless, the tradition of secrecy continues, and remains a significant issue with which parents struggle.

Conclusion

Third-party reproduction has offered parenthood and even pregnancy to couples who previously would have suffered the consequences of diminished or lost fertility. But, given the fact that third-party reproduction is not without significant issues, it is the responsibility of the mental health professional –more than any other member of the reproduction treatment team– to insure that the couples pursuing

parenthood via this avenue consider all its consequences. This responsibility means considering the well-being of all participants in the third-party reproduction process – first and foremost, the child, in addition to the potential parents and the assisting party, whether that is a gamete donor, embryo donor, surrogate or gestational carrier.

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