Effects and outcomes of third-party reproduction: parents

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Third-party reproduction has introduced a host of changing family constellations. Research has shown that children conceived through third-party reproduction are doing well psychologically and developmentally, but what about their parents? How have they coped with the transition to third-party reproduction? Has the experience impacted their marital stability or the quality of their parenting? This review will address parents of children conceived through oocyte donation, parents of children conceived through gestational surrogacy, and gay male parents of children conceived through oocyte donation and gestational surrogacy. (Fertil Steril® 2015;104:520–4. ©2015 by American Society for Reproductive Medicine.)

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Wikipedia defines third-party reproduction as "any human reproduction in which DNA or gestation is provided by a third party or donor other than the two parents who will be raising the child" (1). It is true that treatment with sperm donation has been used for over a century, but it was the innovation of IVF leading to such advances as oocyte donation (OD), gestational surrogacy, and embryo donation that truly brought the term to the forefront. In any case, the definition is misleading when it emphasizes that it is "two parents" rearing offspring conceived through the success of this technology because single women and, of late, single men increasingly have opted to become parents through third-party reproduction. In fact, assisted reproduction with donor gametes and/or gestational surrogacy has introduced a host of changing family constellations.

Third-party outcomes are often successful and can bring great joy to patients who otherwise may not have achieved parenthood. The effects, however, may sometimes be controversial both for intended parents and programs alike. For example, the phenomenon of delayed parenthood has resulted in growing numbers of postmenopausal women seeking pregnancy with donor eggs, leaving fertility programs to struggle with the question, "How old is too old?" Gestational surrogacy has made it possible for intended parents to use their gametes for pregnancy in a surrogate when the intended mother is unable to gestate, but the treatment is expensive and illegal in many places and that has led to another growing phenomenon, "reproductive tourism" (2). Same-sex couples increasingly seek parenthood through assisted reproduction, and while lesbians are routinely welcomed by fertility centers, this is not always the case for gay male couples, who may be stigmatized or refused treatment (3).

Parenthood through third-party reproduction involves complex decision making, frequent emotionally charged dilemmas, and potential psychological risk. For this reason, in guidelines on gamete and embryo donation and on gestational surrogacy, the American Society for Reproductive Medicine (ASRM) recommends a psychological consultation with a qualified mental health professional for participants entering these programs, and guidelines from the European Society for Human Reproduction and Embryology state that "implications counseling is mandatory at the time of assessment and that the counseling should focus on the best interest of the child" (4–6). While the consultation is primarily informative, it is evaluative as well. It is informative because patient preparation for the complex decisions and potential hurdles of the process is essential and evaluative because it provides the clinician an opportunity to assess the patient(s)' psychological health and stability and determines how well they are likely to be able to tolerate the stress and

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demands of third-party reproduction. For those patients who present as couples, it is also an opportunity to determine whether they share a committed relationship and are in agreement about moving forward with the treatment. The meeting is also useful in establishing a relationship that provides an avenue for further discussion and emotional support that may be needed during and after the treatment process. Mental health professionals specializing in fertility counseling can also provide long-term follow-up to parents hoping for help in talking to their children about the nature of their conception.

Parents through Third-party Reproduction: Who are They and How are They Doing?

Studies have shown that children conceived through third-party reproduction are doing well psychologically and developmentally and do not appear to be adversely affected by the lack of a genetic or gestational link to the intended parent (7, 8). But what do we know about the psychological well-being of their parents? How have they coped with the transition to parenthood through third-party reproduction? Has the experience impacted their marital stability or their quality of parenting? The ever-changing family constellations through third-party reproduction are myriad in scope, but this article will focus on parents of children conceived through OD, parents of children conceived through gestational surrogacy, and gay male parents of children conceived through OD and gestational surrogacy.

Parents of Children Conceived with Donor Oocytes

In 1984, researchers in Australia reported that the first recipient of a successful OD through IVF was a 25-year-old woman with premature ovarian failure (9). Since that time the profiles of donor egg recipients have changed considerably as the treatment has expanded to include women with genetically heritable diseases, women who have lost ovarian function owing to cancer treatment, and, increasingly, women of advanced maternal age. Because eggs produced by older women are less likely to result in an embryo that leads to a successful pregnancy outcome, older women are more likely to use donor eggs. The Centers for Disease Control described a sharp increase in the use of donor oocytes eggs in women over 40 participating in assisted reproductive technology (ART) cycles in 2012. In women over 48, 87% of ART cycles were with donor oocytes (10).

The success of the treatment has led to growing numbers of parents with children conceived through OD. However, the road to success can be an arduous journey, as is well illustrated by Hershberger. In a series of in-depth interviews with women who became pregnant through OD, she concluded that the subjects' experience is best described in four stages. The first is the acknowledgement of the desire for motherhood. Second is accepting and coming to terms with donor oocytes as a way to achieve motherhood. Third is navigating an intense period of decision making, and the final stage is living with the lasting legacy of achieving motherhood through OD (11).

Coming to terms with the need for OD is easier for some couples than others, but the process almost always involves some emotional loss—loss of a genetic connection to the child, loss of the continuation of the family bloodline, and, for many women, the fear that they "won't see themselves in the baby" (usually a fear that they will not have a normal bond with the resulting infant) (12). For some who may have had years of unsuccessful infertility treatment, hearing that they need to consider OD is not unexpected. For others that news is difficult to hear, and it is not uncommon for them to take a lengthy hiatus from the treatment to give OD a great deal of consideration. Coming to terms with this decision may be facilitated by consultation with a fertility counselor. Even when patients are ready to navigate the "intense period of decision making," they may find that process overwhelming and seek psychological support. For example, if using an anonymous donor, they must decide how much information they want about that donor, how much information they will have access to about the donor, and what donor characteristics are most important to them. If they are using a known donor such as a sister or a friend, it is important to explore the expectations of all parties as to the potential impact of the donation on the parents and the potential child's eventual relationship to the donor.

For both anonymous and direct donation, the issues of disclosure, considering whom to tell or not tell and especially what (and when) to tell their potential offspring about the nature of the conception, are all part of the challenging decisions OD intended parents struggle with and ultimately have to decide. In the past 20 years there has been a trend moving toward more openness in disclosure, and increasingly, some intended parents seek "identity-release" anonymous donors, that is, donors who are willing to meet with the couple before donation or after the child is born or with the child when he or she turns 18. This has long been a practice in many sperm donor agencies, and more recently some oocyte donor agencies and fertility programs in the United States and other countries offer donors who are willing to be identified (13).

Family resemblance, health, intelligence, and personality are important to intended parents choosing a donor (12, 14, 15). It appears that the intended mother's resemblance to the donor is often more important to her than it is to the intended father (12). Disclosure to offspring or intending to disclose seems more prevalent in OD than in sperm donation (16, 17). In a study of parental attitudes regarding disclosure to others such as family and friends and their plans for disclosure to offspring, researchers studied 62 sets of OD parents whose children were conceived in five geographically diverse treatment centers across the United States. Regarding disclosure to offspring, 59% had told or planned to tell their children about the nature of their conception. Regarding disclosure to others, more women than men had told others, but 60% of both men and women regretted that decision because they felt they had subsequently lost control of what was in fact their child's story and feared that the child would learn of it inadvertently from others before hearing it from his or her parents (12). The average age of the children in that study was 2.89 years, but in a longitudinal study from the United