Psychological Concerns in Non-traditional Family Building

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Deciding to become a parent is not always an easy decision. When it involves medical and legal assistance the choice becomes even more complicated. Now add the decision to become a parent as a single woman or man, a same sex couple, or someone over the age of fifty, and the journey seems arduous and overwhelming. When parenthood seems so elusive, asking individuals to explore the long-term implications of these choices can feel pointless.

Thirty years ago, it was an accepted practice for adopted children to be discouraged and even protected from information and knowledge about their origins. Parents often lived in fear that someone would inadvertently disclose to the child, resulting in major psychological harm. Through years of research, clinical experience and the strong voices of those adopted children, there has been a complete reversal in that position. Now it is considered “wrong” not to tell your child from birth, or early on, of their origins. There is a belief that every child has the right to know their medical information. Yet, even for these families there continues to be the struggle of when, how and what information to share with their child and others. Many parents report that the telling is often delayed because they don’t know how to begin and what language to use.

Anthropologists have raised the question of whether genetic material of a third party disturbs the kinship in a family. On a cultural level, gamete donation was thought to be a violation of the traditional family network. A family not supported by genetic relatedness might be considered fragile. Given that many families who adopt are labeled by society, it is not surprising that gamete donation encouraged the rebirth of secrecy. When sperm donation became more common over 30 years ago, it was not unusual to have medical students be solicited by their professors to give fresh sperm, with little information asked on either side. Medical students were never counseled as to what they were doing. After the insemination, couples report being told that they should just go home, have intercourse that night and never look back. Unlike adoption, no one needed to know. The right of a child to know genetic origins was less important than the right of the parents to procreate and have their privacy. No one considered what impact this secret would have on the marriage, and certainly no one thought that there would be any impact on the donor offspring child. For a long time no records were kept. Even today record-keeping continues to be a problem that reflects the continued lack of respect for the rights of donor offspring to have access to their genetic information. It is estimated that over one million children have been born through sperm donation and over 100,000 children have been born with the help of egg donation.[1]

The fight for medical coverage for reproductive treatment has focused on infertility as a disease. No mention was ever made of gay, lesbian, single, HIV individuals who need medical assistance to create their families. In the new world of assisted reproductive technologies the emphasis needs to be less about disease and more about finding solutions that will allow everyone the opportunity to build their families. In her book Mommies, Daddies, Donors, Surrogates, Diane Ehrensaft, PhD, terms it “assisted conception”.[2] Parenthood now includes not only those with impaired fertility, but also those who never thought they would be able to become parents.

While some programs and doctors require psychological interviews, others make it optional. A 2008 study from Sweden [3] suggested that when patients were exposed to negative attitudes about disclosure from their gynecologists/obstetricians, it limited some patients’ ability to discuss their thoughts and feelings about donation. In the same year, a study by Shehab, et al., of donor inseminated and egg (oocyte) donation parents, reported that mental health professionals unanimously encouraged disclosure, while doctors were more variable in their advice to patients. [4]

When the psychological interview is presented as optional, it is not uncommon to have recipients decide to wave the interview. Reasons for this include: its lack of importance; wanting to avoid unnecessary costs; disbelief that the interview could be helpful, and fears that recipients’ marital status, sexual orientation or advanced reproductive age would be singled out by the fertility program. Often recipients express surprise that the interview was insightful and impacted their decision making choices.

The role of the mental health professional in preconception counseling is to help parents “sort through their fears, anxieties, and hesitancies as they come to make the most important decision of their lives. [5] Not having all the body parts means that the child was created with the help of a birth-other; a real life person who gave their egg, sperm and/or body (surrogate) in order for the child to be born. In a single-parent family with an anonymous sperm/egg donor or surrogate, the individual can easily forget or minimize the role of the donor. They can believe that the donor-offspring child is “mine, mine, mine”. [6] For same sex couples where there is a genetic inequity, there may be tension and fears of being dispossessed. It is not uncommon to have the genetic parent feel that this child will be “more mine than yours". [7] Exploring the psychological and legal realities of genetic ties and parenthood early on in the process allows couples to create a dialogue where these recurring feelings can continue to be discussed.

It is not uncommon for partners to express differences in desired donor/surrogate qualities. Being able to self-select their donor/surrogate gives many a sense of control in creating their families. Working through these conflicts can help couples feel positive about their family story. Unfortunately, the media has interpreted the extent of those shopping for particular genetic traits as narcissists who are attempting to create the Faberge egg. In reality, this search is often driven by the parents’ real desire to have a child that feels like it belongs to them. There is a belief that similarity breeds belonging. Therefore, it is not surprising that in this world of collaborative reproduction, with genetics controlling everything from physical attributes to a predisposition for certain illnesses, that parents feel a sense of responsibility for choosing or failing to choose the right traits for their child. Being able to limit heart disease or asthma can give parents a feeling that they are protecting their child.

“If the desire for a biological connection is strong enough to make adults choose donor conception over adoption, then it is the ultimate double standard to imagine that the desire for a biological connection will not be felt just as strongly by the donor-conceived person that results.” [8]

The decision to become a single parent requires exploring the following: support systems; financial concerns which includes the costs of getting pregnant and being pregnant, childcare, and raising a child alone; job flexibility; and understanding the emotional issues of being a single parent. Mikki Morrissette, founder of Choice Moms, an organization that provides education and support for those women who consciously consider single motherhood, believes that while becoming a single parent may not be easy, it can be a healthy and wonderful choice for women who want to parent but do not have a partner. Too often women can get lost or frozen in the endless questions about parenthood and its uncertainty. Many had hoped to meet someone by a certain age, date, marry and then build a family. It is not uncommon to hear of a single 40 year old woman being told by her gynecologist or internist, that she still has ample time to meet "Mr. Right" and have a family with her own genetics. Less are knowledgeable about the costs, both medical and financial, that grow as the biological clock begins to run out of time. The idea that a menstruating woman can run out of eggs when she is healthy and fit seems impossible. Even with this reality, the most confident of single women can feel conflicted when listening to negative anecdotal comments from friends, co-workers and family members about children of fatherless families.

It is not unusual for those considering donor insemination (DI) to be overwhelmed and confused by the choices. Having met with hundreds of single women and lesbian couples, it is clear that few really understand the long term implications of donor insemination. Donor selection options include:

The known sperm donor is a man who agrees in advance, often without legal protection or counseling on either side, to provide an at-home insemination. A known donor can be a friend, former partner, or a friend of a friend. The donor may be married or in another relationship but may choose to not reveal his donation to his partner. In this situation little may be known about the health of the donor or the quality of his sperm. The hope is that in the future, the donor will make himself known to the child. Often no legal agreements have been established concerning child support or future contact. A known donor can be a single woman’s brother or the brother of a lesbian couple. Using a brother can be a creative way to have both partners, where one is donating eggs and the other uses her brother to have genetic equity to their child. For a single woman who must use a donated egg, having her brother’s sperm can enable her to continue to have genetic ties to her child. While some mental health practitioners describe this as the “ick” factor in donor selection, others are comfortable with unconventional options.

The directed donor is a man who agrees in advance to provide sperm for a clinic insemination. He knows the woman he is donating to, but may not be involved with her romantically. Both parties have usually had psychological and medical testing and have been counseled by an attorney with legal contracts in place. Again, the marital status of the donor may not be revealed to his partner, the attorney or to the medical and psychological screeners. While this gives both sides the most protection, it may still be problematic in states where these agreements are not recognized.

The co-parent donor is a man who has agreed to give sperm in order to become a father. There may or may not be a legal agreement between the two parties, or medical testing done. The best case would be that there would be medical, psychological and legal counseling and contracts in place, spelling out the responsibilities, both financially and logistically in this co-parent arrangement. The parties may or may not live together.

The open-identity donor is a man who donates anonymously to a sperm bank. The donor has been screened medically, genetically, and has met the standards established by the American Tissue Bank. Information shared with recipients includes: medical, genetic, educational and some personal questions. While not in the child's life, the donor agrees to be contacted by the donor offspring child at age 18. Donor agrees to remain in contact with the sperm bank, giving any updates to his medical information. Donor can, at any time after his donation, rescind his agreement to have his identity made known to the donor-offspring child. Only in the last few years have the donor offspring come of age. While initial reports suggest positive meetings, it remains unclear whether these reactions reported are due to the contact, or the fact that many of these children were told about the nature of their conception at an early age.

The anonymous donor is a man who donates his sperm to a sperm bank, knowing that he will remain anonymous, with no contact to the recipients and their donor offspring. Some personal information may be shared, as well as medical history. Donor has been medically tested and meets all standards as established by the American Tissue Bank. Donors are asked to update the sperm bank with any new pertinent medical information, but this is voluntary. While this gives the donor and the recipient mother or mothers the safest choice, it gives the child no opportunity to know the identity of their donor or their genetic origins.

While an increasing number of DI children are being raised in solo households, the psychological implications of growing up without a known or designated mother or father, remains unclear. According to Murray and Golombok present studies have indicated positive relationships between solo moms and their children; pointing out that the children in these studies were only infants and young children. [9] It will be some time before the nature of their understanding is revealed and understood. How these children will feel about the fact that they will never know the man or woman who was their donor remains an important and unanswered question. Future studies will help in exploring the comfort level developed in these families around their family story. Too often recipients rewrite their children's conception story, relegating the role of the egg/sperm/embryo donor to a minor walk-on role. Ehrensaft, coins this reconfiguration as the immaculate deception. [10] It allows the mother or moms to delete the donor(s) from the conception process by demoting the donor to a missing body part, not as a person who was vital in helping the family have a child.

Recent research statistics compiled in "Adoption and Foster Care by Gay and Lesbian Parents in the United States" March 2007, report issued jointly by the William Institute of the UCLA School of Law and Urban Institute of Washington DC show that more than one in three lesbians has given birth and one in six gay men has fathered or adopted a child. More than half of gay men and 41% of lesbians want to have a child. In addition, more than 16,000 adopted children are living with a lesbian or gay parent. Finally, 14,000 foster children are living with lesbian or gay parents, which means that same sex parents are raising 3% of foster children in America. Yet, the hurdles continue to exist for gay men and lesbians looking to have families since, in many cases, adoption is not explicitly legal in all 50 states. While most states do allow single LGBT adoptions, they have not taken a formal stand on joint adoptions. The difficulty can often arise when the couple file for the second parent adoption. [11]

Many from the LGBT community have looked to assisted reproductive technologies in helping them achieve genetic and legal connections to their children. The mental health professional can play a crucial role in assisting same sex couples as they examine the psychological realities of these choices. Unlike the educated battle-weary fertility couple, the gay couple is less knowledgeable about fertility treatments and pregnancy issues. Costs can be high, from a simple donor insemination without medications costing $1,000-$2,000 for the medical and legal care, to $5,000-$20,000 with more medical intervention. For those in need of a surrogate and egg donor, costs can run from $100,000-$200,000. Often concerns about monetary costs can dominate discussions, masking feelings about genetic parentage. In an attempt to lower costs, some will look abroad for fertility care where egg donation with a gestational carrier can cost less than $50,000. Others will explore asking family and friends to donate or be gestational carriers. And still others will search the internet to find their own surrogates and donors. Some will omit getting legal counseling when using family or friends or internet candidates. When seeking these services abroad, many will be ignorant about the legal issues. Understanding the ins and outs of these choices is vital in guiding couples to a safe and successful outcome.

When exploring options for egg donation and surrogacy, couples have three distinct mechanisms in finding available egg donors/surrogates. They are:

In-House IVF Program recruiters are individuals employed by the IVF program as part of their staff whose sole purpose is to solicit, employ and evaluate women seeking to become egg donors and surrogates for their own patients. Qualifications of staff recruiters can vary and could include: nurses; mental health professionals; former patients or donors; others with no experience in screening. Some programs will allow recipients to self-select the donor from their own in-house list. Many willingly entrust the match to the reproductive program staff, making a leap of faith that they will respect their donor requests and match them with the right donor. Few are aware of the program matching process and screening criteria, and who is designated to make the donor/surrogate match. Little if any verification of the donor’s education or personal life is investigated for accuracy. All medical and psychological screening of the donor is done in person by the IVF program staff. While most programs are members of the American Society of Reproductive Medicine (ASRM) which has established donor screening guidelines that include mandates from the FDA, there is no one uniform standard that all programs must adhere to. Since guidelines are not mandated, each program may interpret them differently. Information shared with the prospective parents varies from program to program. Donors are asked to remain in touch with the IVF program; reporting any changes in their personal or family health histories. Reporting is voluntary. Information about a successful pregnancy may or may not be shared with the donor or other recipients. Prospective parents who select this option: feel secure that the donor has been thoroughly screened and cleared medically, psychologically, and genetically; feel secure that the donor will always remain anonymous to them and their child; want to downplay the donors role; feel this choice is the most cost effective; are secure that the anonymity will never allow the donor to claim their child; and will avoid pictures of the donor that could be embedded in their minds, disrupting bonding. While many IVF programs use consent forms, others may use legal contracts. There is no uniformity in these forms.

Free Standing Egg/Surrogate recruiters are private businesses that are often staffed and run by former donors/surrogates and fertility patients. These agencies/programs are established for the sole purpose of soliciting, employing and evaluating women to become egg donors/surrogates for recipients signed up with that recruiter or program. Agencies are not medical programs. Initial screening of the donor/surrogate can vary from an in-person interview to a telephone interview. Staff may never meet the donor but conduct their evaluation by phone and e-mail. While donors/surrogates are asked to complete extensive profiles, verification of the information given varies from agency to agency. As professional members of ASRM, these free-standing programs must agree to follow suggested guidelines for compensation. In spite of these guidelines, many agencies continue to offer compensation that is well above the guidelines. Most of the prospective parents who select this option believe they will be more comfortable with self-selection; matched quicker; able to find a better quality of donors/surrogates; able to get more in-depth profiles; able to see donor adult/childhood/family pictures; able to request extra medical/genetic testing; able to request background checks, verification of schooling and test scores; able to have the option of speaking to or meeting their donor; able to create legal contracts between the donor/surrogate and the intended parents that stipulates various levels of contact in the future. With the consent of a donor/surrogate, previous cycle information can be made available as verification of proven fertility and commitment. Donors/surrogates selected through private agencies may not be accepted at every fertility program. Recipients must check with their program about their policies concerning these agencies. Many recipients will first self-select a donor and then find the program that will work with them. Extra costs with this selection may include: the agency fees which can range from $2,000-10,000 excluding donor compensation; selecting and evaluating donors who later fail medical screening; or picking a non-local donor/surrogate who must travel to the facility several times for the evaluation and cycle. When selecting a surrogate, recipients will need counseling to understand what the most common problems are. These problems can be divided into three categories: struggles with medical issues; struggles with the surrogate relationship regarding how much contact; and struggles with logistical surprises. It is important for all participants involved in the creation of this donor-offspring child to have legal, psychological and medical consultations. [12]

Internet Websites are sites on the internet where recipients and donors/surrogates can advertise and search for their own recipients and donors/surrogates. Cost and/or the belief that they are better able to evaluate donors/surrogates themselves are the reasons frequently given. Some will set up separate e-mail accounts to try to maintain some sense of boundaries while others will feel it is unnecessary. It is not uncommon to find donors/surrogates who have been rejected from agencies and programs, contacting recipients. The information shared cannot be verified. Unrealistic demands can be made by all parties involved. Recipients who decide to move forward with this option will need to be screened by an IVF program and may find their candidates being rejected for psychological or medical reasons. Contracts are usually required but in some instances are waved. Difficulties can arise during a gestational or traditional pregnancy when differences of opinion appear with no one to mediate and no contracts in place. Depending on state laws, recipients may have no recourse if problems arise.

In 2004, The ASRM Ethics Committee stated that children created with the help of a donor be informed of their conception. [13] While many have applauded this announcement, there were no guidelines established for professionals, nor for parents, as to how or when this information should be shared. Often, many will disclose information about their child’s conception before they have fully processed the information themselves. Others express fear that the donor information will disrupt their parent-child bonding. It is not uncommon to hear parents express that it is the uncertainty of telling that makes the disclosure process difficult to start. Studies have found it hard to ascertain how couples arrive at their decision to disclose. It may be that parents who are willing to confront and sort through their fears, discomforts, and hesitancies when making this life altering decision may feel more confident about disclosing to their child. In 2009, a study by Daniels, Gillett and Grace reported that parent decisions about disclosure reflected a variety of influences and contexts, including the local socio-political environment, professional opinions, counseling, support networks, religious and cultural backgrounds, and family and personal factors. [14]

Disclosure begins when recipients decide to become parents through third party assistance. In selecting the donor/surrogate, recipients should be mindful of reasons for their choices. Recognizing that disclosing to their child their unusual beginnings will need to include how this birth other became part of the family story. When couples are considering egg donors they need to consider the following:

A known donor is someone who is related to the intended parent or parents; such as a sister, cousin, niece, or aunt. Sisters-in-law, friends or a neighbor can also be considered to be known donors. Concerns with using a known donor focus on issues around coercion: donors who feel obligated to donate because of their relationship with the intended parents. Often it is felt to be unnecessary for legal counseling because of the known status. For lesbian couples where one partner is donating to the other, it is important for there to be legal contracts that clarify the role of the partner who is donating; stipulating that she is donating as the partner and not as an egg donor. Surprises can occur when undisclosed health and mental issues arise during the screening process, which may preclude going forward with this donor. Having other professionals involved with the screening process can be instrumental in avoiding a match that will not be beneficial to all the parties involved.

An Anonymous donor is a woman who elects to donate her eggs to an unknown named couple. Recipients will be given only non-identifying information such as age, ethnicity, health information, general education, and physical appearance. Information might be given in writing or orally. The level of information shared is program specific. These donors tend to be registered with in-house programs. Anonymous donors are asked to remain in continued contact with the fertility program; reporting any changes in their personal or family health histories. Contacts are voluntary and often do not continue once a donor has finished donating. The information shared by an anonymous donor is a snapshot in time of that person at that moment, and may be the only information that will be available.

An Anonymous donor one way is defined as a donor often recruited by free-standing agencies. These donors are self-selected by recipients. Donor profiles are often posted on the agency website and password protected. Donor information shared with perspective parents may include: date of birth/age; educational information; family medical and psychological histories; previous cycle results; restrictions in travel for cycles; family preferences when matched; and personal questions. Questions about future contact with recipients and donor children may also be included. Donors may be given non-identifying information on prospective recipients. It will not be difficult in the future for recipients and donor offspring to locate their donors. While some donors understand that they can be contacted in the future by their online profile, few comprehend this as a real possibility. Donor responsibility for continued reporting of any family medical updates remains spotty.

Anonymous one way donor with meeting with first names only includes all the information shared by an anonymous one way donor plus a meeting in person or by phone with one or both of the recipients where first names are exchanged. The meeting should be facilitated by a mental health professional or a representative from the agency. It also gives the donors some identifying information about recipients and may make it easier for both sides to find each other in the future. Contracts may be legally put in place outlining possible contact in the future. Though the donor is obligated to remain in contact with a designated person (often an attorney), if the donor decides to rescind this commitment, it may not be easy to find her.

Open Donation gives both the donor and the recipients' equality in knowing each other. Both know one another's complete names, addresses and e-mails. This allows all parties, including the donor-offspring and the donor's children access to information now and in the future. It is suggested that legal contracts be put in place to establish the boundaries of the relationships for all parties. Again, the children of both parties are not bound by these contracts.

In January 2009, The ASRM Ethics Committee issued another report entitled, Interests, obligations and rights of the donor in gamete donation. In their report they identified the affected parties in gamete donation as recipients, offspring, and donors. They acknowledged that each of these parties have distinct but, at times, competing interests. The committee recognized that gamete donation is more than a transfer of gametes from one party to another. It is part of a method of family building that involves a complex interchange of emotions and psychological needs of donor, recipient, offspring, and potentially, the donor's family. For this reason, the committee suggested that there be a re-examination of the consent process and new attention to the landscape of ethical responsibilities, as well as the rights of involved parties to one another. [15]

There has been some concern in the last ten years that there is a lack of accurate record-keeping by various sperm banks, egg agencies, fertility programs, doctors, and patients themselves. The failure to have one central registry for donors/surrogates has allowed some to donate to recipients with no regard to their responsibilities. It is not uncommon for these parents to fail to report their child's birth, in the hope of permanently cutting off any ties that link them to a donor/surrogate.

To date there are no controlled studies that indicate that it is better to disclose to your child versus not disclose. Parents who tell their children when they are young are in a position to shape the initial disclosure, using language that is comfortable to them and to create the family story in the way they would like it to be told. [16] "Secrecy within families involves the intentional concealment of information by one or more family members from others who may be impacted by it" (Bok, 1982). "It is important to differentiate between privacy and secrecy. The distinction lies in the relevance of the information concealed" (Karpel, 1980). "What is truly private doesn't impact our physical or emotional health." (Imber-Black, 1998, p.21). Whereas, secrets such as information of biological parentage may have negative effects," for maximizing preventive healthcare and identity formation. Evidence from studies by Imber-Black (1998) and Karpel, (1980), indicate that "maintaining secrets in families creates barriers between the secret holders and those who do not know the information"; affecting the family system and individual family members. "Even secrets made with the best intensions may affect family relationships and interactions (Imber-Coppersmith 1985). Present studies reveal that when disclosing, it appears less detrimental for donor offspring children to be told about their donor conception at an early age. "Clinical family practice has demonstrated that secrets often gather strength during adolescence due to the increased possibility of discovery" (Cain, '06, Imber–Black, '98, Karpel, '80). Topic avoidance is often the mechanism used to avoid disclosure of information relative to deviation from the norm such as infertility and adoption. In using topic avoidance parents, when asked about specifics of the child's conception, may withdraw from their conversation or omit certain content. (Christensen & Heavey, '93, Pike, Jones, & Redmon, '83). [17]

While children of heterosexual couples can choose to be open or closed about their origins, children of gay or single parents don't have that luxury. Gay and single parents understand from a much earlier point that their family story will need to include assistance from more than their parents. They will need to understand that they will be put on the spot regarding their children's conception by complete strangers, random school officials, the check out girl in the supermarket, the pediatrician and others. Having a level of comfort with their own sexuality will enable them to help their children be secure with their identity questions. As children grow up, so will their ability to ask questions. Parents will no longer be able to control information. Children will be able to access information on their own. Part of the family story will be disclosing to the child the information and role that the donor/surrogate played in their creation. The most difficult part of the family story may be sharing how one parent has genetic ties to the child and one does not. The child's questions will focus on making sense of their own unique story, looking to their families to give them the confidence and tools when others ask them questions about how their family came to be. Wendy Kramer is the Director of the Donor Sibling Registry a website that allows individuals conceived by donor, to search for and make contact with their donor and donor siblings. She states “putting one’s fears aside, parents need to be brave enough to ask the question, What is in the best interests of my child?” [18]

In shaping the narrative for their children, parents begin the process of redefining how their family was formed. Normalizing the story is extremely important. Parents need to remember that these discussions will evolve over time, taking on new and changing dimensions as children's cognitive abilities expand. According to Ehrensaft, telling the story is not a stage production but a dialogue that will happen again and again. Parents need to be able to put aside their own anxieties and go into listening mode versus lecture mode. Even if parents have little information on their donors they need to be honest with their children about what they do have. Research by cognitive scientists has shown that “experiences not framed into story form suffer loss in memory.” Mandler, ’84; & Mandler & Johnson, ’97. [19] We remember stories and information better when framed in a narrative form. Stories must be age appropriate, introduce the theme, be memorable enough to grab the child’s attention and create context for the child who will be able to absorb information over time as they build on a story begins as unfamiliar and grows into the familiar.

“When donor conceived children search out their roots, it is not to find replacement parents, but to complete their own identities”. [20]

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[4] Ibid.

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[6]<!--[endif]--> Ibid., p. 80-81.

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