3.1 Introduction

In considering the interrelated social and psychological aspects of surrogacy we acknowledge that society has long accepted the delegation of various parenteral functions and explore the role of a surrogate in relationship to this as well as alluding to commoner comparisons with prostitution and adultery. In particular, the "birth mother" rule, the public antipathy to "commercial" surrogacy and restrictive legislation are explored and found to be inappropriate. It is concluded that the regulation, surveillance and assessment needed to ensure the best outcome for all concerned would perhaps be easiest achieved in programmes that are formally licensed under permissive legislation and adequately funded by "commercial" means.¹

Surrogacy is an arrangement in which a woman carries and delivers a child for another couple or person. She may be the child's genetic mother (the more traditional form of surrogacy), or she may carry the pregnancy to delivery after having an embryo with another female's genetics transferred to her uterus.

An increasing number of couples are turning to the option of surrogacy to achieve their dream of having a family. Although this method continues to be controversial, there are many happy families that have expressed unqualified support for the use of surrogacy. Yet while many happy outcomes have resulted, there are psychosocial effects of surrogacy on both the biological and surrogate parents.

3.2 Psychological Aspects of Surrogate Motherhood

3.2.1 Introduction

Surrogacy is a treatment option available to women with medical problems, including mal-formations of uterus, like mullerian agenesis, to help them have their own genetic children. The indications for this infertility treatment option include absent uterus, recurrent abortions, repeated IVF failures and some other medical conditions. With regards to the effects of this approach on patients’ lives, it is necessary to evaluate the psychological and social aspects of surrogate motherhood. The purpose of this study is to review the results of researches done on surrogacy, experiences of surrogate mothers and the effect of this method on their marital and social relationships and their psychological health.

It has been suggested that relinquishing the child may be extremely distressing and may result in psychological problems for surrogate mothers. It has also been feared that the surrogate mother may prenatally form a bond with the baby that would make it particularly difficult for her to hand over the child to the commissioning parents. For those women who do relinquish the child, the risk of post-natal depression, as well as feelings of anger or guilt, may add further strain to the woman's psychological health.

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Such that woman may enter into surrogacy arrangements because of financial hardship without being fully aware of its potential risks. Other concerns relating to surrogacy include the impact on the surrogate mother's partner, her parents or any existing children, and its destabilizing effects on her family integrity. On the other hand, case series that have explored the experiences of surrogates and commissioners, have not noted any substantial psychological problems and surrogates have not experienced a higher than average postpartum depression rate. By a comprehensive and precise consultation and support of an expert team, many of these surrogate mothers could experience this period positively.

Surrogate pregnancy should be treated as a high-risk psychological experience. In addition, it is recommended that surrogates receive professional counseling before, during and after pregnancy.

This review addresses the psychosocial research carried out on surrogacy triads (surrogate mothers, commissioning mothers and offspring) and shows that research has focused on a number of specific issues: attachment and disclosure to surrogate offspring; experiences, characteristics and motivations of surrogate mothers; and changes in profiles of the commissioning/intended mothers. Virtually all studies have used highly selected samples making generalizations difficult. There have been a not able to lack of theory, no interventions and only a handful of longitudinal studies or studies comparing different populations. Few studies have specifically questioned the meaning of and need for a family or the influence and impact that professionals, treatment availability and financial factors have on the choices made for surrogate and intended mothers. Societal attitudes have changed somewhat; however, according to public opinion, women giving up babies still fall outside the acceptable remit. Surrogate and intended mothers appear to reconcile their unusual choice through a process of cognitive restructuring, and the success or failure of this cognitive appraisal affects people’s willingness to be open and honest about their choices. Normal population surveys, on the contrary, are less accepting of third party reproduction; they have no personal need to reconsider and hence maintain their original normative cognitively consonant state.
The aim of this review was to address the social and psychological issues involved in surrogate motherhood triads:

(i) the surrogate mother (or couple) relinquishing the baby at or soon after birth,

(ii) the commissioning or intended mother (or couple) receiving the commissioned Baby and

(iii) The offspring.

The study of surrogate motherhood is of considerable theoretical and practical/clinical interest because it goes against the norm of couples creating families. The clinical place for surrogacy is obvious, for example in cases where a uterus is removed to treat cancers. However, surrogacy also involves ethical and moral dilemmas because commissioning or intended couples seek out a woman to initiate, gestate and deliver a baby for them, usually in return for financial compensation. The surrogate, in turn, does not find her inadvertently pregnant (as is the case in adoption or social termination of pregnancy): she conceives purposefully with the intention to relinquish the baby and not to keep it as part of her family.

The psychosocial concerns are therefore 3-fold:

(i) Are individuals characterized by different psychological traits and or different social circumstances?

(ii) What are the psychosocial effects of surrogacy on the populations involved in these triads? and

(iii) What are the long-term outcomes for each, and for the offspring?

In theory, surrogacy can be carried out according to any one of a number of sequences outlined in Figure 3.2. This diversity can cause significant psychological and social uncertainty in the short and long term for all individuals depicted, including the offspring at the centre of this chaotic representation, because cognitively people feel uncomfortable if their thoughts (a mother and father and a baby conceived within the relationship, genetically both theirs and gestated by the mother) do not match their behaviors (organizing multiple people to contribute to the achievement of another type of family). Broadly, these combinations include only two types of surrogacy: genetic surrogacy, which refers to the
surrogate using her oocyte, and gestational surrogacy, which refers to the combinations where the surrogate does not use her own oocyte.

**Figure 3.2**

The nine (theoretically) possible combinations of offspring resulting from surrogate arrangements, where the gestation in all instances is with the surrogate mother.

In general, the popularity of ART is affected by differences in the procedures available (including technological advances), economics, time, stigma, suitability, assessment/quality control and genetic link considerations. Furthermore, social and cultural attitudes to any new innovations or interventions are largely shaped by what is considered the norm. Although it is thought that surrogacy has been practiced since ancient times, there is no widely acceptable precedent in the practice of gestating and relinquishing babies. Nevertheless, trends have shifted. Early reports in the scientific literature of donor insemination in the *BMJ* in the 1940s generated a great deal of controversy. The cycle of resistance followed by acceptability was similar for IVF in the 1970s and oocyte donation in the 1980s. This pattern also repeats itself within the relevant professions where, according to Addelson (1990), the ‘public problem of reproduction becomes transformed into a
battlefield on which many experts fight for ownership and for the right to define’.

Another immensely confusing factor in the determination of parenthood in the present era of reproductive technology concerns the classification used to define preferred or true parenthood. Current laws and most cultural values define parenthood and the family in biological rather than social terms, contributing to the overwhelming preference for medical interventions for treatment of infertility in infertile populations. Interestingly, however, popular discourses of motherhood and fatherhood leave out important biological facts, as is seen for example in (I) the absence of heterosexual sex in establishing an assisted reproduction technique (ART) pregnancy and (ii) the absence of gestation and delivery in gestational surrogacy parenthood. In these examples, the resultant individuals who became the parents consider themselves to be the real parents because their chromosomes were involved, even though the biological components were not. Strathern refers to this as a ‘new reality’. This new reality is not limited to chromosomal parenthood: intended mothers of genetic surrogate babies will also describe themselves as the real mother, based on yet another reality (that of being the social mother), and the surrogate mother considers herself not to be the real mother, even though in legal, biological (gestational) and genetic terms, she is. This latter new reality goes against the Oxford Dictionary definition of motherhood. According to the dictionary, the true surrogate is the one who acts in place of another and this, in surrogacy (if the birth mother is the legal mother), is the intended mother!

Fears have also been expressed about the possibility of the inappropriate use of surrogacy, as for example a ‘convenience’ for non-medical reasons. The UK Government, nevertheless, has legalized non-commercial surrogacy (see Surrogacy Arrangements Act UK, 1985), although the contracts are unenforceable in law [Human Fertilization and Embryology Authority (HFEA) Act, 1990; Brazier et al., 1998]. Within the professions, the British Medical Association (BMA, 1996) changed its stance on surrogacy from seeing it as an unacceptable means to overcome childlessness to accepting it as an inevitable option. They issued further guidelines for support
and good practice, but unfortunately, a decade later, the legal literature is still fraught with regulations which can have devastating effects on the triads involved in surrogacy arrangements. To date, in the UK (unlike some states in the US), no one in the surrogate triad can be sure about the child’s future because arrangements and contracts in the UK cannot be legally enforced. The surrogate is always registered as the legal mother of the child, even if an embryo from the recipient couple was used as in gestational surrogacy. Lastly, although surrogacy is carried out relatively openly within the UK, social support for the practice is still lacking. Appleton noted, ‘surrogacy puts human nature under pressure because it creates uncertainty in relationships—those uncertainties go far wider than the couple who is desperately seeking a child. It raises fundamental questions about how other people’s lives are going to be affected by a surrogacy arrangement and how people can be open and honest about their actions’.

These apparently minor ‘problems’ can have significant effects on the couples involved in surrogacy, as it instills uncertainty in those involved and makes a farce of any attempts to behave within a legal/contractual manner. The fact that most surrogacy arrangements take place within licensed clinics, however, makes it unlikely that commissioning mothers would use surrogacy for social reasons, at least in the UK, because clinics can only be licensed by the HFEA if they comply with their code of conduct, which demands that surrogacy should only be considered when it is ‘physically impossible or highly undesirable for medical reasons for the commissioning mother to carry the child’. Nevertheless, although the risks are small, it is possible that in cases of ‘at home surrogacy’ (self-insemination by the surrogate with the commissioning males’ semen) any legislative specifications can be ignored.
Surrogate motherhood is a controversial subject that is not yet widely accepted by society. While having a baby for an infertile couple could be considered a selfless gift, the idea of a woman carrying her child for nine months only to give it away may cause uneasiness among some. The psychological issues a surrogate mother faces before, during and after her pregnancy are potentially significant and are worth considering if you or someone you know is considering surrogacy.

As one can well imagine, the social, psychological, and legal complications increase dramatically as the number of people necessary to conceive a child is increased from the traditional two people.

Review of the literature on contractual parenting reveals a wealth of discussion about the ethical, moral, legal, and psychological implications, but limited empirical data on the psychological and social aspects. Discussion of surrogacy has been ripe with controversy and has assembled some unusual allies.

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3 Psychological Aspects of Surrogate Mothers by Kristen Moutria, Demand Media

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Religious Fundamentalists, the Roman Catholic Church, and feminists alike have condemned the practice of contractual surrogacy as "baby selling"—one that demeans and threatens women. The level of controversy engendered by surrogacy is reminiscent of the abortion controversy in the United States. Surrogacy, like abortion, is controversial precisely because it evokes and often contradicts basic concepts about family, motherhood, and gender roles. Conservative groups are fearful that surrogacy will undermine traditional cultural values about the two-parent family with wife primarily responsible for childcare and husband as provider and patriarch. On the other hand, many feminists are alarmed about the co-modification of women (Tangri & Kahn, 1993) and both groups deplore contractual surrogacy as the selling of babies. Few issues have so deeply divided the feminist community.

Pitted against the large group of feminists who oppose contractual surrogacy are others who fear that any limitation of women's reproductive freedom will provide inroads toward curtailment of women's reproductive rights by groups, often religious in nature, that are opposed to women's access to abortion and contraception. Given the level of controversy engendered, one might expect considerable research activity. Yet the research literature is extremely sparse for a number of reasons. First, the absence of funded research on the topic suggests that financial support for research on such a controversial issue may be difficult to secure. Governmental support may be absent when a practice (e.g., abortion, surrogacy) conflicts with the policy of the administration in power. Second, despite the flood of media attention, particularly in the late 1980s and early 1990s, surrogacy arrangements are less common than generally perceived. Historically, there has been no way to track the number of children born as a result of AI. However, since 1992 federal law has mandated that fertility clinics track and report statistics relating to IVF cycles and births (Fertility Clinic Success Rate and Certification Act). The first compilation of these statistics was published by the Centers for Disease Control (CDC, n.d.) in 1995. Unfortunately, this mandate did not include segregating the number of IVF surrogate births from the total of IVF births. Reporting on IVF surrogate births became a requirement for fertility clinics in 2003.
Nonetheless, the American Society for Reproductive Medicine has attempted to compile information regarding IVF surrogacy and non-surrogacy births prior to the enactment of the law. According to their statistics, from 1985 through 1999 there were 129,000 babies born as a result of IVF. From 1991 through 1999 there were 1600 babies, included in this total, who were born as result of IVF surrogacy (American Society of Reproductive Medicine, personal communication, June, 2002). The numbers pertaining to IVF births, including surrogacy births, may be low since, prior to enactment of the above mentioned act in 1992, reporting was voluntary. Further, until 2003 reporting regarding surrogacy still was voluntary. In any event, it is clear that contractual parenting is infrequent in comparison with the overall birth rate, even for birth rates involving assisted reproductive technologies.

Third, given the social stigma associated with surrogacy, parties to surrogacy agreements, particularly the contracting couple, relish their privacy and therefore may be unlikely to agree to participate in research. In addition, those who arrange contracts and counsel the parties involved are committed to protecting their privacy for ethical and legal reasons. Low prevalence of surrogacy arrangements and concerns about privacy have led to limited availability of research participants, especially intended parents.

Research information is important to clinical psychologists and other mental health providers because it is difficult to screen, advise, and counsel both surrogate mothers and intended parents if there are no empirical bases for such professional activities. Due to lack of empirical data on surrogacy screening and counseling, some clinicians have attempted to glean data from the adoption literature for use in surrogacy. Such comparisons appear inadequate since surrogacy is exceedingly more complex than adoption and has many fewer government laws and regulations structuring it.

Research about the ramifications of creating a family through contractual parenting can provide infertile individuals with information that can facilitate informed decisions about their options and suggestions for improving the surrogacy process for all parties involved. Examination of two online databases, Psych. Info. and Digital Dissertations (i.e., Dissertation Abstracts), identified only 27 empirical studies (published articles, books, chapters, or doctoral dissertations), from January 1983 to December 2003, that
directly studied characteristics and interaction patterns of surrogate mothers; characteristics and interaction patterns of the intended/social parents; and/or attitudes about contractual parenting, surrogate mothers, and intended/social parents (see Table 1). The research literature primarily describes the motivations and characteristics of surrogate mothers. Many (e.g., Blyth, 1994; Ciccarelli, 1997; Hohman & Hagan, 2001; Migdal, 1989; Preisinger, 1998; Ragone, 1996; and Roher, 1988) are small sample studies of less than 30 surrogate mothers (range of 4 to 28) that primarily analyze qualitative data. A few small studies (Einwohner, 1989; Fischer & Gillman, 1991; Hanafin, 1984; Parker, 1983) assess personality characteristics of surrogate mothers using standardized personality tests. Four studies (Blyth, 1995; Hughes, 1990; Kleinpeter, 2002; Ragone, 1996) examine characteristics or interaction patterns of the intended/social parents and another seven investigate attitudes toward contractual parenting. Finally, we could find only four studies which included comparison or control groups. In three, (Fischer & Gillman, 1991; Hanafin, 1984; Resnick, 1990) surrogate mothers were compared to non-surrogate mothers. The fourth (Hughes, 1990) examined the psychological characteristics of a sample of 95 participants that included both individuals who had become a parent though contracting with a surrogate mother and individuals who had adopted a child. Below we integrate research on contractual parenting from a number of major subareas. Although it is possible to dismiss this research as preliminary as well as identify significant methodological flaws in many studies, the consistency of results often is impressive. Moreover, empirical data offer little support for widely expressed concerns about contractual parenting being emotionally damaging or exploitative for surrogate mothers, children or intended/social parents.

3.2.2 Attitudes about Surrogacy

A reproductive technology will be used only if it is considered acceptable by potential consumers. Studies to date support the assertion that contractual parenting, especially when it involves a financial payment to the birth mother for carrying a child, is perceived as the least acceptable of all assisted reproductive technologies, with approval percentages ranging from below 10% to about 25% in surveys of college students, Canadian women of
child-bearing age (Krishnan, 1994), and infertile women in Great Britain (van den Ackers, 2001). This is a much lower percentage than people who approve of or state that they might consider IVF, embryo transplant, and AI by husband. In general, methods that involved third parties (AI by donor and surrogacy) have lower approval rates.

Demographic differences in approval rates appear quite minimal. In Krishnan’s (1994) analysis of data from a Canadian national fertility survey of over 5,000 women in the childbearing years, size of family of origin, age, and religiosity were negatively associated with approval of commercial surrogacy whereas education was positively associated. Together, however, these and other demographic variables explained only seven percent of the variance in attitudes toward commercial surrogacy. One characteristic that may be associated with approval of contractual parenting is infertility itself. Miall (1989) found that 73% of a small sample of women diagnosed as infertile in Ontario, Canada stated they approved in principle of surrogate motherhood. In the larger Canadian fertility survey, childless women had the most favorable attitudes toward contractual parenting. However, differences in attitudes between women known to be sterile and fecund women were very small (Krishnan, 1994). Thus, it is unclear if an inability to produce a child of one’s own leads to greater acceptance of surrogacy, as an unwelcome but necessary reproductive option.

3.2.3 Surrogate Mothers -Characteristics and Motivation

There has been great curiosity about what the typical surrogate mother is like. While it is easy to understand the unhappiness and despair that motivate an infertile, childless couple, who desire children, to enter into a surrogacy arrangement, the motives of women who choose to be surrogate mothers, despite general public disapproval of third party assisted reproduction, are more puzzling and more suspect. Contrary to popular beliefs about money as a prime motive, surrogate mothers overwhelmingly report that they choose to bear children for others primarily out of altruistic concerns. Although financial reasons may be present, only a handful of women mention money as their main motivator (e.g., Hanafin, 1984; Hohman & Hagan, 2001; Migdal, 1989; for exceptions see Einwohner, 1989, in which 40% of women state the fee was their main, although not their only, motivator and Baslington,
2002, in which 21% only mentioned money as a motivator). Rather, the women have empathy for childless couples and want to help others experience the great joy of parenthood. Also, some want to take a special action and, thereby, gain a sense of achievement or enhance their self-esteem.

Some surrogate mothers report enjoyment of pregnancy as a motive. In addition, a substantial minority of women have experienced a prior loss, such as an abortion or having given up a child for adoption that they perceive as motivating them to be a surrogate (Parker, 1983).

Interestingly, Parker reported 26% of his sample of women seeking to be surrogate mothers previously had a voluntary abortion and 9% previously placed a child up for adoption.

However, we could not find documented evidence to suggest that these events are more prevalent for surrogate mothers than other birth mothers with characteristics.

It is possible that verbal self reports reflect socially accepted reasons rather than underlying motivation. Ragone (1994) commented that the "stated motivations of surrogates are often expressed in what can be described as a scripted manner" (p. 52) of consistency and conformity in surrogate responses. Based on her ethnographic research at six surrogacy centers including interviews with 28 surrogate mothers, Ragone (1994, 1996) contends surrogate mothers report motivations that reflect traditional culturally accepted ideas about reproduction, motherhood, and family while devaluing characteristics of the surrogacy relationships, such as financial payment, that depart from traditional values and beliefs. Although they may value traditional motherhood, surrogate mothers are engaging in a behavior that represents a radical departure from traditional views of motherhood and family. Ragone believes that many women become surrogate mothers in order to transcend the limits of traditional female roles by doing something special for another couple while at the same time they struggle to confirm the value of such roles.

The literature also provides information about the socio demographic characteristics and personal traits of women who become surrogate mothers. Scholarly discussions of social class and socioeconomic issues have deplored the potential for exploitation of poor women as surrogate mothers. It is often
implied that surrogacy contracts could exploit poor, young, single, or ethnic minority women. Yet, the data do not support this since, in fact, most surrogate mothers are in their twenties or thirties, White, Christian, married, and have children of their own. However, our discussions with surrogacy agencies and professionals suggest that it is likely that surrogate demographics are due, at least in part, to the screening which is utilized by surrogacy agencies in selecting candidates to be surrogates. These screening procedures are specifically designed to circumvent arguments that the process could be exploitive of poor, young, ethnic women.

Surrogate mothers' family incomes are most often modest (as opposed to low), and they are from working class backgrounds. Also, as previously stated, most do not report financial considerations as their main motivation for being surrogates. Moreover, women of color are greatly underrepresented among surrogate mothers. Despite lack of research support for the economic exploitation of surrogate mothers, it is understandable how some scholars would be concerned that the disparities in income and social class between surrogate mothers and intended parents could create the potential for exploitation.

Personality traits of surrogate mothers also are of interest. Are these women mentally stable with personality traits in the normative range or do they have dysfunctional characteristics? Small, non-representative samples; lack of control groups; and ambiguous or flawed comparisons with test norms make it difficult to reach any conclusions about the personal traits of women who become surrogate mothers. At best, it cautiously can be stated that most surrogate mothers are within the normal range on personality tests such as the MMPI. Moreover, they do not differ from mothers who are not surrogate mothers in reported early attachment history (Resnick, 1990). On the other hand, women willing to be surrogates may be more independent thinkers (Migdal, 1989), less bound by traditional moral values. Kleinpeter and Hohman (2000) report that surrogate mothers scored lower on Conscientiousness and Dutifulness on the NEO Five Factor Test, which could suggest that they have a more flexible approach to the application of moral and ethical principles as currently defined by traditional values about family and the meaning of motherhood.
3.2.4 Experienced Satisfaction

Surrogate mothers generally report being quite satisfied with their experiences as surrogates. Ciccarelli's (1997) research was a follow-up study in which 14 participants (7 traditional surrogates and 7 gestational surrogates) were interviewed 5 to 10 years after serving as surrogate mothers. The surrogates were identified through surrogacy agencies with which the surrogates had worked, and were selected based on their willingness to voluntarily participate in the study. Nearly all participants were California residents, Caucasian, and in their 20s or 30s; most were Christian and had at least one child prior to functioning as a surrogate. All were satisfied with their decision to become a surrogate and perceived the experience as enriching. Nevertheless, pre- and post-birth experiences, relationship with the contracting couple, and whether expectations about surrogacy are met are important influences on the surrogate mothers' level of satisfaction. Several studies confirm that the surrogate mother generally forms a relationship with the couple rather than the child. Women consistently refer to the developing fetus as the couple's child, rather than their own, and they evidence lower attachment to the fetus during pregnancy than other pregnant women. Thus, it is the quality of the relationship with the couple that largely determines the surrogate mother's satisfaction with her experience. Moreover, further examination shows that the relationship with the couple is primarily a relationship with the intended mother. In effect, the pregnancy is defined as a woman's role and the two women share experiences and events related to the pregnancy, thus often forming a close bond.

Unmet expectations are associated with dissatisfaction with the surrogacy experience. In Ciccarelli's (1997) study, 4 of 14 women had unmet expectations and, in two of these cases, expectations regarding level of closeness with the couple were not met. Such unmet expectations can arise at any time during the initial surrogacy arrangements, pregnancy, or many years post birth. Couple interaction with the surrogate immediately post birth appears important. If the surrogate mother is allowed to see and hold the baby and she feels she is being treated with respect, her satisfaction level is high.
Few studies have examined surrogate mothers' relationship with the couple and satisfaction levels up to 10 years after the birth of the child. Most surrogate mothers have some limited contact with the social parents (e.g., pictures of the child, telephone calls) for several years after the birth. Long-term satisfaction continues to depend on the surrogate mother's relationship with the couple and whether her expectations about the relationship and types of contact with the couple and child are met. According to Ciccarelli (1997), as contact with the couple begins to taper off, a minority of surrogate mothers become increasingly dissatisfied with the surrogacy arrangement. The type of surrogacy does not in itself seem to influence satisfaction; rather, the perception of the surrogate regarding her relationship with, and importance to, the couple is determinative. It is particularly damaging if the surrogate mother begins to feel increasingly abandoned by the couple over time.

### 3.2.5 Effects on Other Social Relationships

Almost all surrogate mothers identified in the literature have a child or children of their own, and the majority are married or with a partner. Although family disapproval is not absent entirely, surrogate mothers perceived their decision to bear a child for a couple as having a positive effect on close family members, in particular their children, or at worst perceive their own children as not being negatively impacted by the experience. Half of the women in Ciccarelli's (1997) study reported becoming closer to a family member as the result of the surrogacy experience and nearly three-quarters of the surrogates indicated that the experience affected their own children in a positive way.

Husbands and partners in the Hohman & Hagan (2001) study were generally seen as supportive of surrogacy. Most women who did not have partners reported some support from close family members, friends, the couple, and/or the surrogacy agency director. In contrast, extended families and friends showed mixed reactions. Less than one-third of the responses by extended family were consistently supportive. In Ciccarelli's (1997) research more than half of the participants experienced conflict in interpersonal relationships as the result of being a surrogate mother and over 40% mentioned having lost a relationship as a result.
3.2.6 Negative Effects

Thus far, we have painted a generally rosy picture of the outcomes of surrogacy arrangements for the birth mother. Nevertheless, navigating this rocky terrain in which few known ground rules exist is not easy and may have significant negative emotional effects for some surrogate mothers. Mild and transient negative repercussions of the surrogacy experience probably occur in varying degrees for all women. Most are general side effects of pregnancy that involve physical discomfort, experienced by all birth mothers. Women who become surrogate mothers usually have good reason to believe they will have normal, relatively easy pregnancies, but all experience routine aches and pains and some experience complications that may lead to a difficult pregnancy.

Occasionally women regret their decision to become a surrogate. As previously stated, dissatisfaction with the surrogacy arrangement may increase over time as contact with the couple diminishes. Blyth (1994) identified 2 out of 17 women who regretted their decision. His is also the only study that reports a significant minority of women (about 25%) who experienced significant emotional distress in giving up the child. It is unclear whether the dissatisfaction stems from the surrogacy process itself, the lack of therapeutic intervention, or both. The considerable proportion of emotionally distressed and dissatisfied women may be exacerbated by the lack of professional support for women in Great Britain, where surrogacy agencies are illegal. However, surrogacy arrangements, including those involving payment to the surrogate mother, are not banned.

Professional support and intervention, including therapy, before and during the surrogacy process may maximize satisfaction rates among surrogates. In addition to initial screening of potential surrogates, most surrogacy agencies offer psychological support and intervention throughout the entire process. Nearly all surrogate mothers in Ciccarelli’s research indicated that their satisfaction was increased due to access to competent professionals who helped guide them through the process and deal with emotional issues and any problems that arose. This raises the question of whether the therapeutic process alters one’s inherent reaction of experiencing emotional distress when participating as a surrogate mother. This may explain, in part, why the incidence of dissatisfaction increases over time when there is
no longer active participation in therapy by the surrogate mother. In contrast to the Ciccarelli (1997) study, another study (van den Akker, 2001) indicated that the perceived usefulness of counseling varied among surrogates. Of the 15 surrogates who participated in this study, 1 indicated that she received "a lot" of practical support, 7 received "some" practical support, and 7 received "no" practical support from counselors (van den Akker, 2001). None of the women indicated that they received "a lot" of emotional support, 5 received "some" emotional support, and 10 received "no" emotional support from counselors (van den Akker, 2001). Since there are no data on how often therapy is needed and for what specific reasons, this may be an important area for future research.

In an effort to reduce negative effects, many surrogacy agencies in the United States will contract with only women who have previously given birth and have children of their own. This maximizes chances of a successful birth and fulfillment of the surrogacy contract; women who have experienced bonding with a child during pregnancy may have a more realistic perception about what it will be like to relinquish a baby to another couple.

Additionally, the negative effects reported in Blyth's study (1994) may be due, in part, to the fact that all but two of the surrogate mothers were traditional surrogates. In van den Akker's (2001) study, all the genetic (i.e., traditional) surrogates reported believing a genetic link to the child was unimportant while most of the gestational surrogates disagreed. This raises the question of whether surrogates select the type of surrogacy that fits with their beliefs and values. These types of issues are routinely addressed by surrogacy professionals during the screening process. The above evidence supports the importance, as many surrogates themselves have noted, of using a competent agency that includes a mental health professional in order to minimize potential psychological problems and other negative effects of the surrogacy process.

3.2.7 The Intended/Social Parents

The large bulk of psychosocial evidence on contractual parenting is based on interviews with traditional surrogate and gestational surrogate mothers. We identified only four studies that included intended/social parents. Blyth (1995) interviewed 20 individuals (9 couples, 1 man and 1 woman) in
Great Britain who had a child through surrogacy or were in earlier phases of surrogacy arrangements. Participants were recruited through a self-help group for intended parents and surrogate mothers. The majority of couples contracted with traditional surrogates. In all but one case, the decision to consider surrogacy was made by the wife alone who then convinced her husband to consider surrogacy.

In general, the accounts of intended/social parents mentioned the difficulties and anticipated embarrassment in finding out information about the potential surrogate mother, and providing her with information about themselves. Also, some noted the awkwardness of maintaining contact with the surrogate, especially for the father, presumably because of the ambiguity of gender relationships in surrogacy arrangements (Blyth, 1995). Responses of others were reported as generally positive to the arrangement, although usually only close family members and friends had been told.

Kleinpeter (2002) used grounded theory to examine telephone interview data from 26 parents (24 women) involved in surrogacy arrangements through one California-based surrogacy program. Most intended/social parents were married, white, and had incomes over $80,000 per year. One dominant theme that emerged was the desire to have a genetic link to the child. Although all parents had concerns about the surrogacy arrangements (e.g., financial stress, legal issues, concern that surrogate would not take care of herself and the unborn child), most described their relationship with the surrogate during the pregnancy as positive. Areas of conflict that sometimes emerged primarily related to the surrogate not attending to the health of the fetus. Close to half of the participants perceived their families (mainly parents ad parents in-laws) as supportive while many others experienced mixed reactions; in contrast, almost all described friends as supportive.

Ragone's (1996) wide ranging ethnographic study of six surrogate programs included an analysis of couples. Although not formally interviewed, an unspecified number of couples were observed interacting with program directors and being interviewed during consultation with a staff member. Ragone (1996) concluded that biological relatedness was a primary motivation for couples' deciding to pursue surrogacy. However, surrogacy violated
accepted cultural norms, thus requiring couples to use various cognitive
dissonance reduction strategies to resolve the problems and ambiguities
associated with surrogate parenthood. In particular, in AI surrogacy, the father
feels discomfort and awkwardness that a woman other than his wife is the
mother of the child. Two primary strategies employed by the couple and the
surrogate mother to resolve cognitive dissonance are to (a) de-emphasize the
man's role by defining pregnancy and birth as women's business; and (b)
downplay the significance of the biological link to the child. The intended
mother often justifies the lack of genetic ties to the child through development
of a mythic conception of the child that emphasizes her intentionality in the
process (it is her desire that ultimately brings the child into being; Ragone,
1996). Moreover, she develops a relationship with the surrogate mother and
experiences pregnancy by proxy (e.g., attending Lamaze classes, being present
in the delivery room, and going to medical appointments). Thus, reproduction
is defined as primarily a woman's concern.

Finally, Hughes (1990) compared the personal characteristics of 53
intended/social parents from a surrogacy program with 42 individuals who
adopted children and 20 control subjects. All groups were generally college
educated, Caucasian, professional, and had high average self-esteem. Those
involved with the surrogacy program were older, had higher household
incomes, and were less likely to be Catholic than other participants. In
addition, they scored lower on the Marlow Crowne Social Desirability Scale,
indicating less need to present in a socially desirable way (Hughes, 1990).

The high socioeconomic status of intended parents is to be expected as
the financial costs of surrogacy are high. In addition to the $10,000-20,000
paid to the surrogate mother, the couple must incur many other costs such as
payment to the surrogacy agency and all medical expenses leading to a typical
total cost of between $25,000 and $100,000, with IVF surrogacy on the high
end (Center for Surrogate Parenting, 2003). All studies found that
intended/social parents are well off financially; for instance, Ragone (1996)
found an average income of over $100,000 for contracting couples.

Thus, except in rare cases of non-commercial surrogacy usually for
family members or friends who cannot have a child, contractual parenting is
possible only for the wealthy or upper middle class. The lack of access to
surrogacy arrangements for lower income infertile couples is a major ethical and sociopolitical concern for feminists and others who support equal access to reproductive health services for all individuals regardless of socioeconomic status or racial/ethnic origins.

3.2.8 Children Resulting from Contractual Parenting

We could find no studies examining the cognitive or social development of children born as the result of surrogacy. An exploration of related areas revealed that there are no appropriate parallels. Adoption does not appear to be a good comparison because adopted children have no genetic connection to either parent and adoption is a more socially acceptable action that does not violate traditional norms.

There are some studies that may provide some limited comparison. Research on the cognitive and social development of children produced through other assisted reproductive technologies, most usually IVF, may be tangentially related, while studies of children conceived through egg donation provide a somewhat better comparison. Reviews of the literature suggest that IVF children in developmental stages from infancy through adolescence show comparable cognitive functioning to other children and in some cases score higher in social and communication skills. Some studies even suggest that the experience of infertility and use of Assisted Reproductive Technologies (ARTs) actually may be beneficial for parent-child relationships. One study (Golombok, Murray, Brinsden, & Abdalla, 1999) comparing egg donation, donor insemination, adoptive families, and IVF families reported no overall differences among groups in quality of parenting or psychological adjustment of children aged three and a half to eight. It seems likely that, from the child's perspective, the mechanisms of how a pregnancy was achieved would be a minimal psychological issue compared to whether one's birth mother chose not to keep the child. Research to date is only suggestive and, clearly, it is necessary to explore the social, psychological, and cognitive development of children born through surrogacy.

Notwithstanding the foregoing, one underlying issue for all types of ARTs, but especially those that involve third parties, is whether, when and what to tell the child about his or her origins. Blyth reported that all intended parents in his study believed the child should eventually be told the truth about
his or her biological origins (Blyth, 1995). However, there is no consensus due to a lack of research on this issue.

3.2.9 Giving Baby Away

Giving a baby away is one of the most difficult tasks faced by a surrogate mother. Even if the baby is genetically unrelated to her, the fact that she carried it in her womb for nine months makes handing it to another person very challenging. Researchers Fazli Khalaf, Abdollah Shafiabadi and Majid Tarahomi report in "The Journal of Reproduction and Infertility" that giving the child up may be extremely distressing to the mother and may even result in psychological problems.

3.2.10 Abortion

Psychologist R.J. Edelmann reports in the "Journal of Reproductive and Infant Psychology" that a surrogate mother may have to face the reality of parents who want her pregnancy terminated if it is discovered that the baby has some sort of birth defect. While surrogate mothers often sign a contract agreeing to an abortion if this were to happen, many do not plan for the unexpected and face psychological crisis at the idea of having to follow through with it. Although the law usually protects the right of the child over the wishes of the prospective parents, each case is different, and the complications of what to do with the child who is no longer wanted by the adoptive parents can cause tension and depression in the surrogate mother.

3.2.11 Refusing to Relinquish Her Child

In extreme cases, a surrogate mother may refuse to give up a child to the prospective parents. Dr. Connie Shapiro reports in "Psychology Today" that legal protections for surrogate parents have been slow to develop, and that oftentimes the surrogate will get to keep the child. A surrogate mother's attachment and bonding to a baby may cause a host of legal problems if she refuses to follow through with her agreement to give the child up.
3.2.12 Family Conflicts

Edelmann states in the "Journal of Reproductive and Infant Psychology" that surrogate motherhood can cause conflicts in the family, as well as strained relationships between the surrogate mother and her husband. He may struggle to accept the fact that his wife is pregnant with a child unrelated to either of them, and the children in the family may wonder why they are not going to have a new sibling. Although oftentimes the family is accepting, if they are not completely supportive of the idea of surrogacy there will likely be tension.

3.2.13 Mental Health

Many health issues arise for the surrogate mother. A major issue is how much control a physician can exercise over a surrogate mother. For example, is she obligated to change her current living style? How often does she need to have vaginal ultra-sounds or amniocentesis? An important question to consider is if and when she should be allowed to terminate a pregnancy. In general, this decision would be free of the complicating factors of STDs, as physician will ensure that the pre-embryo is free of viruses such as human immune-deficiency virus (HIV), cytomegalovirus (CMV), and hepatitis B&C viruses (HBC and HCV). These viruses could compromise the health of the surrogate mother and that of the newborn. In this section, we will focus more on the psychological effects of surrogacy.⁴

Although there is a lack of scientific proof, many psychologists, psychiatrists, and developmental biologists believe there is a special tie that develops between a pregnant mother and a child in her uterus. A study done in Japan that was designed to evaluate the maternal-fetal relationship found no significant correlation between the maternal-fetal attachment and depression. Additional research has shown that surrogate mothers are less attached to the fetus, which is most likely due to encouragement by their agency to feel detachment toward the fetus during pregnancy. Although many surrogate mothers admit to feeling sorrow and distress when relinquishing the child, they also felt a sense of happiness and satisfaction for the new parents of the baby. In this study, the intended mother was more anxious than the surrogate mother, but overall they were found to share comparable stable psychological characteristics. This study also reassures the fact that many surrogate mothers are capable of feeling a lack of anxiety and flat responses towards the baby and pregnancy, which suggests their psychological state, may not lead to prenatal or surrogate arrangement complications.

Another important factor of mental health is the relevant familial and spousal support of women in surrogacy arrangements. In one study done in the UK by the Center for Human Reproductive Sciences, psychologists found that the intended, genetic mother had more support from the important people in her life. For surrogate mothers in stable relationships, social support from husbands and partners was more negative than the corresponding support from husband/partners of intended mothers. Weaker social support received by surrogates suggests that counseling should be provided to surrogate mothers after their pregnancy to monitor their longer term welfare.

This study also emphasizes the social stigma attached to surrogacy. Additionally, two studies that investigated attitudes towards surrogacy in the US and Canada found similar results. One study in Canada found that three-quarters of 5,000 women of reproductive age disapproved of surrogacy. Similarly, a smaller study in the US showed the majority of the 400 people randomly surveyed were against surrogacy. Unfortunately, societal attitudes towards surrogacy have been highly stigmatized by a few exceptional cases.
such as the 1986 Baby M case. In this complicated legal case, the surrogate mother, Mary Beth Whitehead, violated the surrogacy contract by refusing to give up the child to Elizabeth and Howard Stern.\textsuperscript{5}

However, such cases are extremely rare. Although findings show surrogate mothers rarely suffer from extreme psychological distress when relinquishing the child, surrogacy still affects the mental health of these women. In societies where surrogacy is stigmatized, it is important to provide these women with support both during and after the pregnancy.

### 3.2.14 Comparisons with adoption

In treatment for infertility, the aim is to obtain a pregnancy or baby for the infertile parent; in adoption the opposite occurs: the aim is to obtain a family for the baby. Children available for adoption also tend to be older, with few healthy infants or young children available for adoption placement. They are therefore not good comparisons in all respects. Nevertheless, some of the research and practices on adoption can serve as models for surrogate practices.

Research into adoption has shown that information and practices change rapidly. Adoption has moved from ‘closed’ to ‘open’ adoption, ensuring the adoptive children feel secure within their new families but also maintain contact with important people from their past. Indeed, current debates and new legislations enforce a similar level of openness and disclosure for donor conception practices, showing how ‘good practice’ transfers between different families composed of entirely different triads.

### 3.2.15 Surrogate mothers

Research is beginning to develop some understanding of surrogate mothers’ characteristics and motivations. Surrogates themselves believe surrogacy takes a special type of person.

Somehow, they say, they ‘know’ if they can do a genetic surrogacy that is if they can or cannot relinquish a baby that is genetically theirs, although there are exceptions. Some surrogates are very young and may not understand the consequences and regret their decisions later at the time of relinquishment or even later in life, when it is too late to do anything about it. Overall, no psychopathology was evident in surrogates studied by van den Akker (2003) and Hanafin (1987), although Franks (1981) did report some minor psychological problems in his American surrogates. Baslington (1996) interviewed 19 surrogate mothers and found them to be assertive and not medically or otherwise controlled. In the latter study, genetic surrogates in particular felt in control.

3.2.16 Motivations

Ragone (1994) summarizes American surrogate mothers characteristically as women willing to ‘give the gift of life’. To some extent, this altruistic picture of surrogates has been supported in British studies. Blyth (1994) interviewed 19 surrogates and van den Akker (2003) asked 15 surrogates to complete long questionnaires 7 years later. The socioeconomic status, educational level, age and parity were similar in the latter studies. Few surrogates explicitly stated that money was one reason for becoming a surrogate, and the majority said they did it for altruistic reasons. Most surrogates enjoyed pregnancy and childbirth, and many surrogates said surrogacy fulfilled or added something to their lives (increased feelings of self-worth and self-confidence, and the development of intense and unusual friendships with the commissioning parents, particularly the commissioning mothers). In van den Akker’s (2005c, in preparation) samples, some surrogates went through a phase of positive personal development (climbing a mountain, starting a degree, studying midwifery, etc.). Relinquishment of the baby was a happy event for most surrogates, although some said they felt relief when it was all over. Happiness was mixed with sadness during relinquishment for a proportion of the women. Similar sentiments were found in American surrogates by Ragone (1994).
3.2.17 Anonymity and contact

The surrogates from Blyth’s (1994) and van den Akker’s (2003) UK studies unequivocally said they believed the commissioning mothers should disclose the arrangement to their surrogate children. Where ‘closed’ arrangements have been used, regrets have been reported. Cotton’s revelations about her first genetic surrogate baby produced some heart-wrenching truths about the disadvantages of ‘closed’ or anonymous surrogacy. She admits that this can have ‘barbaric’ consequences for the surrogate and can be as dramatically perceived by the child once he/she finds out. Similar concerns were expressed by Davies concerning an anonymous arrangement. A longitudinal study of surrogate mothers in open arrangements has noted that in the first 6 months following relinquishment, no negative psychological consequences are reported.

3.2.18 Relinquishing the surrogate baby

Conceiving, carrying and delivering a baby is the start of a process of care and commitment to nurture the baby through childhood and into adulthood. This is culturally expected. Having a social termination of pregnancy or giving a child up for adoption are controversies to the accepted norm, and for surrogacy, where the surrogate conceives only to give the baby up following delivery, the process is even more unconventional. Theoretically, women are known to develop varying degrees of attachment to their fetus during pregnancy, and this is carried over to the baby following birth. According to research in the 1980s and 1990s, prenatal attachment is influenced by a number of factors such as maternal age and attitude towards the pregnancy. These factors are relevant in explaining the surrogate’s ability to relinquish the baby after delivery; surrogate mothers tend to be in their late 20s or older, and most believe they have completed their own family. Research, which has looked at attachment, has found that surrogate mothers are less attached to the fetus and less attached to the baby following delivery. Both studies have shown that surrogates are advised by their surrogate agency to ensure they understand whose baby they are carrying and giving up. Consequently, surrogate mothers do not allow themselves to be attached to the
baby or infant following delivery. The practice of handing the baby over to the commissioning couples straight after birth also reinforces the advice. The surrogate agencies assist surrogates in reconciling their own maternal thoughts and feelings, by cognitively restructuring these feelings to match their behaviors relinquishment of the baby. In fact, in general, the surrogate agency information appears to be quite successful in assisting surrogates to achieve a cognitively consonant state.

3.2.19 Surrogate welfare

Van den Akker 2003-2005 assessed self-efficacy in surrogates in relation to the process of gestating and relinquishing the baby. Surrogates were confident about the surrogate arrangement and about the health and well-being of the surrogate baby. They also thought it would be easier for a commissioning mother to accept a baby that would be genetically hers. The latter statement was particularly pronounced in gestational surrogates, who did not believe they could relinquish a genetically related baby as easily as a non-genetically related gestated baby. Furthermore, although research has shown that most surrogates said they would do it again, some would not. In Blyth’s study, one surrogate could not relinquish the baby. Lastly, although genetic and gestational surrogate arrangements are different in some respects including their stance on the importance of a genetic link, in terms of psychological functioning, van den Akker -2003 found no significant differences between them on standardized assessment scales. In the longer term, however, differences may well emerge, because as Blyth pointed out, gestational surrogates benefit from the ‘full panoply of regulation (as it is)’ involving organizational control and support provisions, while genetic surrogates operate ‘in a moral and psychological twilight’. Only one study has followed surrogate and intended mothers from the start of the arrangement through to 6 months post-partum. In that study, van den Akker found that the beliefs and attitudes surrogate mothers had before the arrangement were stable over time, with little differences noted up to 6 months post-relinquishment. Any differences that were apparent indicated a more conservative attitude to some of the questions. One notable exception was that before the arrangement, some surrogates thought the fact that this was an ‘arrangement’ which
included a financial component made it easier to relinquish the baby at birth, whereas 6 months post-delivery, fewer surrogates maintained that belief. Zweifel et al., in a study of pre- and post-assessment of oocyte donor’s responses to various uses of their oocytes, substantiated these findings.

3.2.20 Social support

The lack of equivocal support for surrogacy, as previously shown in studies of population attitudes, has impacted upon the stigma some surrogates report and the lack of social support they received, which could predispose them to be particularly vulnerable. It has also been noted that the continuing contact which many surrogates hope for with the commissioning mother could be problematic. For example, Brazier suggests that the surrogate mother could be reminded about the child she has given up and the commissioning couple could fear interference in the upbringing of the surrogate child. Furthermore, the surrogate’s own children could suffer fears of being relinquished too. Either way, whether contact is discontinued or continued, counseling for the surrogate mother before, during and after the pregnancy is advocated, and research about the surrogate’s own children is essential.

3.2.21 Exploitation

Few surrogates report feeling exploited in Blyth’s and van den Akker’s studies, and many surrogates involve their own family in the surrogate process. In addition, in van den Akker’s studies, surrogate mothers expected their commissioning parents to be open about the child’s origins, as they themselves had told all their own children about the surrogate baby being part of the intended couple’s family—not their own. As a result of this, most surrogate mothers expected some contact between them to continue following relinquishment of the baby, so that they maintained their new friendships and their children could still see the surrogate child. It was argued that this made it easier for their own children to understand what is involved and who the couples are who will have their mother’s ‘tummy baby’. Unfortunately, in some cases, this contact ceased unexpectedly after the legal proceedings had been completed. It is seen as a betrayal when the intended couple with the surrogate baby disappears from the surrogate and her children’s lives. The
long-term care and support for surrogate mothers is not always considered by intended couples, once they remove themselves from the surrogates’ life. Further longitudinal research on surrogate mothers is needed, and this should also address the well-being of the surrogate’s own children.

3.2.22 Commissioning/intended mothers

The socioeconomic status of intended couples is significantly different from that of surrogates, and this has been an issue of concern to the Government, the clinicians treating them and researchers. Intended mothers also tend to be older, have a more notable obstetric/gynecological history and are better educated. Reassuringly, no negative effects of the socioeconomic inequity have been reported. Surrogacy offers a unique option for infertile mothers. It differs from adoption because it allows for a full or partial genetic link with the child and differs from donation because a pregnancy is not possible. In a study of 29 women commissioning a surrogate baby, reasons for considering having a surrogate baby were mainly that ‘it was the only way for them to have a child’. Other reasons were because they would have a full or partial genetic link with the child or because IVF or adoption failed. Langridge et al. (2000) in their study of reasons for parenthood found that couples expressed a desire to have a child that is theirs (i.e. genetically part of both of them). Few psychological studies have been carried out in the UK on intended mothers, and even less is available on the fathers studied intended mothers in the UK. In general, surrogacy was largely initiated through information from the media and was based on gut feelings in the matching process and trust (the surrogate trusting the commissioning couple to pay the fee; the commissioning couple trusting the surrogate to care for the baby in utero and relinquish it upon delivery). Recipients were happy with their choice and told their social network, and in studies where psychopathology was investigated, none was found. A number of concerns have also been documented including financial exploitation, medicalization (Baslington, 1996), fear of non-relinquishment by the surrogate mother, legal, emotional and social stigma, genetic links and baby worries. Nevertheless, in Golombok and Murray’s study of 42 commissioning families and van den Akker’s study of 28 intended mothers
using standardized psychological assessments, the psychological well-being of the parents was good.

3.2.23 Psychological consequences

Some surrogates who have experienced closed surrogacy arrangements have reported difficulties coming to terms with this. Long-term difficulties in women relinquishing a child for adoption have also been reported and should be borne in mind as possible also in surrogacy in the future. Psychological functioning in the recipient families tends to be good, as are parent/child relationships. Consequently, from a psychological health point of view, the specific aim of counseling is not to curtail psychological disturbance because all parties appear to be well adjusted, but to assist to ‘ease specific anxieties, facilitate decision-making and ensure that issues are resolved at an early stage before difficulties have a chance to arise’. Unfortunately, despite efforts made to highlight the importance of counseling in the latest report concerned with surrogacy, counseling and follow-up procedures although available, are not always used by all parties.

3.2.24 Welfare

Patient welfare is crucial in any evaluation of the psychosocial, ethical or moral consequences of surrogacy arrangements, whether these arrangements were successful or not. A study monitoring patients following a failed first IVF cycle reports that 21% of patients whose first treatment fails opt for counseling. Grief scores are higher in women who discontinue treatment at midcycle, and feelings of sadness and depression are higher in women failing to conceive following treatment or who voluntarily give up. Other infertile people may give up following rejection on medical, psychological or social grounds. Edelmann (1990) and Greenfield and Haseltine (1986) reviewed some of the issues involved in patient selection and reported that it is extremely difficult to decide on who should assess patients for suitability, what should be used to determine suitability and when suitability assessments should be carried out. Even if an optimum professional, measure and time are found, it is possible that infertile populations will respond with bias, knowing that a good profile is more likely to get them
accepted than an unstable profile. In UK surrogacy, assessment is largely carried out *ad hoc*. Ten years after Edelmann and Connoly’s statements regarding the lack of evidence-based procedures adopted by counsellors, some progress is evident. We are developing a better understanding of the needs of infertile couples, and we know what coping strategies they use, but we do not know what success of counseling means. What is also known is that not all the patients’ needs are met and that issues of honesty and lineage are not resolved. Studies of patient satisfaction have revealed that counseling or support particularly after successful or unsuccessful treatment is seen as beneficial.

### 3.2.25 The Psychological Effects of Deciding to Use a Surrogate

Many couples struggle with infertility, finding that the associated distress eventually affects all aspects of their lives. Yet the decision of how to pursue the goal of parenthood is profoundly personal. Thus, many physicians have a counselor who specializes in reproductive issues available for couples who want to take advantage of this resource.

With some exceptions, couples generally attempt alternate methods to surrogacy first. This is often due to strong negative emotional responses when thinking about including another individual in the birth process. In addition, fears regarding whether the surrogate will change her mind about giving up the child can create anxiety leading to hesitancy similar to that found in couples considering adoption.

Couples may choose surrogacy due to opposition to some assisted reproduction methods especially those that greatly increase the chance of a multiple pregnancy. Often couples are required to sign a document stating they will agree to undergo selective fetal reduction, eliminating a certain number of fetuses at 11-12 weeks of gestation. Couples may find this practice unacceptable for religious or personal reasons or change their minds after becoming pregnant, which can interfere with a positive patient/physician relationship.

Couples may also choose surrogacy after learning they will not be able to adopt due to either not meeting required age limitations or reluctance to
place a child with a single parent or a homosexual couples. In addition, when
using an agency, the waiting time can be extremely lengthy. Some of these
families initially lose hope and go through a grieving process but eventually
begin to consider other options and feel the return of optimism about the
potential of establishing a family.

Medical reasons may also create a situation where surrogacy is
recommended. When the probability of successful implantation or gestation is
low, physicians often suggest the possibility of surrogacy. This is often an
option couples never thought of using and they frequently experience a sense
of shock when learning this process is their only option. They may also feel
confusion over the desire to have a child and initial reluctance to use a
surrogate.

3.2.26 Psychological Reactions to the Type of Surrogacy Utilized

There are two types of surrogacy. In traditional surrogacy, the birth
mother is inseminated with the sperm of the father, such that the surrogate’s
egg is used. This method may be chosen due to the mother lacking viable eggs
or the couple being unable to afford IVF, as intrauterine insemination is
considerably less expensive. This type of surrogacy may require the couple to
adopt the child after birth.

This can result in emotional difficulties especially for the adoptive
mother given that her husband will be the biological father and another woman
will be the biological mother creating resentment. These future mothers then
feel guilty since they agreed to the process and feel they should be grateful to
the surrogate. They may then enter a stage of self- blame since the reason they
aren’t the biological mothers is because of a perceived defect within their
bodies and this can lead to depression and negative self ~concept. Ideally,
when the pre-procedure evaluation identifies possible emotional problems
before, during and after implantation occurs it is recommended that supportive
counseling be started prior to the beginning of the medical process and
continues during the pregnancy and after the birth.
It’s not only the mother who experiences these emotions. Fathers often feel guilty that they are the only biological parent, knowing that this is negatively affecting their wives or partners. They also may experience guilt over feeling happy that they are the biological father. Couples often find it impossible to discuss these types of issues, underscoring the need for appropriate intervention to help the couple talk about their feelings and learn how to better support each other.

In gestational surrogacy, the couples sperm and egg are fertilized and transferred into the surrogate through IVF. In most states, the intended mother is allowed to put her name on the birth certificate after birth. There are far fewer negative psychological effects when using this type of surrogacy though the anxiety, jealousy and resentment related to another woman carrying their child can surface.

3.2.27 Effects on the Surrogate

There have also been concerns raised over the impact of the process on the surrogate. Many surrogates report experiencing negative reactions from those around them and some report negative effects on their relationship with their spouse and children. However, research suggests that surrogate mothers feel positively about their decision to act as a surrogate. Although some experience problems giving up the baby, these difficulties were not severe and dissipated quickly.

In one study, after giving up the baby, 35 percent of the surrogates experienced mild to moderate problems within the following two weeks, 15 percent reported problems three months afterwards, while only 6 percent reported problems one year afterward. Prior to the birth 9 percent of the surrogates experienced psychological problems, 6 percent consulted a general practitioner for help, and 3% had regular appointments at an outpatient clinic.

Research also demonstrated that there was a significantly higher number of known surrogates (e.g. mothers, sisters, friends), who experienced problems after giving up the baby when compared to unknown surrogates.
Few surrogates experienced conflicts with the commissioning couples and there was no difference in the reactions of known surrogates to unknown surrogates. All surrogates reported either positive or neutral reactions in their children. However, there was a mixed reaction from partners. At the time the women decided to become surrogate mothers, 57 percent of partners responded positively, 24 percent responded neutrally/ambivalently and 19 percent responded negatively. 12 percent of the surrogates reported the arrangement had resulted in a poorer relationship with their partners, while 3% reported very severe relationship problems.

3.2.28 Future Directions

- Research Issues

There is an abundance of potential research questions involving contractual parenting that appears worthy of investigation. Both researchers and those debating the moral, ethical, legal, and social aspects of contractual parenting have supported the need for more empirical data and proposed questions of interest. While it is not difficult to identify research directions, it is more challenging to prioritize directions. In this section we describe several research questions that warrant priority.

Clearly, a primary focus should be on the potential impact on the children that are born as a result of third party assisted reproduction as well as children in the surrogate's family. Although there is no particular reason to believe that AI and IVF children born as a result of surrogacy arrangements will differ in development from other children born through ARTs, studies of the development of the offspring of surrogacy arrangements still are important. Pragmatic issues provide guidance for future research on the post-birth effects of surrogacy arrangements. According to Blyth (1995), many social parents intend to tell their child about his or her origins. As far as is known, however, few children have been informed presumably because of their still-young age. If, indeed, interpersonal issues are more important for the child's development and well-being than the fact that conception occurred through assisted reproduction, then researchers need to consider questions such as how best to explain their origins and the birth mother's relationship to children of various ages, how much contact should the birth mother have with
the child, and do different issues arise for children born through traditional versus gestational surrogacy. Research issues involving communication with the child include when—or if—to tell children of their biological origins, how much to reveal, and the long-term consequences of deception versus honesty. Issues related to birth mother contact with the child that need investigation involve the benefits or detriments of the child remaining in contact with the surrogate mother and the long-term impact on the family dynamics—both for the intended parents and the surrogate and/or her family—in cases where all parties stay in contact as well as cases where contact diminishes or stops. In some cases, critical analysis of extant parallel bodies of research on, for instance, other types of assisted reproduction or adoption may be most appropriate.

Another priority is to heighten access to participant populations and enhance their voluntary response rates to research requests. Both surrogate mothers and intended/social parents have a vested interest in promoting the view that surrogacy is acceptable and that those who commit to surrogacy contracts are well-adjusted individuals. In addition, all parties are interested in the cognitive and social development and best interests of the resultant child. Moreover, parties to surrogacy agreements may be motivated to support extensions of this option to other infertile couples who desire a family and to increase public understanding of this issue. These are powerful hooks that can be used to interest these parties in voluntarily participating in research. Of course, identification and recruitment of samples of surrogate mothers and intended parents is not easy. Most often such identification has occurred through surrogacy agencies or support groups. As access to the Internet increases and many surrogates and commissioning couples use net-based resources to attempt to find a match, this, too, may prove a valuable recruitment avenue.

The issue of what to research is largely defined by studies that are strikingly absent. More attention has been given to the surrogate mother than to the intended parents. Moreover, although there is research on relationships of the surrogate and the intended parents and their perceptions of their social networks, these studies (with the possible exception of Hohman & Hagan, 2001) are not based on a firm conceptual or theoretical framework about
complex interpersonal relationships under conditions of stress. Yet, surrogacy arrangements involve complex interpersonal processes and interactions. There are three individuals, all with their own needs and desires, plus their families, which, in the case of the surrogate, usually include children who are minors.

Although we do not advocate studies of the motives or personalities of women who choose to become surrogates as a priority, another post-birth effect that needs more attention is the potential level of regret experienced by surrogate mothers over time. In particular, we need to determine how psychological intervention alters perceived dissatisfaction with the surrogacy process, for instance, by comparing the level of satisfaction of the surrogacy process of surrogate mothers who receive different types or amounts of counseling both before entering into surrogacy contracts and during the surrogacy process.

Finally, the future of surrogacy arrangements is dependent on what people find acceptable both personally and as a matter of public policy. In part, surrogacy has not evoked as much controversy as abortion because it is relatively rare. Still, it touches upon basic beliefs about what constitutes parenthood, the importance of a genetic link to the child, and gender relationships. World views and values regarding family and gender roles of anti- and pro-surrogacy groups should be studied as should differences in the positions of pro- and anti- surrogacy feminists. Also, it would be useful to analyze the basic cultural values that have led countries such as Australia to outlaw surrogacy. Such studies of cultural beliefs, values, and attitudes will provide more valuable information than have previous surveys that simply determine the percentage of a group supportive of a specific type of surrogacy arrangement.

- **Treatment Service Issues**

  Because of the deficit of empirical evidence, it is premature to advocate many specific changes in treatment services or social policy. There are general approaches, however, that should be followed to alleviate some of the anxiety, distress, and post-birth regret experienced by one or more of the parties involved. For instance, it tentatively can be assumed that satisfaction with contractual parenting is largely influenced by satisfaction with the relationship
between the surrogate and the commissioning couple, which in turn is largely
determined by the extent to which expectations about this relationship are met.
Therefore, counselors need to provide accurate information to participants
about all phases of the surrogacy process and determine during screening that
the parties have adequate personal resources and support networks to
withstand the stress and disapproval that engaging in this process may
engender. Moreover, it is important that counselors and other mental health
professionals with knowledge of the potential pitfalls of surrogacy
arrangements be available to participants at all stages (pre-contract, during
pregnancy, post-birth, and long term).

- **Legal and Public Policy Issues**

  Surrogacy as a process can "go bad" at many points. Although this souring
  of relationships and resultant high profile legal cases are relatively rare,
  statutes that require use of reputable surrogacy agencies with well-trained
  mental health and legal professionals can minimize both the contractual
disasters and the milder, but still painful, long-term feelings of regret of some
birth mothers. Couples who choose this option usually have exhausted more
traditional alternatives, and have lived with the stress of infertility for years.
As elaborated in Ciccarelli and Ciccarelli (this issue), the ambiguity of the
legal situation in some jurisdictions makes it most difficult to assuage the
additional stress that intended parents experience because of the myriad of
things that could go wrong in their relationship with the surrogate. Any
statutes that clarify the procedures and allow for pre-birth adoption of the baby
can help alleviate the anxiety evoked by the uncertainty and ambiguities of
surrogacy arrangements for commissioning couples, but perhaps at the cost of
the rights of the birth mother.

  Finally, both acceptability and accessibility will determine the extent to
which this new technology is used. To the extent that public policy
institutionalizes this option, it will become more acceptable to couples with no
other options and to women motivated to perform an altruistic service. There
will always be cultural groups, however, who because of basic religious values
will find such arrangements unacceptable or even immoral.

  Greater focus on the prevention and early treatment of causes of
infertility such as sexually transmitted diseases can reduce the need for
surrogacy as well as other expensive ARTs. Yet, contractual parenting appears to be here to stay. Thus, the politics of social class and socioeconomic resources need to remain in the forefront. A remaining predominant issue for third-party assisted reproduction, as well as most other ARTs, is unequal availability, with access usually limited to the top socioeconomic echelon of our society. Unless sweeping changes in the structure of health care occur or disparities in socioeconomic status are reduced, this situation is unlikely to change.

- **Foetal – Maternal Bonding**

  Important biological bonds are established between the mother and her foetus during Pregnancy. One of the most concrete examples of the importance of this bond comes from knowledge of foetal-maternal physiology. The hormone oxytocin plays a crucial Role in priming the gestational mother to respond in accordance with her natural maternal instincts. In a recent review of the importance of mother-infant bonding, the authors describe elements of the interaction between a mother and her newborn child, which include skin-to-skin contact, eye gazing, and breastfeeding. These actions initiate the simultaneous release of oxytocin, which facilitates important physiological processes that help the newborn to develop and the mother to recover. In addition to providing health benefits, this hormone-like substance promotes bonding patterns and creates desire for further contact with the individuals inciting its release.

  In addition to this biological bonding, the cognitive and developmental psychology literature indicates that there is a crucial window of time from the moment of birth onwards, whereby the baby begins to form cognitive attachments through intersubjective interaction with the gestational mother. Rather than living in a buzz of ambivalence or confusion as envisaged by some, an infant’s behavior is innately fashioned to coordinate with the social behavior of other people.

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This is because an infant already has the cognitive mechanisms and psychological capacities in place to influence as well as be influenced by other people, and in particular his or her birth mother.

Therefore, at the very least, one ought to be especially concerned with any process that disrupts the important bond between mother and child, which derives from both biological and cognitive/psychological aspects of human nature, beginning during gestation and continuing after birth. Surrogacy ruptures this bond and such is the importance of the emotional attachment between the surrogate mother and the child she has carried, that it has lead to many cases from around the world where surrogates have been unwilling to relinquish their child, such as the Baby M7 and Evelyn cases. As evidenced in these much-publicized cases, having to relinquish a child can be wrenching, the end result being custody battles. Added to this is the evidence that surrogates may live with the psychological burden of giving up their gestational child for many years.

These matters reinforce the difficulty, if not impossibility for a surrogate mother to give informed consent. In relation to the difficulties with relinquishment, certain critical questions must be asked.

- What happens when there is a reluctance or refusal to stick to the original agreement?
- What if neither the surrogate nor the commissioning parents want the child? Should there be penalties if the agreement is not honored?

No legislation permitting surrogacy can accommodate such complications without leading to seriously undesirable consequences, and the onus rests with those who would permit surrogacy contracts to answer these questions adequately. Furthermore, because surrogacy results in the fragmentation of motherhood by separating the genetic, social and gestational components, the Statutes Amendments (Surrogacy) Bill 2006 would therefore sanction this fragmentation and devalue the importance of the foetal-maternal relationship.

• **Contractual Disputes and Health Risks**

A diagnosis of disability or disease, even if equivocal, could lead to serious problems with a surrogacy arrangement. For example, a prenatal diagnosis of disability or perceived imperfection could result in the commissioning couple reneging. At least one such case has occurred in the US. In the case of a diagnosis of disability, depending on the circumstances and severity, the option of abortion could be considered by the surrogate; however, differing moral perspectives on abortion have the potential to result in an irresolvable stalemate. The surrogate may still wish to proceed with the birth; however, the commissioning couple may no longer want the child. Alternatively, the surrogate may choose an abortion contrary to the wishes of the commissioning couple, but presumably the surrogate’s decision for abortion under law would prevail. The Dawkins Bill makes no provision for such disputes, and so any burden remains with the surrogate, commissioning couple and others involved.

Given that gestational surrogacy involves ART, the health risks in ART are pertinent to surrogacy. According to a recent review, ART is responsible for approximately 50% of all multiple births worldwide, and about half of IVF pregnancies in the US result in multiple births, with a high risk of premature delivery. One-third or even one-half of infant mortality is due to complications of prematurity, and a large contributor to prematurity is infertility treatment. In addition to these risks, there is a growing concern that other risks to children born of ART may occur. The point here is that in gestational surrogacy, the contractual arrangement makes these problems more acute as it involves parties whose response to these issues cannot be predicted. Yet these matters have the potential to undermine the whole contract in seriously damaging ways. In a gestational surrogacy agreement, the increased chance of multiple births could lead to contractual disputes if the intention of the commissioning couple was to have only one baby. For example, a British woman pregnant with twins sued a California couple because they backed out of their surrogacy contract after she refused to abort one of the foetuses.\(^8\)

There are also other significant health risks for surrogate mothers. Whilst pregnancy is natural, it is not without risk. Whereas a woman choosing to become pregnant and committed to raising her child is prepared to bear that risk, in surrogacy, the concern is that she bears the risk without the natural benefit of motherhood. There is therefore a sense of futility if something goes wrong for her.

If the Dawkins Bill is passed, it is hard to imagine how the contractual agreement between the surrogate and the commissioning couple can possibly protect either party. It appears that far too much is expected of the contractual agreement, and indeed it carries a disproportionate expectation compared to what the Bill itself provides. This is a limitation of the legislation in its current format, although it is difficult to see how it could be remedied.

- **Genealogical Bewilderment**

As discussed above in relation to the effect that surrogacy may have on the bonding between a surrogate mother and her child, deliberately creating family structures that are confused, as this Bill would allow, has the potential to produce genealogical bewilderment for the child and a desire to understand and restore relevant relational Connections.

In the context of ART, the idea of genealogical bewilderment is emerging in cases where donor sperm has been used. Aside from within ART - and the fact that genealogical bewilderment is a relatively new phenomenon and few studies have been undertaken in the area - there is ample evidence for genealogical bewilderment in adoption, which shares similarities with surrogacy. Many studies have shown the long-term effects of adoption on those involved. David Kirschner, a clinical child psychologist, has coined the term “Adopted Child Syndrome”.

In case after case, I have observed what I have come to call the Adopted Child Syndrome, which may include pathological lying, stealing, truancy, manipulation, shallowness of attachment, provocation of parents and other authorities, threatened or actual running away, promiscuity, learning problems, fire-setting, and increasingly serious antisocial behavior, often leading to court custody. It may include an extremely negative or grandiose self-image, low frustration tolerance, and an absence of normal guilt or anxiety.
There is a well-established history of problems for an adoptee that are associated with not knowing origins because of secrecy. However, knowing genealogical origins does not necessarily alleviate an adoptee’s sense of inner turmoil. On the contrary, in some extreme cases, an adoptee’s awareness of origins has led to extremely antisocial behavior. However, this does not amount to an objection to adoption per se, since the crucial distinction between adoption and surrogacy is that the latter is an intentional decision to relinquish a child to a commissioning couple without the welfare of the child being paramount, whereas adoption is, in a sense, “rescuing” a child from difficult circumstances, in which case it is the child’s welfare that is of primary concern. It might be expected that a child born of surrogacy would experience the difficulties experienced by an adoptee in addition to those unique to surrogacy.

- Susan Golombok’s Studies

Whilst there is little in the way of empirical studies into the long-term effects that surrogacy has on the surrogate, the child and the family of the commissioning couple, a search shows that the majority of studies that have been conducted are by Susan Golombok and her group. Hers is almost the only group that reports that the various procedures in ART and surrogacy do not have a negative impact on the social or emotional development of all parties involved.9

However, there are a number of caveats to these studies that must be pointed out. First, the studies are limited in their longitudinal extent, in that analysis of the development of a child born from an ART procedure and/or surrogacy arrangement has only been studied up to the age of twelve. Second, the issue of disclosure versus non-disclosure is not controlled for in any of the studies. This is crucial because a child who does not know about their origins is unlikely to experience the full impact of genealogical bewilderment. Third, the participants in the studies were recruited from surrogacy agencies primarily in the UK and US, where selection criteria for surrogates may mask problems that may arise, such as exploitation of the surrogate.

The counseling services and programs that these agencies provide for the participants of a surrogacy arrangement are an attempt to ensure the greatest likelihood of a successful outcome for all parties involved. This is especially the case with commercial surrogacy agencies in the US, where unsuccessful arrangements are detrimental for business.  

This is also a crucial point that is discussed below, because one of the psychological counseling strategies involves a deliberate effort to de-emphasize the significance of the gestational maternity of the surrogate, in order to encourage the surrogate to cope with relinquishing the child (cognitive dissonance reduction). Furthermore there is some evidence to suggest that verbal self-reports of surrogates are scripted to reflect socially accepted reasons for surrogacy.

The significance of the caveats mentioned thus far brings into question the representativeness of the participants in these studies and demonstrates flaws in the experimental design, in particular the absence of necessary experimental controls. Needless to say, much more research is required to determine what the psychological ramifications are for all participants of a surrogacy arrangement, and in particular the child, whose welfare ought to be of primary concern. The burden of proof for the legitimacy of surrogacy is upon those who would permit it. Some researchers in this field would welcome experimental legislation permitting surrogacy, such as this Bill, as it could increase the opportunity of access to data about the participants in surrogacy.

- **Objectification and Exploitation of Surrogate Mother**

Is parenthood grounded in biology or in an agreement? It is counterintuitive to consciously decide to terminate one’s parental rights and duties prior to conception.

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Legal norms typically affirm rather than confer parental duties and the existing moral obligations that come with it, for there is a sense in which even though a gestational mother has decided to relinquish her child (parenthood rooted in an agreement) she is still the child’s mother (parenthood rooted in biology). Therefore, one can make the a priori conclusion that there is a sense in which self-deception is required on the part of the surrogate in order to break this natural maternal bond she has with her child so as to make it easier to relinquish the child she has nurtured in her womb. In addition, there is also empirical evidence to support this conclusion, that transferring parental rights does not annul but rather it conceals the existing parental bonds between the gestational mother and her child.

Treating both the surrogate and child as mere means to an end may be a method by which some attempt to deal with the damage to relationships that surrogacy is likely to entail. Such objectification opens the surrogate in particular to exploitation. Is there any empirical evidence of the attempt by the surrogate mother to reconcile the circumstances of the surrogacy arrangement with the norms of maternal-foetal relationships? And does the attempted reconciliation proceed in a manner that is deceptive or underhanded? There is fairly sound evidence of this approach by the surrogate. In order to make it easier for her to relinquish the child, she must invoke a number of “cognitive dissonance reduction strategies”, which in the case of surrogacy, it will be argued, amounts to a form of objectification via self-deception, affirming the conclusion that one cannot annul the natural maternal bond between child and gestational mother.

In a study by Ciccarelli, fourteen surrogate mothers were asked to report their feelings or concerns about relinquishing the child. One mother reported emotional distress over the relinquishment and two others reported a strong instinctual urge to bond with the child. The remaining eleven did not feel bonded with the child, which may seem to indicate that for the majority of surrogates the issue of having to relinquish the child did not appear to be a problem. However, surrogates employ cognitive dissonance reduction strategies to cope with their loss, implying that the issue is much deeper seated, which accords with knowledge about the strength of the bond between gestational mother and child. So why did it seem relatively easy for eleven out
of fourteen mothers to relinquish the child in this study? The typical response given was that “I had it in my mind from the beginning that it was not my child, I didn’t feel bonded”, or “I almost felt guilty for not feeling bad about giving up the baby”.11

In another study by Van Zyl and Van Nierkerk the typical responses given by Surrogate mothers, with regard to how they felt about their relationship with the foetus, were as follows, “I don’t think of the baby as mine. I donated an egg I wasn’t going to be using”; “The baby isn’t mine. I am only carrying the baby”; and “I am strictly a hotel”. Hence, having effectively denied that the surrogate is the mother of the child, the only logical outcome is to view the relationship as one of ownership, the surrogate as a “human incubator” and the child as the “product” who bears no relationship to her other than partly being the result of her physical labor.

A study by Ragone12 found that when therapy designed to maintain the “desired state of mind” of the surrogate was withdrawn, due to the surrogacy agency becoming bankrupt, All of the surrogates involved subsequently expressed intense separation anxiety, as Ragone states: When the support services are removed and the structure of the program dissolves, it is difficult, if not impossible to maintain the prescribed and desired boundaries between the surrogate and her child: hence, surrogates report feelings of loss, pain, and despair when parting with the child.

This entirely unnatural ongoing effort to deal with a surrogacy arrangement, and the subsequent relinquishment, underscores the damage that the surrogate undergoes, even though in this case masked at least temporarily by considerable cognitive dissonance reduction techniques. Thus a woman’s natural intuitions are being subverted by cognitive dissonance reduction strategies. It is clear from these studies and the statements by surrogates, that the nature of such strategies requires the surrogate to view herself as an object or as mere means.

11 Ibid, 56
In a study by Baslington, the majority (ten out of fourteen) of the surrogates reported that they were able to cope well with the relinquishment, though the general experience was to feel unhappy in the short term and if a good relationship was forged with the commissioning couple then this also eased the burden of relinquishment. What this indicates is a concern on the part of the surrogate to develop a relationship with the commissioning parents that actually goes beyond the surrogacy arrangement, and beyond the mere utilization of a functional womb. Surrogates want to be more than just “womb for rent”. They do not want to feel used but rather they wanted to be a part of the commissioning couple’s lives. As van den Akker comments it is seen as a betrayal when the intended couple with the surrogate baby disappears from the surrogate and her children’s lives.

Hence there is an objectification of the surrogate mother, which is maintained by cognitive dissonance reduction, and which is assisted by a good relationship with the commissioning couple. These and other studies highlight recurring themes such as self-denial, objectification and the need for subverting natural intuitions for the sake of the surrogacy arrangement. The Bill is silent on the ongoing relationship between surrogate and commissioning parents and it would be hard to imagine that commissioning couples could be forced into a long-term relationship with the surrogate, even though she might suffer without that relationship.

In relation to cognitive dissonance reduction, the principle of not using people as “means to an end” is deliberately undermined in an attempt to uphold the principle “does no harm”. In attempting to reduce her own psychological pain from relinquishing her baby, the surrogate has to think of herself as an object. The studies cited in the above sections show that this is not necessarily a very successful strategy. Furthermore, perhaps the strategies not only objectify surrogates but also act to deny the reality that an problem exists, and in doing so only serve to bury the problem which may then emerge later with significantly increased power to harm the surrogate.
3.3 What's Wrong With Surrogacy?

In its purest form, a surrogate mother has no genetic link to the child she bears. An embryo that is the genetic offspring of another couple is implanted in her uterus. The surrogate is a mother only biologically and only for nine months; she gives the child to its genetic parents at birth.

When all goes as planned, a healthy and very much wanted child is born and the three adults involved all get what they contracted for. But is surrogacy ethically acceptable?

3.3.1 Traditional Family-Linked Concerns

Several of the religious traditions represented at the conference have family-linked problems with surrogacy, problems that many outside these traditions will not find compelling. There is the possibility that surrogacy may be a form of adultery. Though there are no sexual relations, there plainly is a reproductive relation with a third party outside of marriage. Surrogacy might also lead to incest of a sort. The child might marry another offspring of the surrogate mother, a child she only gave birth to or a genetic descendent. While there would be no genetic relationship, the marriage partners would be siblings, after a fashion. Finally, inheritance questions could become confounded. Does the child have any right to inherit from a birth mother or not? Finally, some suggested that such interference with a natural process is a violation of God's will, a view that requires powerful assumptions about the relationship between God's will and reproduction. Is it God's will, for example, that an infertile couple not have a genetically-related child even when means to do so are available; or God's will that new reproductive technologies be developed and used?

3.3.2 Effects on our Self-Respect asPersons

Another line of argumentation is harder to evaluate. The use of surrogacy, especially the wide use, might lead to a cheapening of our idea of what it is to be a person, to a decline in self-respect. It might cause future
generations, for example, to think of the human embryo or fetus as interchangeable parts, reproduction as a mechanical process, wombs as organs for rent, etc. The implication is that thinking of us in this fashion would bring serious negative consequences, a slippery slope concern that is difficult to assess. Surrogacy will probably always represent only a small percentage of births since the more usual method has substantial attractions of its own. If so, surrogacy may have little impact on our self-image, little compared, for example, to the daily assault on respect for persons on television and in the movies.

3.3.3. Effects on the Child

Several presenters speculated that surrogacy will create harmful effects on the child. When he or she discovers that gestation and birth involved another mother, the child may be affected by feelings of being different or of having been deceived. This is certainly a possibility to guard against, but it is not substantially different from the challenges facing families that have adopted children--challenges that are routinely met with compassion and success.

3.3.4. Untoward Motives

Some of the visiting scholars raised questions about the moral acceptability of the motives of the couples who would seek a surrogate solution. Why shouldn't infertile couples turn to adoption as the solution? Only because they desire a genetically-related son or daughter--and isn't this a morally defective desire? Isn't it self-indulgent to demand a "copy" of oneself and one's partner when so many other children stand in need of loving homes? The trouble with this objection is that it proves too much. The sort of "self-indulgence" decried here is plainly a most natural desire, accounting in large part for much of human generation. And there is no reason why the infertile should have a special duty to adopt needy children; those with their "own" could also adopt others. But surrogacy certainly does suggest a morally defective motive if it is done for the economic convenience or comfort of the couple rather than as a desperate measure around infertility.
3.3.5 Effects on the Surrogate

By far the most persuasive set of arguments against surrogacy involved potentially negative effects on the women who may be motivated to become surrogates for money. There is an obvious possibility for exploitation of poor women who may sell wombs-for-hire. Though it might be argued that adult women should have the right to make such choices for themselves, some choices are so potentially harmful or so inherently degrading that they should not be permitted, at least not as a matter of commerce. Consider the difference in moral complexion between these two cases of surrogacy: a career surrogate contracting for her services as a job versus an unpaid relative or friend motivated by affection for an infertile couple. The first case is objectionable; the second is tolerable, even laudable. This is society's general stance on prostitution versus promiscuity, the marketing of human organs versus donating them as gifts, and the buying and selling of children versus the renunciation of parental rights and adoption. The first activity of each pair is demeaning in it and can lead to multiple negative consequences because of its commercial motivation. This is also the case with surrogacy.

3.3.6 Money at the Root

There are thus plenty of reasons to be suspicious of surrogate motherhood but the most convincing have to do with the motives of the couple and the effect on the surrogate. Both are connected to problems raised by commercialization of the relationship. It is unseemly to want to buy out of a pregnancy and delivery that is otherwise possible and demeaning to sell one's body to serve such a desire. The potential for abuses by both buyer and seller are serious and far-reaching. If money lies at the heart of the ethical issue, then Professor Field of Harvard may have offered the best practical advice of the day.13

13 Charles J. Dougherty Center for Health Policy and Ethics
http://moses.creighton.edu/csrs/news/S92-1.html
She recommended that surrogacy contracts not be made illegal. Instead make them legally unenforceable, allowing the birth mother to change her mind at any time and decide to keep the child. Such a public policy avoids the obvious difficulties of policing a prohibition but will certainly undermine development of a market for surrogate mothers.

### 3.4 Social Surrogacy

For resources concerning surrogacy as an alternative for persons with medical or gender-specific issues,

- Is your career booming and pregnancy would be inconvenient?
- Is your svelte figure your claim to fame?
- Would nine months of bulges and sags take too much of a toll on your mirror?
- Ah, and you want children who are yours biologically, and you don't have any medical problems that would interfere with your becoming (and staying) pregnant?
- Just supply your genetic material (sperm and egg), fertility specialists will add the IVF technology, and get connected with a woman who, for a basic fee upwards of $18,000 (not including the extras, lawyers, etc.), will agree to go through gestational surrogacy, carrying your biological child. She will go through the morning sickness, get the swollen ankles and stretch marks, and give birth - to your child.
- Depending on the state and the terms of statutes covering surrogacy (if any), your child either comes complete with a birth certificate conveniently free of any names but your own, or you go through an adoption process.
- We're not talking about infertility. We're not talking about medical hurdles to getting and/or staying pregnant. This is strictly about surrogacy for social reasons - too busy, the pressures of commitments, a career based on looks, etc.
What do you think? Should surrogacy be limited only to those with medical issues that preclude carrying a pregnancy to term (or men, without female partners, seeking to become parents)?\footnote{14}
3.5 Commercial Surrogacy and the Redefinition of Motherhood

3.5.1 Introduction

Since the 1970s, there has been rapid and wide ranging development in the field of new reproductive technologies (NRT). With donor insemination (DI) and *in vitro* fertilization (IVF), previously infertile couples have been given new hope and the chance to have children. A more recent addition to these new methods of reproduction has been the combination of DI and IVF with surrogate mother arrangements. This technique has subtly changed the realm of reproduction, for with the addition of a third party (the surrogate) to the reproductive environment, the nature of motherhood, fatherhood, and the allocation of parental rights and duties has come into question.

Before the advent of NRTs, there were essentially two forms of motherhood recognized in Western society, the biological and the social mother. Except for adoption, fostering, or step parenting, the biological mother was assumed to also be the social mother. This is not surprising, as motherhood has never been ambiguous; one might not know who one’s father was, but one’s mother’s identity was rarely in question. However, before women were granted legal personhood (1929 in Canada), a child’s legal guardian or parent was the father (based on property rights arguments); historically, illegitimate children were not considered to have a legal parent, either mother or father.

The use of IVF and DI in conjunction with surrogacy arrangements, raise a number of important social, legal, and ethical issues. Much of the discussion of commercial surrogacy turns around key legal cases, such as *Baby M* or *Johnson v. Calvert*, or explores feminist arguments for or against the practice of surrogacy. In this paper, however, I propose to draw upon legal, anthropological, and feminist literature to see how commercial surrogacy has changed the way we construct motherhood, and to better address the ethical issues at the core of the debate. For example, is the surrogate simply a ‘womb for rent’ who has no interests in the child she carries, or does the fact that she carries and gives birth to the child make her a mother with legitimate parental...
rights? Is there a moral difference between a genetic and a gestational surrogate? Does commercial (as opposed to altruistic) surrogacy essentialism a woman to her reproductive capacity and lead to commoditization and exploitation? In other words, has commercial surrogacy changed the traditional Western understanding of motherhood and does it do an injustice to the surrogate, the contracting mother, and/or women in general? I will argue that the fragmentation of the legal concept of ‘mother’ has created a range of social and ethical problems that need to be addressed; nevertheless, the basic societal definition of ‘motherhood’ remains substantially unchanged.

3.5.2 Kinship, Nature, and Procreation

To gain a clear understanding of how motherhood has been traditionally defined in the West, it is first necessary to explore conceptions of kinship. In the Western context, we tend to divide kin into either blood or marriage relations, though with the changing social dynamic of modern families, individuals who are related neither through biology nor marriage may come to be seen as part of the family, e.g., children who are adopted or conceived through donor insemination, gay and lesbian families, etc. In general, current Western conceptions of the family still see biological relatedness as primary and prior to the social construction of relations. These ‘natural’ facts are often taken for granted in discussions of kinship and family, and people may give special consideration (or have obligations) to blood relatives, because “blood is thicker than water.”

The importance placed on biological connection is further exemplified by traditional understandings of procreation and the resulting cultural definitions of ‘mother’ and ‘father’. The doctrine of “one child, one genitor” has been a part of Western tradition for more than two thousand years. While there are many historical antecedents to the modern view of conception (Aristotelian and ancient Greek atomistic views), it has only been in the last hundred years or so that the mechanisms of conception and fertilization have been fully explained by the biological sciences. The procreative act and the general connection between mother, father, and child was likely well understood, but until relatively recently the uniqueness of biological paternity
(as opposed to the obviousness of maternity) has been a cultural construct based on little scientific evidence.

3.5.3 The Impact of New Reproductive Technologies

With their rootedness in social relations of natural fact, traditional notions of kinship made the kin relations essentially non-negotiable, and the givenness of the relation was symbolized by the blood tie. One could not choose one’s parents or one’s relatives, and this led to one having certain unavoidable kin obligations. However, with an increased emphasis on autonomy and freedom of choice, we may encounter or participate in new and unconventional kin relations. Traditional notions of parenthood that presumed a relationship between family members are being challenged by a more biological view that emphasizes genetic relatedness and questions the quality of social relations. With technologies such as IVF and DI, children may be born from the product of donor sperm or ova, in which case they may be genetically related to only one (or possibly neither) of their social parents. The transmission of the genetic substances is seen to confer identity on the child, thus on becoming self-conscious, the child may assert a right to know about his or her genetic identity and biological parents. This situation raises the question of what it means to be a parent and who can be said to fit this role.

In the West, the child is seen as an independent and autonomously produced individual, the result of biological processes. It depends for its initial existence on its parents, but exists as a separate being from birth onwards; Canadian law makes explicit the difference between a fetus and a child. But parents only come into being through the existence of their children. People are not presumed to be parents, either socially or legally, without the known existence of children. Parenthood is always constructed while childhood is a given. The parent constructs the child biologically, while the child constructs the parent socially. The mother (and her identity) is constituted through her relationship to her child. The father is constituted through his relation to the mother and participation in the mother-child relationship; marriage assesses putative parenthood to the father.
The legal system is currently faced with the challenge of defining ‘motherhood’ and the various relations contingent in conception and pregnancy. There can now be multiple actors in the reproductive process that may have or desire recognized social roles, regardless of their biological ones. For example, under British law, the woman who carries the child is considered the mother, whether or not the child is genetically linked to her. Furthermore, the husband of the woman who gestates the child is considered the child’s father, regardless of genetic link to the child. The intention to treat a person as mother is a social construction which may contrast with the natural facts. “In the past, the natural facts that define a mother always seemed more comprehensive than those defining her partner. She both donated genetic material and brought the child to term, elements combined in the former cultural assumption that childbirth was a supreme natural fact of life.” The gestation period has now become culturally ambiguous.

### 3.5.4 Surrogate Mothers

Assisted reproduction has contributed to the fragmentation of motherhood. Historically, the social and biological aspects of motherhood resided in one person. Maternity is now divisible into genetic, gestational, and social motherhood, and these roles can be spread amongst a number of women. This division is most apparent in the case of surrogate mothers, where at least three (and possibly as many as five) women can attempt to claim parental rights over a child. “If Mrs. A is infertile and Mrs. B agrees to provide ova to be fertilized in vitro with semen from Mr. A, and embryos are transferred to Mrs. C, who agrees to carry the baby to term and hand it over to Mrs. A and her husband after birth, the situation becomes extremely complex and the basic tenets of family law uncertain.”

This situation creates the potential for enormous conflict over who should be considered the ‘mother’ and has the concomitant parental rights and responsibilities for the child. For example, in the Baby M case, there was a conflict between two conceptions of ‘motherhood’, the legal (commissioning mother) and the biological (surrogate mother). Surrogacy breaks down and
devolves the role of mother, separating the social and nurturing part of motherhood from the genetic contribution and the birthing process.

### 3.5.5 Motivations and Methods

If surrogacy fragments our understanding of motherhood and creates the potential for social and legal conflict, what then motivates women to become surrogate mothers? In a study of established surrogacy programs in the U.S., 28 surrogates from six different programs were interviewed. A striking revelation was the almost unanimous feelings expressed about the influence of remuneration in decisions to become surrogate mothers. Most surrogates interviewed stated categorically that they were not doing it for the money; altruism was the primary motivation and remuneration was simply compensation for family work – surrogates were paid $10,000 to $15,000, an amount held artificially low to screen out women motivated solely by the lure of financial gain. Surrogates did not spend the money on themselves alone, but usually on their other children, home improvement, etc., and surrogacy was viewed as a part-time job that would allow women to stay home with her children.

The surrogates interviewed also felt that the remuneration they received was insufficient compensation for nine months of pregnancy. This view may in part be an example of the cultural belief that children are priceless – the child produced is conceived of as a gift, a view that reinforces the idea that having a child for someone is beyond monetary compensation. Ragoné argues that in the U.S., remuneration is devalued by surrogates as a means of maintaining an acceptable balance between reproduction and work. If it is work, it should be compensated, but because it is also reproduction, it must be done out of ‘love’ rather than for ‘money’. Thus, surrogates attempted to balance public and private views of ‘motherhood’ – many of the women interviewed became surrogates to “transcend the limitations of their domestic roles as wives, mothers, and homemakers while concomitantly attesting to the importance of those roles and to the satisfaction they derived from them.” Remuneration is the most problematic aspect of surrogacy because it challenges the cultural ideals of women and mothers as selfless nurturers;
admitting that remuneration was adequate would eliminate the ability of the women to classify their work as an altruistic “gift of life” to an infertile couple.

At a practical level, surrogates have to be able to strongly disassociate themselves from the children they bear. In a study by Snowdon, she notes that some women found it harder giving away children that were genetically linked to themselves: “Giving away a child that is half mine—I brainwashed myself so much that I never thought about it, but at the end of the day you are still giving away something that belongs to you, your flesh and blood.” Two women interviewed opted for IVF and gestational surrogacy because they felt that the baby then belonged more to the contracting couple, and it was easier for the surrogates to think of themselves simply as carriers or incubators. This attitude of distance or separation was used as a mechanism to help a woman part with the child at birth. As one woman observed,

With your own children it is totally different. It is a joyous occasion where you share everything with your husband and your family. With surrogate pregnancy you almost cut out the family. You don’t encourage the grandmother to be a grandma, and you don’t start nest building and buying things for the baby. There is no comparison between the pregnancies, except that you are pregnant, only the physical symptoms.

Snowdon did not see the fragmentation of ‘motherhood’ as causing any difficulties with the women she interviewed. The consensus was that the social mother, the woman who raised the child, was the true mother. The surrogates interviewed placed a great deal of emphasis on nurturing as the fundamental aspect of motherhood. With ‘motherhood’ now defined as separable into the roles of nurturer (social) mother and biological mother, women are given a choice about motherhood. Either role can be accepted or refused, thus in deciding not to be the social nurturing mother, the value of the biological (surrogate’s) contribution is minimized “while the adoptive mother’s choice to nurture activates or fully brings forth motherhood.”
Adopted mothers attempt to resolve the lack of biological or genetic relationship with their children through what Ragoné calls “mythic conception” – the idea that the desire and intent to have a child is what makes surrogacy possible. Some adoptive mothers also experienced the pregnancy by proxy: they followed the surrogate through medical exams, birthing classes, and through the delivery of the child – the adoptive mother was “emotionally pregnant” while the surrogate was only “physically pregnant.”

### 3.5.6 Genetics and the Essentialization of Women

Motherhood has been widely portrayed in North America as one of the core aspects of a woman’s life, without which her life is considered incomplete. We hear discussion about infertility treatments, techniques of *in vitro* fertilization, etc., where these technologies are presented as almost a panacea that can make infertile couples whole, functioning, normal. However, these procedures do not solve the problem of infertility – they are simply methods of providing childless couples with access to the fertility and childbearing abilities of others. These technologies also provide contracting mothers with the opportunity to have a child that is genetically ‘theirs,’ particularly in the case of gestational surrogacy.

Some feminists argue that legalizing surrogacy would help liberate women by de-bipolarizing motherhood. Women could become mothers without having to go through pregnancy and birth. On the other hand, it is argued, especially by religious and conservative opponents, that surrogacy violate a natural maternal instinct and bonding thereby undermining the structure of the nuclear family. Even some former surrogates, such as Mary Beth Whitehead, invoke the language of maternal instinct and essentialized motherhood, instead of feminism, to oppose surrogacy.

Raymond rejects the essentialist argument of maternal bonding and maternal instinct as a tool for opposing surrogacy, as she believes these arguments have little legal weight in opposition to a father’s right to the child. In the market, the surrogate is often not considered to be contributing to the pregnancy, aside from donating an egg and gestating the fetus; the real value
comes from the donor sperm. For example, in the *Johnson v. Calvert* case, the California Superior court awarded custody of the child to the commissioning couple, the Calverts, because they were the providers of the gametes which formed the embryo and produced the child. Genetic contribution was the primary criterion of parenthood; the role of the gestational mother was reduced to that of an incubator.

This view ties in well with the traditional Western understanding of procreation described above, that sees the man as providing ‘the seed’ and women as simply incubating the child and being ‘the soil’ from which the seed can grow. The egg only acquires the status of the sperm, as important contributor, when it does not conflict with the rights of the man. In *Johnson v. Calvert*, the sperm and egg came from a married couple and were thought to be working in co-operation to arrive at a commonly desired goal. When the egg is from a woman who decides she wants to keep the resulting child, e.g., Mary Beth Whitehead, the egg is then reduced in meaning and the sperm is said to predominate in importance of contribution.

Genetics has often been treated as determinative in the assignation of parental rights, because it is believed that genes are what give children their individual and unique traits, characteristics, and helps to form their identities. Gestational surrogate mothers may thus be considered not to be contributing anything physical to fetal development, aside from care and feeding. It is argued, as in *Johnson v. Calvert*, that the surrogate makes no contribution to the physical features, behavior, etc., of the child and therefore has no justification to argue for parental rights over the child. However, this view is far from unanimous in the U.S. or internationally. For example, the American College of Obstetricians and Gynecologists (ACOG) maintains that gestation, and not genetics, determines motherhood.

In other words, the ACOG makes no distinction between the usual forms of surrogate parenting and gestational surrogate parenting. This follows the position of the Warnock Report in the U.K., which argued that egg or embryo donation is treated as an absolute separation that does not confer any parental rights to the donor. If a couple donates an embryo to a gestational
The surrogate, the surrogate becomes the legal recipient of the embryo, and the legal mother and parent of the child when it is born. The surrogate thus has the choice of honoring the contract and transferring parental rights to the commissioning couple, or deciding to break the contract and keep the child for her.

The positions taken by the ACOG and the Warnock Committee are based on a positive valuation of the contribution that a mother makes during conception, gestation, and birth. It is argued that nine months of labor and the process of giving birth constitute a major investment of a woman’s time and effort towards the child’s well-being. Furthermore, recent work in prenatal psychology and physiology have demonstrated that the maternal environment can have a positive or negative impact on the developing fetus, depending on the mother’s sense of well-being, whether she is prepared for and wants the child, etc. For example, referring to studies by Lester Sontag, Rae states that there is some evidence that women undergoing severe emotional stress give birth to children who are more irritable. These types of studies help demonstrate that the gestational contribution of mothers is far more dynamic and relational than simply being “fetus sitters” or carriers of the child.

However, by arguing for this type of maternal contribution and connection to the fetus, Raymond worries that this may further contribute to what she calls a “creeping maternal essentialism” in the debate over surrogacy. Feminists advocating for surrogacy are concerned that prohibiting this arrangement will biologist motherhood and entrench it in an understanding of female nature. Yet, according to Raymond, where the real essentialism lies is the assumption that women have a desperate need to have children and remain fertile: “maternal essentialism confines women to the ghetto of motherhood.” To argue that maternal instinct and bonding is paramount is to reduce motherhood to biology; instead, Raymond maintains that motherhood is primarily a relationship that exists within a social, political and historical context, thus it cannot be reduced to an unchanging basic instinct. In becoming pregnant, a woman forms both a personal and social relationship with the fetus she bears. This relationship may be positive or negative, depending on the
circumstances of the pregnancy, whether the mother feels forced or coerced, or is unprepared to deal with having a child at a given point in time.

3.5.7 Commercialization and Exploitation

While surrogacy in general raises a host of social and ethical problems, I believe that commercial surrogacy in particular can crystallize the difficulties that many people have with surrogacy, and help us get to the core of how surrogacy affects our understanding of motherhood. Commercialization and its use of market rhetoric, treats surrogacy as a service arrangement between a number of individuals, leading to the creation of a product and the transfer of rights to that product. In the law in the U.S., this is represented in the form of contracts signed by the commissioning couple and the surrogate mother. In exchange for between $10,000 and $15,000, the surrogate mother (and usually her partner) agree to abstain from intercourse for a number of months, submit to regular and extensive medical exams, and agree to transfer parental rights to the couple once the child is born.

3.5.8 Contracts and Baby-Selling

As noted above, many women adapt well to surrogacy and are able to distance themselves from the pregnancy and the fetus. To create such distance, they must be able to alienate themselves – the worker – from the child, literally and figuratively the product of labor. These women must also deal with a cultural construct of motherhood that sees it as something private, and not to be commercialized. Thus, commercial surrogates have the uneasy task of, on the one hand, feeling they are due remuneration for their services, while on the other, downplaying the role of remuneration in favor of gift giving and altruism so that they can maintain their place within the social context of motherhood. They are often torn between wanting to be respected for providing a valuable service while at the same time embodying the nurturing and caring roles that are still commonly assigned to mothers.

According to Rothman, this means that “the baby like any other commodity does not belong to the producer but to the purchaser.” However, instead of an assembly line model of production, a more accurate analogy
might be the work of a commissioned specialty craftsperson that creates something which they own, but then decides to put that product up for sale. In most legal jurisdictions, the child is considered to belong to the surrogate (although this is less clear in the case of gestational surrogacy), and she must then transfer her parental rights to the child for the contract to be completed; but the surrogate retains the option of breaking the contract and keeping the child. Nonetheless, there is still the sense that a product, the child, is being produced for the specific purpose of being transferred and sold to the commissioning couple.

Market rhetoric collapses the natural properties of the product into culturally defined qualities, making them one with the object being presented for social consumption; the market analogy tends to also collapse all other concepts or metaphors into market rhetoric, e.g., “products of conception” or the “fertility industry”. The focus is not on motherhood or fatherhood, but on the creation of children. Issues of money, cost of treatment and services, and so forth are always present in the background in discussions of reproductive technologies. The commoditization of reproduction is clearly seen in the development of surrogate motherhood – services are bought and body parts rented as if the woman in which these parts reside did not exist.

This sense that women are being treated simply as means of producing babies, and not as individuals, is highlighted by the nature of many of the commercial surrogacy arrangements. To begin with, much of the commercial surrogacy in the U.S. is processed through surrogacy centers or “baby brokers”. Classified ads appear in the newspaper and on the Internet seeking surrogate mothers, and offering $10,000 to $15,000 plus expenses; the brokers, however, charge contracting couples between $30,000 and $45,000 per child. Surrogacy agreements often have clauses in the contracts stipulating that the surrogate must undergo frequent medical examinations, tests, and amniocentesis, must follow detailed nutritional guidance, and limit consumption of certain products, such as cigarettes or alcohol which may endanger the fetus. Some agreements even include a statement that the surrogate will agree to abort the fetus on demand if or when the
commissioning couple decides to terminate the surrogate’s service. Contracts provide only limited compensation up front, with the bulk of the fee being provided not at the birth of the child, but after the transfer of parental rights from the surrogate to the commissioning couple. As Kimbrell notes, “no product, no payment.”

When this arrangement is treated purely as a contract, it cannot help but be the case that the surrogate is being compensated for both her services and the delivery of a product, namely the baby. The baby is separated from the birth mother in a commercial transaction, which treats the baby as little more than a commodity. What then, is the difference between this form of baby selling and illegal forms of baby selling through adoption on the black market? Proponents of commercial surrogacy would likely argue that the woman is being paid for her services only, and the remuneration is simply due compensation for time and effort provided during pregnancy. This argument is unconvincing, especially when it is commonly the case that the surrogate only receives full payment for her services after signing over parental rights to the child. There can be little doubt that what are being purchased are not the surrogate’s services to help a couple produce a child; instead the child itself is the product purchased.

3.5.9 Exploitation and Third World Mothers

One of the primary concerns about commercial surrogacy is the very real potential for exploitation and coercion. Surrogacy does not, however, have to be commercial to be coercive. In situations where a couple is infertile, there may be intense family pressure upon a female sibling to become a surrogate to provide a child for the couple. Moreover, this pressure may not be overt, but might manifest itself through feelings of guilt or through strong family opinion, so that the potential surrogate sees no other means of remedying the situation for the infertile couple. Whether or not surrogacy is commercialized, when set within the context of women’s inequality, it inevitably supports and reinforces the view that bearing and raising children is what being a woman is all about.
When large sums of money are involved, there is a greater likelihood that unscrupulous individuals will seek to exploit others in order to make a profit. For example, in the U.S., there have been at least 55 lawsuits and complaints filed against brokers because of abuse and intimidation. To ensure the effective transfer of the produced child to the commissioning couple, surrogates must sign contracts that, as some have argued, amount to little more than commercial servitude. When sperm, eggs, embryos, and even women’s reproductive processes are seen as marketable, it raises concern for many that a ‘breeder class’ of women will develop, women whose only means of making a living is by renting their bodies and selling their body parts. This is especially true where there exists a power and financial differential between those procuring and those providing services.

Citing a 1988 study by the former U.S. Office of Technology Assessment, Kimbrell asserts that most commissioning couples tend to be well-off, well educated, and with incomes in excess of $50,000. By contrast, “most surrogate mothers earn just above the poverty line, and less than 4 percent of surrogate mothers are reported to have received graduate school education. Over 40 percent of surrogates are unemployed, receiving financial assistance, or both.” When this disparity in income, education, and social class is combined with the restrictive nature of commercial surrogacy agreements, it becomes less clear that poor women can have a choice other than to rent their one main skill/resource, i.e., their reproductive capabilities. However, as the work of Ragoné and Snowdon demonstrate, many surrogates in North America choose surrogacy as a means of increasing family income, paying down the mortgage, purchasing material goods, etc. It is women in developing or underdeveloped countries who are most vulnerable to exploitation, although women in developed countries are not necessarily free of this concern.

Poor women may make ideal surrogate mothers as due to their financial need, they are more likely to alienate themselves from the children they produce, and being poor will not seek or be able to challenge surrogacy contracts in court. With better embryo transfer techniques, commissioning couples would not have to worry about the surrogate contributing genetic
material to their child. Instead, the surrogate would be simply a gestational surrogate and little more than a ‘fetus-sitter’ for the couple’s future child. Further, the price paid to surrogates could be reduced even further, perhaps to one tenth of the present fees, as poor women are often simply trying to survive and support their own families, and thus may simply “take what they can get.” This situation puts into stark contrast the difference between surrogacy in the developed and underdeveloped world. In developed countries, surrogacy may be a choice for women to improve their financial situation and perform an altruistic act; in underdeveloped countries, surrogacy may be a form of slavery, reminiscent of the black nannies that raised white children in the American South during the slavery era, or in Apartheid South Africa.

3.5.10 Motherhood Redefined?

New reproductive technologies and surrogacy in particular, challenge our understanding of ‘motherhood’ and force us to question what it means in our society. Has the very definition of ‘motherhood’ changed, or is it simply that its application in the modern context of surrogacy arrangements has changed? As was argued in the first section of this paper, the advent of new reproductive technologies has led to a fragmentation of the components that are normally assigned with the role of ‘mother’, and who is assigned to a particular category. Under the traditional view, the ‘mother’ was normally the woman who gave birth to the child and was biologically related. With surrogate ‘motherhood’, the biological connectedness to the child is brought into question. How much relationship is entailed by gestation, nursing, and mother-child bonding as compared to simply donating an egg? This is the crux of the argument over whether non-genetic gestational surrogates are ‘mothers’. The courts in the U.S., e.g., in Johnson v. Calvert, have tended to rule against these women, treating their gestational contribution as insufficient.

However, by contrast, the ACOG and the Warnock Committee maintained that the woman who gestates and gives birth to the child is the legal mother – her contribution of time, effort, and the intimate relational nature of the maternal environment are sufficient for her to be considered the mother. In other words, they argue that the other primary element of
‘motherhood’, i.e., ‘love’, must be considered of equal weight as ‘blood’ or genetic contribution when assigning parental rights. The relational aspect of motherhood is as important as the biological connection between mother and child.

This focus would allow surrogate mothers, be they genetic or gestational, to claim parental rights as mothers of the children they bear. In the case of the gestational mother, this claim may create a conflict with the biological mother who donated her egg, but it is a conflict over who has parental rights and not so much a conflict over who is ‘mother.’ Gestational surrogacy creates the new situation in which a child has not one, but two biological mothers – one genetic and the other gestational. While having multiple biological mothers is new, it has long been accepted that a child could have multiple social mothers, i.e., adopted mothers, step-mothers, or foster mothers. If the motherhood can be divided into social and biological components without the concept of ‘motherhood’ being changed, why then cannot the biological roles be subdivided as well? I therefore agree with Schneider that the definition of ‘mother’ has not changed, despite new understandings of what constitutes ‘blood’ relations. The idea that motherhood includes social and biological aspects, ‘blood’ and ‘love’, is still present. It is simply the case that these aspects of motherhood have fragmented and can be allocated to multiple women. This fragmentation may create social difficulties in determining who the legal ‘mother’ is, but I think our basic definition of ‘motherhood’ remains unchanged.

What then are the affects of commercial surrogate arrangements? Does commercial surrogacy threaten motherhood? As Ragoné’s study shows, commercial surrogacy can challenge our ideal of mothers as being selfless nurturers, free from the pressures of the market place. Remuneration seems to reduce surrogates to the level of reproductive laborers, but surrogates also strive to downplay this role and attempt to balance it with notions of altruism and gift giving. In a society that does not really condone the commercialization of the private family domain, surrogates are caught in an
awkward position – they want to be mothers and at the same time be valued for their reproductive work.

Nevertheless, according to Rothman, motherhood resists commodification. This is particularly evident in the difficulty that many women go through in deciding to have an abortion. They cannot maintain the medical language, but instead often use the language of infanticide, grief, and responsibility. With respect to surrogacy, not all women are able to alienate themselves from their pregnancies. Some women, such as Mary Beth Whitehead, change their minds when they realize that they cannot go through with the process of giving up their child to another couple. They cannot put price tags on their children, and cannot commodity their motherhood. It is therefore unclear that surrogacy in particular devalues motherhood; even though it changes the way mothers view themselves and are viewed by others.15

Commercialization may well lead to the exploitation of women in some situations (particularly in developing or underdeveloped countries) and be justifiably prohibited for this reason. Moreover, it may further contribute to the reduction of women and motherhood to a purely biological understanding, such as seems to be evidenced by the California court’s ruling in Johnson v. Calvert. However, as with surrogacy in general, I do not believe that commercialization changes our understanding or definition of ‘mother’. Mothers will still be seen as embodying nurturing and ‘love’ relations, even if this role as social mother is separated from the biological role.15 As Rothman observes, women can still reject the commercialization of their motherhood. Some women may be forced by oppressive or coercive Circumstances to essentials themselves as being simply reproductive vessels for the development of another’s child, and thus feel alienated from their motherhood. But in the act of gestating and bearing a child, the woman reinstates herself as a mother by participating in one aspect of motherhood – whether or not she is defined as a ‘mother’ by others, she is still a mother.

3.6 Emotions for Surrogate Mothers & Families

During the years 2006 through 2010, roughly 6.7 million U.S. women between the ages of 15 and 44 struggled with infertility issues, according to the U.S. Centers for Disease Control and Prevention. For some women facing such challenges, reliance on a surrogate mother may be an option. Like the women whom they help, surrogate mothers may experience a host of emotional issues.

3.6.1 Emotional Attachment

Developing an emotional bond with a baby during pregnancy knowing that you will soon hand her over to another woman can result in confusion, sadness or even anger. During the nine months of gestation, the biological mother bonds with and becomes emotionally attached to the baby growing inside her. For some women, giving the baby up after birth may present a loss too challenging to overcome without outside help. Professional counseling during and after the pregnancy can help to minimize the effect of such emotions.16

16 retrieved from   Last Updated: Feb 06, 2014 | By Erica Loop dated 10-Jun-16 10:30:00 AM
3.6.2 All in the Family

Chances are that the surrogate isn't the only person other than the parents-to-be who is invested in this pregnancy. She may have a husband and children of her own. If so, they also can develop an emotional attachment to the unborn baby. Additionally, the surrogate's parents and extended family may become emotionally and psychologically involved. For example, psychotherapist Ellen Speyer on the American Fertility Association website, the surrogate's mother may feel that the baby should be her grandchild. Including the family in the surrogacy process or allowing the family alone time with the baby after birth can help to relieve some of these tensions.

3.6.3 Feelings and the Law

As if the tangled web of emotions that come along with surrogacy weren't complicated enough, legal issues can make the process even more of a struggle for mothers and families. While there's no doubt that carrying a baby for nine months and giving birth creates an emotional attachment, additional problems can arise if the surrogate has the legal option to keep the baby. Surrogacy is not equally enforceable in all states. This may mean that the intended parents have no legal right to claim the baby as their own. That may complicate the decision-making process for a surrogate who can't bear the thought of giving up the infant.

3.6.4 Love and Joy

While being a surrogate mother has potential for a flood of negative emotions, it can still be a joyous occasion. Bringing a child into the world for someone else is an experience with which there is no comparison. The surrogate mother who recognizes this is likely to feel happiness for the intended parents. “This feeling of helping another couple become parents -- something they’ve wanted to do for so long -- is indescribable. Next to having my own children, it’s my proudest moment,” writes surrogate mother and author Sara Chinn in her article "I Gave Birth to Someone Else's Children -- What It's Like to be a Surrogate" on the "Women’s Health" magazine website.
This can translate into love not just for the child but for the new parents as well. In such a case, handing the baby over means the beginning of a new extended family and a close relationship instead of a tearful goodbye.\textsuperscript{17}

3.7 Counseling and Surrogate Parenting

The psychologist's role in surrogate mother arrangements is approximately sixteen years old. Despite the sixteen years and the approximately 4,000 cases, there is very little research exploring long-term issues. There are doctoral dissertations and other studies that address surrogate mother's psychological profile. Given the focus of psychology, most of this research has attempted to identify the psychopathology of the surrogate mother population. Yet, this research to date has not identified any psychopathology. The current research is focusing on designing a salient assessment protocol and on the long-term effects of those who have participated in surrogacy.

The psychological screening and counseling of participants is thus mostly based on clinical observations and collaboration with colleagues. It is important to note before addressing specifics, that psychological assessment and counseling is still optional. Unless a program, the physician or the patients deem it necessary, surrogacy agreements can proceed without the benefit of mental health professionals. However, most of the IVF clinics in my area and the program with which I am associated do mandate psychological screening. This role of gate keeper is controversial. Over my twenty years of evaluating surrogate mothers, prospective couples, and, more recently egg donors, it is clear that the assessment and counseling is effected by one's perspective on openness, child welfare, women's issues, child development and the pains of infertility.

3.7.1 Screening of Surrogate Mother

The psychological screening of surrogate mothers is very similar for both traditional artificial insemination surrogates and IVF gestational surrogates. The important differences will be addressed at the end of this section. In both programs, it is crucial that the candidate already have at least one child that she has given birth to and parented. If she has not had pregnancy and parenting experience, it would seem impossible for her to give any level of informed consent and it may be difficult for her to empathize with the parents and the child. Additionally, it seems risky for a doctor to endorse
women without such obstetrical histories. We also do not accept women on government aide, in major life transitions, or who do not have a stable income. This role criterion is an attempt to prevent collusion with denying important feelings because of an immediate need for money.

One role of the psychologist is to help the candidate see if being a surrogate will serve a positive functional purpose or a negative dysfunctional purpose in her life. Thorough assessment can prevent collusion with pathology, exploitation, and unhealthy degrees of denial.

The clinical interview reviews her history in an attempt to screen out women who have traumatic histories from which unresolved feelings may surface during crisis or during stressful conditions. It is interesting to note, one study conducted on surrogates discovered no differences in early attachment and loss histories of surrogates and non-surrogates. The clinical interview also addresses motivations. Studies across the nation seem to report similar motivations (Hanafin, 1987, Parker, 1983, Resnick, 1989). It is crucial that the candidate obtain something for herself beyond financial remuneration. If she cannot focus on what being pregnant and relinquishing a child can do for her, then traits such as low self-esteem, low intelligence and martyr patterns should be evaluated carefully.

Related to motivations are the candidate's expectations concerning her relationship with the prospective parents? It is crucial to explore her needs for contact and her hopes for openness. This issue can reveal such dynamics as unrealistic expectations, an attempt to use surrogacy to fill void in her life, fragility or mistrust, and an inability to predict her own behavior. Specifically, a woman who assumes she will be an "aunt" or a woman who wants no contact is of concern. An ability to do reality testing, an ability to understand boundaries, and an ability to trust her to set limits are vital variables. Furthermore, what a surrogate's wish list and criteria as it pertains to the new parents is very revealing and can provide some predictive information. Of course general mental health is an obvious necessity. Psychological testing, clinical interviews, observations in a group setting, and feedback from others involved in the case are all important. Specifically, it is important to eliminate
sociopaths, depressed persons, borderline personalities, and those who have little ego strength. It is important to assess their coping mechanisms, defenses, and resiliency especially when under duress. Surrogates also need an intellectual ability to do abstract thinking, conceptualizing, and retain a lot of information. It is vital that she have the ability to think independently, as well as take care of herself so to prevent exploitation.

Over the years, evaluating a surrogate's support system, resources, and immediate family has become increasingly important. Assessing the husband's beliefs and thinking is most revealing. A surrogate with minimal to no resources or minimal ability to use resources is often indicative of a person with poor judgment who will need a lot of case management. Furthermore, her children are of utmost concern. Discovering how she plans to tell her children, and assessing how much life trauma the children have undergone are important considerations for surrogacy to precede safely. If a candidate answers that she may not tell her children the truth or if her children have a history with much loss and/or trauma it is often best not to accept her. As mental health professionals we have a responsibility to protect children psychologically where possible. For a child's mother to be a surrogate is of unknown consequences, therefore it is best to eliminate families who have come to surrogacy with minimal support and/or painful histories.

3.7.2 Assessment and Testing

The challenge in testing surrogates has been that their norms are often similar to the general population's norm. Historically, my practice has given the MMPI. Candidates usually score within the normal limits. The MMPI has helped to eliminate psychopathology but because the scores are usually within normal limits, we need to turn to other measures to gain a fuller understanding. Projective tests such as the Rorschah and sentence completion often help assess how a client copes under stress and how easily she remains integrated. Dr. Suppes (1993), Carol Wolfe, MFCC and Dr. Rice (1991) have each administered over twenty Rorschah tests. They have revealed an intimate picture of the candidate response to stress and change, as well as their
perceptual accuracy and defenses. Administering projective measures or personality tests based on non-psychiatric populations is recommended.

In addition to clinical interviews and testing, it can be helpful to do reference checks and/or a criminal background check. Furthermore, often crucial pieces of information are shared by doctor's offices or other professionals involved in the case. Observation in a support group setting allows the psychologist to further assess the candidate's personality style, anxieties, retention of information, and ability to get her needs met.

AI v. IVF As stated earlier, the important variables for screening are very similar in both AI and IVF programs. However, when evaluating and counseling women there are some program-specific issues that need to be addressed in the initial interviews. An IVF gestational surrogate needs to be able to manage a taxing amount of medical information, injections, and logistical inconveniences. Coping with impositions, sacrificing a lot of time, and being flexible are vital. Furthermore, beliefs in selective reduction, perspectives on multiple gestation, and beliefs about pregnancy termination all are very pertinent in this population.

On the other hand, AI (artificial insemination) surrogates need to address feelings, beliefs, and fantasies about their genetic birth child. The genetic link is a real one, despite the fact that many candidates tend to minimize it. The child to be conceived will have a birth family, including half-siblings. Again, though many surrogates and prospective couples tend to minimize this fact, it is important to explore. Surrogates relinquishing a child that is genetically linked also tend to receive more negative feedback than non-genetic surrogates. Their reaction to critical judgment by others needs to be assessed.

3.8 Social aspects in assisted reproduction

In-vitro fertilization (IVF) and assisted reproductive techniques have become common practice in many countries today, regulated by established legislation, regulations or by committee-set ethical standards. The rapid evolution and progress of these techniques have revealed certain social issues
that have to be addressed. The traditional heterosexual couples, nowadays, is not considered by many as the only ‘IVF appropriate patient’ since deviations from this pattern (single mother, lesbians) have also gained access to these treatments. Genetic material donation, age limitation, selective embryo reduction, preimplantation genetic diagnosis, surrogacy and cloning are interpreted differently in the various countries, as their definition and application are influenced by social factors, religion and law. Financial and emotional stresses are also often described in infertile couples. Information as deduced from the world literature regarding IVF regulation, as well as about the existing religious, cultural and social behaviors towards these new technologies, is presented in this article in relation to the social aspects of assisted reproduction\(^\text{18}\).

### 3.8.1 Introduction

Of all the structures composing the human organism, the reproductive system has special societal sensitivities. The social issues related to the application of assisted reproduction should certainly be interpreted according to this assumption.

New reproductive technologies are being developed rapidly nowadays, so that every aspect of society needs to re-evaluate and reconsider its reaction to this new form of treatment as the changes arise. Since the introduction of in-vitro fertilization (IVF) and the birth of Louise Brown, advances in assisted reproduction technologies have resulted in the creation of family types that would not otherwise have existed. With IVF using the father’s spermatozoa and the mother’s egg, the child is genetically related to both parents, whereas children conceived by donor insemination (DI) are genetically related to the mother but not the father, and children conceived using donated eggs are genetically related to the father but not the mother.
When both egg and spermatozoa are donated, the child is not genetically related to either parent. This latter group of children is similar to adopted children in that they are genetically unrelated to both parents, but differ in that the parents experience a pregnancy and develop a relationship with the child from birth. In the case of surrogacy, the child may be genetically related to neither, one or both parents, depending on the use of a donated egg and/or spermatozoa. Erroneously, it is pointed out that it is now possible for a child to have five parents: the egg donor, the sperm donor, the birth mother, and the two social parents whom the child knows as mother and father. All these complex social structures forming after the performance of Assisted reproduction, as well as the rapidly changing technologies, have captured the public imagination and preyed on widespread fantasies.

IVF and assisted reproductive technology (ART), today, are common practice in many countries around the world. Since their evolution there has been an ongoing debate in society, especially among members of the medical profession, as to the necessity of judicial regulations and public control concerning their practice. As a result, some countries have established legislation pertaining to the various aspects of ART (i.e. UK, Sweden and Spain). In a number of countries, ART are practiced according to regulations that have been laid down by fertility societies (i.e. USA, Canada and all of Australia except the state of Victoria, which has enacted a state statute), medical research councils (i.e. the Netherlands, Hungary) or religious authorities (i.e. Egypt). Other countries spread over the continents (i.e. Greece, Finland and Korea) operate actively in the ART field without either statutes or guidelines (Jones, 1996). Legislators have raised doubts as to whether any single piece of primary legislation will ever be sufficient in itself to deal with such a complex area and with such fast-moving technology.

The purpose of this article is to present the social aspects of ART and to analyze in this respect, issues such as the structure of the assisted reproductive family, the welfare of the child, genetic material donation, age and assisted reproduction, selective embryo reduction, pre implantation genetic diagnosis, surrogacy, cloning, informed consent, medical record keeping and central reporting of data obtained. In support of our article, we
use information, recently reported in the literature, about the IVF regulations and existing religious, cultural and social behaviors towards these new technologies in Europe, Asia and North America. Information about the current attitudes in South America was obtained after direct contact with fertility clinics operating in these countries.

3.8.2 Assisted reproduction families: family functioning and child development

Most professional bodies in the various countries recommend that ART should be restricted to heterosexual couples who are legally married or at least living in a stable relationship. In the majority of nations reviewed in Europe and in South America, ART is offered either to married couples or to couples pertaining to have a stable relationship; it is often stated that cohabitation of 2 years fulfils this requirement (i.e. France). In Asia, marriage is usually the requirement, as in many of these countries religion significantly influences social life, whereas Hong Kong, India, China and Israel also allow these procedures to cohabiting couples. Israel is the only country from the Asian region that provides IVF to single mothers. In Europe, this practice is found in Belarus, Italy, the Netherlands, Russia, Spain, Ukraine and the UK, whereas it is forbidden in South America mainly due to religion reasons. The remaining reviewed nations make no mention of a specific societal relationship of the prospective parents. In two nations Denmark and Argentina, the statute is quite clear, verifying that IVF cannot be offered to lesbian or homosexual couples. The welfare of the child, from infancy to adulthood, is gaining worldwide acceptance as a basic factor in evaluating ART outcome, and thus some countries have already established some form of regulation or law (i.e. Australia, Belgium, and Denmark) regarding this issue.

Despite the changes that have occurred in society during the past few years and especially in the interrelationships between people, the most widely accepted structure of the family remains that comprising two heterosexual married parents who are genetically related to their children, while all other deviations from this classic schema are considered to be non beneficial for the child. Restriction of IVF to married or cohabiting couples may be explained
by the widely accepted public view that children raised in a family frame have an advantage over children living with a single parent.

Families that have resulted through assisted reproduction, although continuously increasing in number, may differ from the normal, either because of a non-genetic relationship of one or both parents with the offspring (sperm, egg, embryo donation, surrogacy) or because of structural differences, as it is well known that a growing number of single heterosexual women and lesbian women are opting for assisted reproduction. In the USA, a woman has the right to decide when and how to conceive. Under the European Convention of Human Rights (1978), a single woman, or even a lesbian couple, is entitled to have children, even though these children may have no legal father. The creation of these new types of family raises important questions about the psychological consequences for the children who result, and for this reason many have recommended that follow-up studies of these families should be carried out.

The social recognition and acceptance of these families, their social context and the processes through which social environment affects family relationships are issues that have raised many disputes and attention. It is important to emphasize that negative attitudes may exist towards reproductive technologies, with procedures such as IVF and DI sometimes considered being immoral or unnatural. As a result, families with a child conceived by assisted reproduction may experience overt prejudice not only from the wider community but also from relatives and friends.

Several other concerns have been expressed regarding these families, such as the effects of the long-endured infertility and the multiple and often painful diagnostic and therapeutic procedures (many times for years) that the couple has undergone, as well as the intense economic burden resulting with these treatments. It has been suggested that the stress associated with this problem may make bonding with the child difficult or even lead to marital problems with a certain appeal on the child. In this respect, sociological studies have shown that several aspects of parenting influence the development of children: sensitive responding, emotional availability and a combination of warmth and control are associated with positive outcomes, whereas marital conflict and parental psychiatric disorder have a negative
effect. Taking this into account, society is now facing the dilemma of the ‘ideal structure’ of families resulting after assisted reproduction, since social groups considered in the past as not appropriate for parenting have been re-evaluated and their rights have been reconsidered.

A European study (conducted in Italy, UK, Spain and the Netherlands) of family relationships and social and emotional development of children in families (heterosexual couples) created by IVF and DI compared with control groups of families with a naturally conceived child and adoptive families was recently presented. Mothers of children conceived by assisted reproduction expressed greater warmth towards their child, were more emotionally involved with their child, interacted more with their child and reported less stress associated with parenting than mothers who conceived their child naturally. Similarly, assisted reproduction fathers were found to interact more with their child and to contribute more to parenting than fathers with a naturally conceived child. With respect to the children themselves, no group differences were found for either the presence of psychological disorder or for children’s perceptions of the quality of family relationships.

Previous studies have stated that, on average, children in single-parent families do less well than those in two-parent households in terms of both psychological adjustment and academic achievement. They are also less likely to go on to higher education and more likely to leave home and become parents them at an early age. In these cases, the rather non-optimal outcome is not only explained by the fact that the child is raised by a single parent, but other factors also seem to play an important role, such as economical distress and the psychological influences of being exposed to conflict and family disruption that is commonly associated with their parents’ separation or divorce.

Children born to single mothers following DI differ in important ways from children who find themselves in a one-parent family following divorce, in that they are raised by a single mother from the beginning without experiencing the detrimental effects induced by the separation of their parents. However, these families still have to face several social adjustment problems as a result of the occasional reluctance of society to accept single mother families and because of possible financial scarcity. These children might be
forced to attain an attitude of solitude and isolation as a result of the absence of a father and thus their single parenthood.

Despite the lack of studies on single mother families resulting from DI, other studies conducted on fatherless or so-called ‘sole mother families’ show that whether or not these children do less well than those from two-parent homes seems to depend on their financial situation and the extent to which their mother has an active network of family and friends to offer social support. The currently existing information indicates the best predictor of outcomes for children in these families to be the family circumstances rather than single parenthood per se Weinraub and Gringlas.

Lesbian families, although similar to those headed by a single heterosexual mother in that the children are being raised by women without the presence of the father, do differ in the sexual orientation of the mother. The raising of a child by a lesbian couple encompasses certain disadvantages. Firstly, these children have a higher possibility of developing psychological problems due to their family structure and the reactions it raises in society, especially at school. Secondly, the absence of a male eliminates the traditional father figure of a normal family model, endangering the normal sexual development of these children: that is, boys may be less masculine and girls may be less feminine. This might lead them into homosexuality, an outcome that is often considered undesirable by courts of law, policy-making bodies, and a large part of society.

Earlier studies checking the outcome of children in lesbian families included women who had become mothers in the context of a heterosexual marriage before adopting a lesbian identity and who were compared with single heterosexual mothers. No differences between their children were identified for emotional-well being, quality of friendships or self-esteem, or in terms of masculinity or femininity. Regarding the parenting ability of the mothers themselves, it was demonstrated that lesbian mothers were just as child-oriented, just as warm and responsive to their children and just as nurturing and confident as heterosexual mothers19.

Controlled studies of lesbian couples who conceived their child through DI have recently been reported. In the UK, 30 lesbian mother families were compared with 41 two-parent heterosexual families using standardized interview and questionnaire measures of the quality of parenting and the socio-emotional development of the child. Similarly, Brewaeys et al. (1997) studied 30 lesbian mother families in comparison with 68 heterosexual two-parent families in Belgium. These studies proclaim that the children’s development, thus far, does not seem to differ from that of their peers in two-parental heterosexual families in terms of gender development, implying that the presence of the father is not necessary for the development of sex-typed behavior for either boys or girls, and that the mother’s lesbian identity, in itself, does not have a direct effect on the gender role of behavior of her daughters or sons. In terms of socio-emotional development, the children appeared to be functioning well; there seemed to be no evidence of raised levels of emotional or behavioral problems among the children raised in a lesbian mother family.\textsuperscript{20}

These results show that society, either as expressed through laws or legislation, or as influenced by religious or cultural issues, maintains in the majority of cases a more compassionate and supporting role to the normal heterosexual family (Marriage or stable relationship), and hesitates to provide full access to other ‘deviated’ groups. On the other hand, findings from recent studies suggest that all of these ‘new’ aspects of family structure may matter less for children’s psychological adjustment than warm and supportive relationships with parents and a positive family environment.

It is our view that society should not seek to prevent any fertile person, whatever his marital status, from reproducing, and the written law or professional bodies should not discriminate against any group of society. Each case should be judged on its merits, leaving aside the question of whether or not infertile couples or single persons have an inalienable right to a child whatever the method or cost to society or themselves.

There should be the provision, however, that IVF in unmarried couples should not be carried out without the written consent of the man involved. Regulatory bodies in countries dealing with assisted reproduction should set laws or other statutes through which the welfare of the offspring should be followed.

3.8.3 Genetic material donation

The widespread availability of IVF and the growing acceptance of egg and sperm donation have made third party involvement in the reproductive process commonplace throughout the world. Indications for artificial donor insemination have expanded and include cases of male partner sterility, presence of severe semen abnormalities, genetic disorders, non-curable ejaculation dysfunction, or a single woman who wishes to have a biological child. It is extensively used throughout the world and thousands of infertile couples today have children who were conceived through this procedure. Oocyte donation is indicated in cases of infertile women who are suffering from gonadal failure or in cases where the ovaries do function but other problems (i.e. poor responders to ovarian stimulation, abnormal oocytes, oocyte retrieval problems, or genetic abnormalities) interfere with fertilization success. Pre-embryo donation is indicated in cases of both male and female infertility, habitual abortions and genetic diseases.

Statutes or regulations have been established regarding genetic material donation in the majority of nations reviewed. This form of treatment is strictly prohibited in Muslim countries, since according to Islam, the practice of DI is considered to be adultery and leads to confusion regarding the lines of genealogy, whose purity is of prime importance to Islam. Ovum donation and pre-embryo donation are also not permitted by Islam. Sperm donation, provided in the majority of nations reviewed, is practiced on a wider base than donation of the other two forms of genetic material. The reluctance of women to donate their oocytes in combination with the more complex technique for their retrieval may explain the delay in the establishment of oocyte donation, and the more complex ethical, legal and social issues associated with embryo donation seem to be related to the fact that it is practiced in even fewer nations Taiwan, Singapore, Thailand, India, Belgium, Finland, Greece, Russia, Spain, Ukraine, UK.
The privacy versus disclosure debate is one of the main issues of controversy in assisted reproduction with donor gametes, centered on the traditional anonymity, if not secrecy, of the procedure (Templeton, 1991). It has been argued that it is designed to protect the adults involved, either the prospective parents, especially the male partner in the case of DI (Daniels and Taylor, 1993), or even the intermediaries, donors, and practitioners (Haimes, 1993), rather than the prospective child, toward whom all parties share responsibility. Thus, debates about the anonymity of donation and the secrecy of the procedure have often overlapped, but these issues bear more than a semantic difference. In Europe, the majority of prospective parents still choose to keep the means of conception after gamete donation secret. On the other hand, legislation in some countries (Sweden) recommends that the child, upon reaching the age of 18 years, should have access to the hospital’s records to obtain information concerning the ethnic origin and genetic health of his biological father.

In the field of assisted reproduction, the absence of a genetic link between the child and a parent or both parents may endanger the relationship between the non-genetic parent and the child. Family relationships in which the truth is withheld from the child (either in cases of DI or egg donation) may be undermined, contributing to the possible appearance of identity confusion in these children. Whether or not children conceived using donated gametes should be told about their genetic origins remains one of the most disputed ethical issues raised by the practice of assisted reproduction. Whereas parents have generally not been encouraged to tell their children, there is a growing body of opinion which believes that it is not justifiable to keep such information secret, either because it is argued that children have a right to know, or because of concern about the effect of secrecy on family relationships.

From a psychological perspective, the quality of children’s relationships with their parents, and particularly how securely attached they are to their parents, is considered to be central to their emotional well-being throughout childhood and into adult life. Studies involving the development of a family, and especially from the perspective of attachment theory, concluded that it is parental responsiveness, rather than biological relatedness, that is
considered to be important for the development of secure attachment relationships.

Aspects of parent–child relationships other than security of attachment have also been shown to shape children’s development, the most widely studied of which are parental style and interrelations. As a result, in cases of children resulting from gamete donation who are not informed about their genetic origins, and who face some difficulties, problems should not be attributed to the fact that the child was not informed about the missing genetic link, but better they should be evaluated from the aspect of the negative consequences that the lack of genetic ties interfered with the quality of the relationship between the parents and the child.

Research on children conceived by gamete donation shows not only that these children are functioning well, but also that they have better relationships with their parents than children who were naturally conceived. This suggests that a strong desire for parenthood seems to be more important than genetic relatedness for fostering positive family relationships, and that conception by gamete donation does not appear to have an adverse effect on the socio-emotional development of the child.

The ‘modern’ family description seems at first glance the result of a technological imperative: a specific characteristic of ART. As such, ART is viewed by some as leading society in a worrying or inappropriate direction. Despite the complex social and ethical issues imposed by ART, it is widely accepted that ART did not create the essence of the issues. It seems that society must accept that the definition of the ‘traditional’ family has changed. Its boundaries have expanded to include alternative arrangements for childbearing and parenting that are accompanied by complex social and ethical issues. Society and practitioners of ART alike should contemplate all these issues. Families resulting from gamete donation mirror society’s norms and emulate society’s example. Claims that medical technology merely implements the technological imperative fail to recognize the enormous social evolution that has occurred.
3.8.4 Age and assisted reproduction

The progress achieved through assisted reproduction has led to the rise of another critical issue: the age limit until which these new techniques can be applied. The oldest woman to date to become pregnant by this means was 62 years old at the time of birth of the offspring. The technology used to establish a pregnancy in women beyond the natural reproductive age, that is post-menopausal women, is itself not new. IVF with donated oocytes has been used for some time to treat infertility in women who have no oocytes of their own, owing for instance to premature ovarian failure, or whose oocytes cannot be used for medical reasons. In older women the absence of oocytes caused by the natural depletion of the available stock can also be remedied by oocyte donation.

Because of the medical context in which the problem originated, the on-going debate is whether an age limit should be imposed for medical assistance. From the very beginning late motherhood is presented as a medical problem. A question that has to be settled is whether it is acceptable that a woman above a certain age bears a child with or without medical assistance. If it is irresponsible for a woman to have a child when she has reached a certain age, it is also unacceptable to assist in the deliberate initiation of such a pregnancy by means of medical technology.

There is a growing trend among modern day women to delay childbearing, so that there are a greater proportion of older women among those who attempt pregnancies. The result of this is an increase in the rate of pregnancies in older age groups. Advanced maternal age is associated with an increase in maternal and fetal morbidity and mortality. Recent advances in medicine and the advent of ovum donation (OD) programmers have enabled the introduction of oocytes into the uterus of menopausal and postmenopausal women. The uterus seems to retain its receptivity to embryo implantation beyond the age of natural menopause as long as sufficient doses of exogenous oestrogens and progesterone are administered. The success of the procedure seems not to be influenced by age. This raises several important ethical and social issues regarding the well-being of both mother and child.
There is an innate imperative to reproduce. In the era of advanced knowledge in the maintaining of a youthful habitués, a menopausal woman may not feel too old to have a child. Modern society protects the individual’s right to privacy and reproductive choice. Couples who have been deprived of their natural ability to reproduce will divert a tremendous amount of personal energy as well as resources in order to achieve conception. Women with premature ovarian failure have no options for achieving pregnancy other than OD. Denying oocyte donation to these women constitutes a denial of their reproductive choice. Life expectancy at 50 years of age is long enough to enable a healthy woman to raise a child to adulthood. Recent societal changes enable women to choose to have a career first and delay childbearing to a later age. Some women in a second marriage find themselves desirous of a child with their new partner. Others may have lost their children to cancer or war. For some women with primary infertility, the technology to solve the problem was not available until they reached menopause, by which time their only option was OD. It may appear as cruelty or unfairness to deny such a woman access to OD, her first chance of reproduction, on the grounds of her age alone.

Society does not view men and women equally when it comes to age, so that an older woman is considered unable to have a child, whereas a man would be considered able to do so. The absence of an explicit condemnation of late fatherhood cannot be fully explained by the impossibility of controlling or regulating the procreation of men. The most important element explaining this discrimination is that men and women are not seen as making the same commitment by becoming parents. The content and extent of their parental duties are filled in by their traditional gender roles, mainly set by society. The father provides protection and income for the mother and child, whereas the mother provides the day-to-day care and the experience which are the bases for the healthy personality of the child. Whereas the father’s job can be taken over by others, the mother’s presence is indispensable and irreplaceable. This unequal weight attributed to the two genders in the upbringing of a child seems to be the main factor for limiting the age at which women can procreate.
Opponents to OD in the older woman may base their arguments on the interests and welfare of the potential child, implying that individuals are less capable of coping with the physical and psychological stress of parenting. Having patterns of advanced age may cause children to endure a greater generation gap or the lack of grandparents. On the other hand, financial and professional security and a greater motivation for parenthood usually characterize older couples. Taking all this into consideration makes it a reasonable supposition that the interests of the child would be better served by being born to older parents than to never exist at all.

Reproduction is a fundamental right in a free society. From the social point of view, the main factor remains the welfare of the child. Denying access to resources and treatment to a population of women who must rely upon them to procreate essentially negates this freedom. This raises the issue of age limitation in the post-menopausal group. Some suggest that this limit should be 60 years, if considering the average life span in developing countries to be near 80 years. The writings in the media are harsh relating to this issue. Doctors who attempt OD in the older woman are likely being accused of tampering with nature and acting irresponsibly, and those who oppose may be accused of arrogance, sexism and paternalism. Recent surveys assessing community attitudes toward OD to postmenopausal women reveal only minority support for this practice.

Almost every application of new reproductive techniques has forced the medical staff to reconsider and clarify their conceptions about parenthood, procreation and family relationships. Late motherhood is no exception. Certainly, guidelines need to be established so that pregnancy can be achieved with minimum harm to the mother and child. Nevertheless, taking into consideration the mother’s and the child’s welfare, an age limit should be set. This, according to the majority of publications, varies between 50 and 55 years of age. Multifocal pregnancy reduction multifocal pregnancy reduction was initially used as a procedure to terminate selectively a fetus affected by a genetic disorder. Subsequently, its usage was extended to eliminate one or more fetuses of a multiple gestation pregnancy while allowing some fetuses to remain alive. Several reports suggest increased prenatal outcome after the use of this procedure.
During the past decade, the use of fertility drugs and assisted reproductive techniques has allowed many ‘infertile’ couples to have their own children. However, there has been a concomitant substantial rise in the number of multifetal pregnancies. The incidence of multiple gestations after ovulation induction ranges from 6–8% when clomiphene citrate is administered, to 15–53% when gonadotrophins are administered, whereas IVF and embryo transfer are associated with a 24–30% incidence of multiple pregnancies (Evans et al., 1995). In addition, multifetal gestation has been correlated with an increased frequency of maternal complications and higher prenatal morbidity and mortality.\textsuperscript{21}

From the early days of its application, multifetal pregnancy reduction has been questioned by several authors, in view of the ethical, legal and social issues arising from the procedure. There seems to be a general consensus in society that selective termination is acceptable in multiple gestations where one or more fetuses are determined to be severely abnormal or where continuation of the multiple pregnancy represents a clear threat to the life or health of the mother, and reduction of the number of fetuses may lessen the risk.

In cases where neither of these risks is present, selective termination of presumably healthy fetuses could be considered a type of abortion. It could be argued that in a society where abortion is available on demand, a multifetal pregnancy reduction procedure requires no additional rationale. However, in the debate over abortion, opinions are considerably diverse. Clinics carrying out selective termination claim that the procedure should not be considered as an abortion since the purpose of selective termination are the continuation of life and not the termination of the pregnancy, thus differentiating the procedure from abortion.

A philosophical similarity to the ‘lifeboat analogy’ is proposed as a medical justification for performing multi fetal pregnancy reduction, which is that some drowning individuals can be legitimately denied access to an overcrowded lifeboat if bringing them aboard will cause it to sink and result in the loss of additional lives. On the other hand, there are physicians who do not approve of abortion and presumably are opposed to any form of selective termination, considering it as an action taken to cause fetal death, which is a criminal offence.

If one ignores social and economic issues and concentrates entirely on those of medical relevance, the existing data indicate that multi fetal pregnancy reduction effectively reduces the risk of very early preterm delivery with its associated increase in prenatal mortality or severe morbidity. The question of how many gestations should exist intern before the option of selective termination is offered to the couple is still under debate. There seems to be no doubt today that quadruplets and higher-order pregnancies are appropriate candidates that benefit from multifetal pregnancy reduction, as both the survival rate and the mean gestational age are intensely improved. We have shown that the survival rate of quintuplets or higher-order gestations after reduction is 75.2%, whereas that of quadruplets also after reduction is 88.7%, survival rates which are much higher than those that would probably be achieved if the multiple pregnancies were allowed to continue without reduction (40% for quintuplets and 78% for quadruplets).

Recent studies suggest that the benefits of reducing triplets to twins exceed the risks involved in the procedure per se, and even more, that the outcome parameters evaluated are improved in the twin gestation after reduction as compared with triplet pregnancies managed expectantly. Reduction of twins or even higher-order pregnancies to a singleton is still controversial. As the ‘learning curve’ of the procedure is moving forward, limiting greatly the risks from the procedure, it can be assumed that reduction of multi fetal gestations to singleton may be justifiable on a clinical basis, since twin gestations have been associated with an increased risk of maternal and neonatal complications compared to singletons. However, the majority of authors still suggest considering the risk of pregnancy loss, and to set the optimum reduction number to twins, except in cases where medical reasons
indicate that a better outcome would be obtained after the reduction to a singleton bicornuate uterus, monoamniotic twins in triplet pregnancy, prior preterm delivery of singleton at 30 weeks of gestation or earlier.

Multifetal pregnancies leading to deliveries are also associated with an increased socio-economic strain on the family. Parents often face severe social and economic problems when they have to deal with the raising of two, three or more children resulting from a multiple pregnancy. Multifetal pregnancy reduction can be used to alleviate these worries by decreasing the number of fetuses carried in a multiple pregnancy. The British Medical Association recently announced, as a result of the request of a single mother to reduce her twin pregnancy to a singleton for social reasons, that no ethical precepts had been violated and that no laws were broken.

A recent study evaluating pregnancies, infants and families after multifetal pregnancy reduction showed that, although 19% of the women remained without a surviving child after the procedure, they still considered that reduction in cases of excessive multiple pregnancies is an acceptable option. There seem to be no adverse effects for the infants and the families provided the counseling before multifetal pregnancy reduction is done properly, the procedure is correctly performed, and the couple is given support before and after the procedure. Another study reported that >65% of the women involved recalled acute feelings of emotional pain, stress and fear during the reduction procedure. Mourning for the lost fetuses was reported by 70% of women, but most grieved for only 1 month. Thoughts about reduced fetuses occurred moderately frequently after the reduction but rarely at follow-up. Persistent depressive symptoms were mild, although moderately severe levels of sadness and guilt continued for many. Normal maternal bonding and achievement of parenthood goals facilitated grief resolution. Nonetheless, 93% would make the decision again. The emotional reactions of patients who miscarried differed little. The small subsample who continued to be most affected were younger, were more religious and had viewed the multifetal pregnancy on ultrasound more often.

Multifetal pregnancy reduction has been established as an efficient and safe way by society and especially the involved population (couples, physicians) to improve the outcome of multifetal pregnancies, and thus in
most nations the opportunity of fetal reduction is provided to IVF patients. Multifetal pregnancy reduction is not performed in Indonesia, Mexico, Thailand, Japan, Iran, China, Pakistan, Portugal and Hong Kong. Until advances in assisted reproductive technology eliminate the iatrogenic cause of multiple gestation, multifetal pregnancy reduction offers hope for a good outcome in an otherwise dismal situation. Preimplantation genetic diagnosis (PGD) is a very early form of prenatal diagnosis aimed at eliminating embryos carrying serious genetic diseases before implantation. It is currently being performed clinically at over 20 centers around the world. More than 160 children have already been born following PGD in over 1200 clinical cycles performed for single gene and chromosomal disorders (data obtained from the 2nd International Symposium on PGD, Chicago, and September 1997). Currently, many genetic diseases can be detected by PGD, and research work is being performed in many centers, so its application should be expanded to the detection of other diseases (Delany and Handy side, 1995).

The main objectives of PGD include an effort to offer the widest possible range of choices to women at risk of having children with genetic abnormalities; to provide reassurance and reduce the anxiety associated with reproduction, especially among women at high risk; and to enable women at high risk to continue a pregnancy by confirming the absence of certain genetic diseases. The emphasis is placed on the provision of life for new children who may otherwise never have been born.

The great advantage that enhances the acceptance of PGD by social groups is that it avoids the implantation of defected embryos, and this process of selection eliminates the need for future termination of pregnancy. Thus, PGD avoids all the debates related with the issue of abortion in society and in individual cases, reduces or prevents the suffering for the affected family, fetus and society and also protects the society’s resources. One of the goals of PGD is to enhance the couple’s ability to make informed reproductive decisions, even though sometimes such a decision is influenced by pressure applied by society.

Preimplantation gender selection, another issue of social conflict, is already practiced in some centers. Gender selection can be used in order to
avoid the almost 300 X-linked recessive diseases that are known today. Typically, healthy female carriers of a defective gene of their X chromosomes transmit the disease to their offspring: females are generally healthy (50% being carriers like their mothers), but half of the boys will be affected with the disease. In genetic conditions such as Duchenne muscular dystrophy or haemophilia, which affect only males, while the exact gene defect may not be known, examination of the DNA of the biopsied cell can determine the sex of the embryo and thus allow only female embryos to be replaced. Family balancing through PGD remains an issue of debate. The subject raises such concerns and emotions that people generally have very polarized views: those wanting complete freedom to choose however they please the sex of their child and those that demand the total prohibition of sex selection for non-medical purposes. The objection to sex selection arises from the examples of countries such as China, Korea and the Middle East, in which boys are highly prized for economic, hereditary or religious/ cultural reasons. The financial hardship of raising girls in some of these countries has led to the abandonment of female children and the widespread use of abortion and infanticide in favor of boys, and this would ultimately alter the established sex ratio. Family balancing as a procedure strikes an equilibrium between too much control and too much freedom.

The development of PGD has also been related to a future possible use for the detection of polygenic disorders. The clarification of the multiple genetic factors responsible for a large part of the susceptibility to diseases such as diabetes mellitus, coronary heart disease and malignancies will greatly affect the moral problems. The genetic information obtained by PGD may in the future affect specific individuals and family members. There are several late-onset genes, perhaps even genes predisposing to cancer, where diagnosis could result in the carrier being ‘typed’ socially for the affliction by employers, insurance companies and even by potential marriage partners. A positive diagnosis of, for example, the dominant gene for Huntington’s chorea in a fetus implies that one of the parents or a child is affected, and must face the personal consequences of this diagnosis. All of these possibilities pose problems of confidentiality that could conflict with the duty of disclosure. The provision of information should be limited to the person or persons concerned,
as disclosure of information to certain parties may not be used for the benefit of the individual concerned. This scenario enhances the need for confidentiality to be of primary importance in PGD, but also increases the desire for introducing alternative strategies, including even gene correction, for improvement of as many human individuals as possible.  

The low pregnancy rate achieved (~20%) and the high cost of the procedure seem to be the limiting factors which delay its routine application, especially in societies with lack of resources. Nevertheless, in considering its great advantages, the vast majority of the nations reported in our survey have already adopted this technique.

**3.8.5 Surrogacy**

Few would doubt that the important aspects of who we are, what we know, believe or feel and how we function in our societies have little to do with the exact nature of our genetic stock and still less to do with the uterine environment in which we grew as embryo and fetus and most to do with the care, guidance and general experience we received during our rearing. This perception leaves little doubt about the prime value of parental nurturing. However, as important as this prime component of parenting is, few societies have not had qualms or become involved in moral debate when needs dictate re sorting to a ‘surrogate’ for these functions. Wet-nurses, nannies, childminders and boarding schools are all surrogates for parental functions that we must consider as being inherently more valuable to the development of the individual than the initial uterine or even genetic origins. Nevertheless, surrogacy, though already performed, is still viewed by many with suspicion.

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Analysis of the ethics of any action of an individual or society will, usually, take into consideration three interrelated sets of criteria. Firstly, there are the religious and philosophical traditions of that society. These in turn influence the enacted and bench law by which the society is governed. Both forms of law, in a democratic society at least, are also influenced to a greater or lesser extent by the third factor, public opinion. In turn, public opinion may be guided by what is or is not legal and by what is perceived as being coincident with a prevailing moral tradition. None of these are fixed scales of values and even the interpretation of historical ‘truths’ may vary with attitudes and evolution of opinion. Public opinion differs from the law and historical precedence in that, when faced with a new situation outside the exact confines of existing thought, it is more protean and malleable. Assessment of informed opinion and its processing to format law is thus against a background of shifting public attitude.

The extent to which surrogacy arrangements may provoke less adverse public opinion and become more socially acceptable remains an issue of dispute among legislators and other interested political and legal decision-making bodies. The general trend seems to be to view arrangements, certainly of the ‘compassionate family surrogacy’ variety with increasing favor. Exceptions to the already announced good primary results still occur, and adverse comment arises whenever there are additional complexities in an arrangement.

Cases in which the recipient couple refuses to accept the newborn because of a congenital malformation or chromosomal aberration have already been published, confusing and complicating even more the appropriate legal approach to the issue of surrogacy. Surrogate mothers who are still in conflict over access to their child are also known. It is tempting to suggest that the risk of such problems and the adverse comment they attract would, potentially, be reduced with greater counseling and assessment of the intended surrogacy. Provisions for this were included in the Human Fertilization and Embryology Act in 1991 in the UK and, although not guaranteed to avoid problems, as these cases demonstrate, it is obvious that such support is one of the advantages or ‘inducements’ associated with a non prohibitory state regulatory system.
It is apparent that the parties to a surrogacy arrangement, not least the children, will be in an exceptional position with regard to the rest of society. However commonplace the use of assisted conception, or however officially acceptable surrogacy becomes, conventional family structures will be vastly more common. The problems of being different or having an ‘abnormal’ family structure have long been recognized. An exact evaluation of the needs of this small group of people has yet to be evaluated, but it is apparent that many of the problems potentially associated with surrogacy lie within the field of the professional social worker. Pretreatment assessment and counseling, usually in the treatment centers, but also during and after the initiation of the procedure, may enable the collaborating parties to assess and manage their social and psychological conflicts in a more efficient way.

One major social aspect associated with surrogacy, which may be limiting its wide application, involves the fear of financial exploitation of the suffering couple, i.e. commercializing surrogacy. As a safeguard against this risk, it is proposed that the support needed to minimize risk to all parties might best be provided by the state regulation of surrogacy. In 1991 the Ministries of Health and of Justice in Israel nominated a public committee to inspect the social, ethical, religious and legal aspects of assisted reproduction. According to the committee’s recommendations, the Knesset passed a law in 1996 concerning the practice of surrogacy in Israel. The law became possible only after the committee managed to satisfy the Jewish Orthodox (major religious group) establishment requirements. As a result, only full surrogacy is allowed, and the surrogate mother has to be single or divorced. Social aspects of the law are that commercial surrogacy is forbidden, and the surrogate mother has to be anonymous and not a relative of either party. The new surrogacy law sets principles

To protect the legal rights of the surrogate mother and to establish the legal position of the offspring.

The practice of surrogacy is limited in a few countries (i.e. Korea, Thailand, Israel, UK and Holland), which reveals the difficulty of the international community in dealing with this assisted method of reproduction. In Brazil and Hungary, it is only allowed only if a relative is willing to undergo the procedure. The rest of the nations studied either prohibit (IVF
law) or simply do not use surrogacy, mainly as a result of Cultural or religious attitudes.

### 3.11.6 Cloning

Cloning is a biological mechanism of parthenogenesis reproduction by which one or more genetically identical cells, organisms, or plants are derived from a single parent. Although reproduction by cloning is widely used in plants and in the biological industry, the achievement of Wilmut et al. (1997), who cloned a mammary cell from an adult sheep and consequently developed and grew a sheep embryo to term, set this method of reproduction to medical and social criticisms, as it raised the possibility of replicating humans through asexual means. Despite the fact that through cloning several clinical problems might be resolved (embryogenesis, carcinogenesis, the use of embryonic tissue for transplantation), its use as a reproductive method in humans raises serious legal, religious and social problems.

Medical indications for which nuclear cloning and transfer may be potentially applied include cases of women with pre- mature ovarian failure who do not wish to use donated oocytes or are not able to do so due to low oocyte availability; males or females with dominant genetic disease or couples carrying a recessive genetic disease; single women not interested in using donor spermatozoa; improvement of IVF results, especially in low responders who produce only a small amount of oocytes/embryos; sex pre selection; reduction of the incidence of multiple pregnancies and, hence, the number of pre- mature neonates and reduction of the risk for ovarian hyper stimulation syndrome in women with polycystic ovaries by transferring only one embryo each cycle; use of cloned embryos as a part or source for organ transplantation; study of cell growth and development in order to better understand embryogenesis, carcinogenesis, and senescence; and ovulation induction and oocyte retrieval, which need to be performed only once, and the cloned embryos transferred at a different time.

Nevertheless, cloning by nuclear transfer, as asexual reproduction, can lead to detrimental biological effects and evolutionary consequences on the human genome, as well as have ethical, legal and social implications. In the case of a successful human cloning, an indefinite cell line will be created, leading to the loss of the selective advantage of the organism’s interaction
with its environment, which exists naturally. Several generations of cloning by nuclear transfer increase the risk of an accumulation of deleterious recessive genes and the possibility of mutations introduced to the human genetic pool, which may lead to an increase in various diseases and mal-formations. For example, today the genes for sickle-cell anemia and cystic fibrosis occur at a high frequency among the population, but because of their heterozygous forms many mutations exist, creating a large variability in the degree of the disease. Bypassing such evolutionary processes by missing the natural pathways may lead to the creation of organisms with morbid or lethal genes. Such genetic errors would also be reproduced with the germ-line, thereby ensuring transmission to progeny. This is the main biological limitation of nuclear cloning in humans and therefore is unacceptable in clinical practice.

Human cloning by embryo splitting shares certain advantages over nuclear transfer, as the cloned embryos are the products of both maternal and paternal gametes. This eliminates the risk of creating a super human being or of genetic alterations, and also makes biologically impossible the selection of elite individuals. During this micro manipulative procedure the risk of embryo damage and destruction rises. The increasing experiences with its application, as well as, the clinical advantage of the large number of ‘back-up’ embryos limit the importance of these complications. One possible risk for society arising by the use of this method includes the birth of identical embryos several years apart and also the creation of an unlimited number of clones. Supporters suggest that limiting the number of cloned embryos to two and the period of transfer of embryos to 5 years can control this. After the successful delivery of children, the remaining stored embryos should be thawed. Commercializing this process should be strictly prohibited.

The potential of cloning by embryo splitting for reducing clinical risks and costs as well as enhancing success rates for infertile couples who desire children is a challenge. Ovulation induction and oocyte retrieval need to be performed only once and the cloned embryos can be transferred at different time periods.
Such a management would greatly reduce IVF costs and complications.\textsuperscript{23}

In every society, religions influence public opinion greatly, and as with every aspect of reproduction, they have also set their views about cloning. The Roman Catholic Church prohibits it, as it is contrary to the moral law and opposes the dignity both of human procreation and of conjugal union. Islam rejects it also, as it separates the act of reproduction from human relationship and marriage. In Buddhism, cloning may raise the problem of inheriting the Karma, which is in conflict with reincarnation. The Jewish view is that it may be applied only in cases where there is a clear therapeutic indication.

Animal cloning is already supported by international ethical guidelines such as those of the International Federation of Gynecologists and Obstetricians (FIGO), World Health Organization, American Congress and European Council. By retrieving results from our survey, we observed that cloning is not practiced in any country, and that at present several countries, for example the UK, Denmark, Germany, Belgium, the Netherlands and others, have set legislation that prohibits its application. In other countries it is forbidden by regulations. The American Fertility Society is also against the encouragement of this procedure.

\textbf{3.8.7 Informed consent}

The obligation to obtain the informed consent of a woman before any medical intervention is undertaken derives from respect for her fundamental human rights. However, informed consent for treatment is an ethical requirement often misunderstood or not fully appreciated by physicians.

The purpose of obtaining informed consent is to ensure that patients know what doctors propose to do and freely grant their permission. This may be difficult to achieve in cases where women have little education, or where very unequal power relationships in a society mitigate against women’s self-determination. Nevertheless, these difficulties do not absolve physicians caring for women from pursuing fulfillment of the required criteria for informed consent.

Although the purpose of informed consent and the standards by which it is to be employed are the same in all areas of medical practice, special problems arise in assisted reproduction since it applies to some rather unique procedures that are not practiced everywhere but have nevertheless become well established in some parts of the world (i.e. cryopreservation, oocyte donation). These situations call for disclosures and discussions in the informed consent process that go beyond the normal ethical requirements in clinical practice. Assisted reproduction requires no more and no less than any other medical treatment by way of disclosure of the purpose of intervention, the procedures to be done, the risks, benefits and alternatives. At the same time, evidence exists that there have been fewer adherences to appropriate disclosure of information by practitioners of assisted reproduction than is ethically required, such as the failure to provide accurate and understandable information about success rates to couples seeking IVF.

The preparation of an informed consent is required before every procedure in every country studied. In some nations, law regulates the necessity of obtaining the informed consent and in others it is set according to their own ethical standards. There seems to be a mutual agreement in society between the collaborating parties about the necessity of the informed consent. Medical record keeping: central reporting there is a consensus among medical professionals that keeping accurate medical records is essential. Record keeping has always been an important part of both medical practice and quality assurance. However, it raises particularly difficult ethical and legal questions with regard to medical confidentiality and family privacy. The right to privacy is a fundamental human right. In the context of medical information that is personal and intimate, the concern for respect of privacy of the participants is paramount. Truth telling and candidness are values to be respected in the communication between the physician and the patient, and in the case of gamete and pre-embryo donation it may be considered in the relationship between the physician, the donor and the recipient. Candidness with the family after the birth of a child as to the method of his conception or later as to the identity of the donor is of a different nature. Society’s (state) intervention in the privacy and intimacy of the familial relationship, in order to force a greater openness, could be an invasion of the freedom of procreation.
decision making that extends beyond legitimate concern for the quality of services and for the proper follow-up of the offspring.

Legislation and regulations in different countries in which assisted reproduction, and especially gamete and pre-embryo donation, is practiced, consider the nature of the information to be maintained about the parties involved in the programmed. A distinction has been made between non-identifying and identifying information. The non-identifying information includes a detailed description of physical characteristics and ethnic origin, medical history and background and social characteristics like education and profession. When identifying information is required, it will include full names, addresses, date and place of birth, and identity of the parties involved. The responsibility for collection of information should lie with the physician performing each stage of the donation procedure.

There are different opinions regarding the storage of information. Where information should be kept? Who should have access to it? What kind of information should be released to the parties involved in the programmed? In most countries where genetic material donation is practiced, the records of identifying and non-identifying information are kept and maintained by the physicians or medical institutions according to the regulations of the particular country. In some countries, it has been suggested that the identifying information of the parties should be stored in a Central Government Registry. In South Africa, for example, a National Data Bank exists. The advantages of central state registry include the fact that the information can be safely kept for long periods, that there is a protected central control on release of information, update and access to the information can be more feasible, and that a central computerized national register may provide control over the number of donations made by each donor. It is of importance to restrict to a minimum the personnel who have access to this information.

Identifying material may be released according to the legislation in a specific country. In France and Spain, for example, sperm donation is anonymous, while in others, such as Germany and Sweden, the law insists on the child’s right to know the identity of its biological father. Our survey reveals also that in the large majority of the nations involved, results from the
application of IVF and other ART are reported every certain period of time (usually every year) to a central registry. IVF and other ART: financial and emotional stress The resulting competition for available resources between high-technology medicine on the one hand and routine primary health services on the other has created severe shortages and stresses within the health care system. In this situation, which is by no means unique to a particular country, there is an obvious need to assess the public sector costs of the new high-technology medical procedures, including IVF and related technologies.

IVF and other ART are funded differently in various countries. Many private insurance companies do not regard serious infertility treatment as being genuine medical care. In the USA patients are generally able to claim treatment, at least up to a limited number of treatment cycles, on private medical insurance; there is no federal medical cover available for IVF, which reflects the view that infertility is not a disease. IVF was one of the few procedures explicitly excluded from the standard benefit package in the Clinton administration’s Health Security Plan (1993). In Belgium, Holland, Denmark, France, Spain, Norway, Israel and Italy there is limited or full state insurance for IVF and other ART. In Canada, the Royal Commission recommended that it is unethical to offer as services unproven procedures such as IVF and other ART and to devote public resources to them.

In France, the legal context of the different treatment methods is quite nebulous, requiring complicated legal procedures, sometimes with degrading aspects such as a judicial inquiry prior to any embryo donation. Nevertheless, the French may be considered to be lucky, if one considers that infertile couples in the USA almost always have to pay for infertility treatment involving ART themselves, and the average cost ranges from $6000 to $10 000. In Great Britain, infertility treatment is available in most gynecology departments, but waiting lists for treatment within the context of the National Health Service are often prohibitive. As a result, more than 75% are treated in private clinics, if they can afford it (Neumann, 1994).

The wide range in costs and prices in various countries is on one hand due to different ways of calculation and on the other because of differences in wages, equipment and prices among these countries. It has recently been published that for women who did not pursue a second IVF cycle after the first
failed, the major reason was financial infertility, its evaluation, and its treatment have also been associated with significant emotional stress for the couple involved. There have been reports that anxiety related to infertility not only is a problem in itself but also may impact on the success rates of IVF.

Although some people experience early success in the treatment process, with relatively few and non-intrusive interventions being needed, other couples may experience years of treatment with many interventions, some of which are complex, invasive and expensive. Treatment costs and number of tests and treatments received have correlated highly with the stress associated with fertility problems. The difficulties that the time necessary for treatment imposes on the lives of infertile couples, such as time off work and travel to attend appointments and the stress created by continually focusing on the infertility treatment and the fear of failure, have also been described.

Despite these difficulties, infertile couples studied were found to be generally satisfied with their treatment, which was mainly a result of the technical skills and emotional support provided by the therapeutic team involved.

The stress associated with infertility may be lowered if the physicians and their staff pay particular attention to their patients’ emotional needs, to their patients’ understanding of procedures explained to them, to discussing adoption with their patients, to involving men more in the infertility treatment, and to assisting women to have more control over their course of treatment. The introduction of a psychologist, psychiatrist or social worker into the therapeutic team may help to achieve these goals.

These problems encountered in the use of IVF and other ART have led to the formation of several organizations, which aim to support their members by helping them to share information and by promoting the needs and concerns of infertile people in the medical, scientific and political arenas of the international community. One of these organizations, the International Federation of Infertility Patients Association, (IFIPA), aims to achieve open access to infertility treatments for all couples around the world. Application will continue to have implications with regard to many social issues and disputes. Legislation or other type of regulations will be installed by many countries for the control of any undesired exploitation of the patient. Society,
in every case, should weigh the benefits against the risks and set the limits for
the provision of these very useful treatments.

3.9 Conclusion

IVF and other ART, since their evolution and implementation, have
raised complex ethical, legal and social issues. No other medical advent has
ever caused so many conflicts among the scientists, the public and society as a
whole. Despite all the obstacles, the medical world has succeeded in
establishing this new procedure and even more to further increase its
possibilities and range of treatment in many aspects.

While surrogacy arrangements can result in psychological difficulties
for the both members of the commissioning couple, overall most parents
report that while the decision to use a surrogate had been difficult that they
had experienced little anxiety or other psychological difficulties during or after
the pregnancy.

Similarly, while some surrogates and their partners experienced
difficulties during the pregnancy and after handing over the child, for most the
experience appears to be positive and most difficulties dissipate within a year
after giving up the baby.

Commissioning couples and surrogates generally report positive
relationships with each other during and after the birth and transfer of the
baby. They also report maintaining contact and the intention to maintain
contact throughout the child’s life.

Yet it’s important to keep in mind that there are those who do have
psychological difficulties and it is important that there is a method in place
during evaluations conducted throughout the process to assess such factors. If
problems are discovered, encouraging supportive counseling is a crucial step
in helping all participants perceive the surrogacy process as a positive
experience.

Surrogacy fails to respect the dignity or primacy of the welfare of the
child. It involves the subordination of the welfare the child and surrogate in
favor of the commissioning parents desires to have a child. As Rosalie Ber states:

The question of whether the suffering of a childless woman is greater than that of the gestational surrogate, who ‘abandons’ her baby, is ‘solved’ when the surrogate mother is depersonalized, and looked upon solely as a ‘womb for rent’.

Furthermore, surrogacy ignores the fact that foetal/early infant development is a critical determinant of a child’s welfare, whereby the biological and psychological bond between the surrogate and her child is of crucial significance for this development. Moreover, it is likely that the various specific failings in the Statutes Amendments (Surrogacy) Bill 2006 will lead to further complications causing additional distress and harm for all parties involved, along with the litigation that is likely to result.