New Frontiers in Family Building:
The Role of Psychology in Medically Assisted Reproduction

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DISCLOSURES

Nothing to disclose.
LEARNING OBJECTIVES

AT THE CONCLUSION OF THIS PRESENTATION, PARTICIPANTS SHOULD BE ABLE TO...

1. Identify a model for integrating the practice of psychology into the medical management of infertility.

2. Discuss the types of third party reproduction in which psychological counseling is strongly suggested and discuss reasons why psychological consultation might produce healthier outcomes.

OVERVIEW

1. Emotional Aspects of Infertility.
2. A brief introduction to medical procedures.
3. A model for integrating psychology into medical management of infertility.
4. Third party reproduction and the role of psychology.
5. Special needs of LGBT and Single-parent families.
6. The ethical Wild West of Infertility practice and Psychology’s role as ethical gatekeeper.
AWARENESS OF THE PAIN OF INFERTILITY IS AS ANCIENT AS HUMANITY ITSELF. IT TRANSCENDS TIME AND CULTURE.
Sarah and Abraham: “Despite God’s promise, years went by. Still Abram’s wife, Sarai, remained childless.” (Genesis 16:1).

Rebecca and Isaac: Isaac, the son of Abraham and Sarah, “prayed to the Eternal One on behalf of his wife because she wasn’t becoming pregnant.” (Genesis 25:21)

Rachel and Jacob: Jacob married sisters Leah and Rachel. Leah had six sons and one daughter but Rachel did not conceive. Rachel complained often to her husband about her infertility, saying, “I will just die if you don’t give me children!” (Genesis 30:1)
MORE BIBLICAL STORIES

• **Manoah’s Wife, Mother of Samson:** “Manoah, from the tribe of Dan, was married to a wife who could bear him no children.” (Judges 13:2)

• **Hannah and Elkanah:** Elkanah had 2 wives—Penina had children but Hannah did not—”the Lord had closed her womb...So that she wept and would not eat.” (1 Samuel 1:1-7) She did conceive and became the mother of Samuel.

• **Michal, first wife of King David.** “And Michal, daughter of Saul, had no children to the day of her death.” (Samuel 6:23)
HAGAR—A GESTATIONAL CARRIER?
EMOTIONAL IMPACT OF INFERTILITY

VIDEO...

What If?
GRIEF

A diagnosis of infertility elicits similar intensity of emotional distress as a diagnosis of HIV or cancer.
GRIEF

- Private sense of loss—Difficult for others to share or know.
- Intangible loss—not a person, but a hope, a dream.
- Loss of Identity as mother, father, parent, family. Loss of a role they have always thought they would play.
- If religious, may feel abandoned by God or punished by God.
- May include grief for miscarriage, stillborn, failed procedures.
RECURRENT PREGNANCY LOSS

- Compounds grief.
- Typically accompanied by GUILT, SELF-BLAME.
- May include feelings of SHAME.
- May trigger trauma reaction/fear of future procedures.
The English language lacks the words to mourn an absence. For the loss of a parent, grandparent, spouse, child or friend, we have all manner of words and phrases, some helpful some not. Still we are conditioned to say something, even if it is only “I’m sorry for your loss.” But for an absence, for someone who was never there at all, we are wordless to capture that particular emptiness. For those who deeply want children and are denied them, those missing babies hover like silent ephemeral shadows over their lives. Who can describe the feel of a tiny hand that is never held?

-Laura Bush (2010)
SELF-ESTEEM

• Feels like a failure—particularly acute in Type A, high-achieving women. Also in women who are not career-oriented and see their mission in life as being a mother.

• Body has betrayed her—feels damaged.

• Sense of damage compounded by multiple diagnoses.

• Guilt and insecurity about letting spouse down.
Loss of Control

- Can’t have the one thing she/he really wants.
- Also compounded in Type A woman who has controlled lifestyle—eats right, exercises, refrains from harmful substances.
- Multiple medical appointments, medications, procedures—Fertility treatment takes over everyday life and psyche.
- Hamster on a wheel.
PSYCHOLOGICAL DISORDERS

- Anxiety Disorders
- Depression
- Complicated Bereavement
- PTSD
- Pre-Morbid Personality Disorders
MEN AND WOMEN EXPERIENCE INFERTILITY DIFFERENTLY

- Level of emotional distress may be dependent on male factor vs. female factor. In lesbian couples, this depends on who is trying to conceive.

- Research shows that women experience significantly more emotional distress than men. Even when male factor is involved, women experience significant distress.

- Pregnancy for women is tangible & physical from the start. For men it is abstract until second trimester.
For women, pregnancy loss is also tangible and physical.

- Loss of pregnancy symptoms.
- Physical expulsion of embryo/fetus.
- Surgical procedure (D & C) may be necessary.
MARS AND VENUS

There is a Mars versus Venus disconnect in how men and women react to infertility and this can put a strain on the marital relationship.

- Women want to emote and have male partner validate them, feel with them, physically comfort them.

- Men often feel helpless in the face of infertility struggle and want to “fix” it. Often resort to problem-solving or becoming absorbed in work, hobbies. May have delayed reaction.
HARBORING GUILT

- If the infertility is unilateral, whomever has the diagnosis tends to feel self-incrimination and guilt about creating obstacles for the partner.

  “If he married someone else, he would be able to have a family.”

  “If she had a different partner, she would not have to subject herself to shots, medication, surgical procedures.”

- **Rarely**, the healthy partner blames the other.
SEX BECOMES PRESSURE

When a couple is using timed intercourse with or without medication, they are asked to have intercourse at certain times of the month, with a certain frequency and without commercial lubrication.

- Sex loses its function as an expression of love and its spontaneity. Couple already under stress can lose one arena of connection and fun.
- Performance issues are magnified.
- Pre-morbid sexual dysfunction becomes greater source of problems.
STRAINED RELATIONSHIPS

• Within the family there may be pressure for grandchildren, especially in traditional cultures.

• Family celebrations are often centered on young children. Pregnancy announcements of relatives may occur when family is all together.

• Family members may hover for good news. After a while, patients keep information to themselves so that they don’t disappoint or have to share bad news. This leaves them feeling isolated and unsupported.

• Family dynamics—sibling rivalry, resentments, poor communication—magnify bad feelings.
STRAINED RELATIONSHIPS

Many women in 20’s and 30’s are surrounded by a social group of friends in the midst of family-building.

- Baby showers are agony.
- Feel bruised by others complaining of pregnancy symptoms, children misbehaving or expense of baby paraphernalia.
- Feel isolated from support system when it revolves around family/babies.
- Friends don’t “get it.” Make insensitive comments.
FINANCIAL STRAIN

Only 15 states in the U.S. mandate insurance coverage for infertility:

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“....and this is our cheapest fertility treatment.”
COSTS OF TREATMENT

• Most treatment is paid for out-of-pocket.

• The American Society of Reproductive Medicine (ASRM) lists the average price of an in vitro fertilization (IVF) cycle in the U.S. to be $12,400. Average cost of an IUI cycle is $865.

• Additional fees for tests, surgery, donor sperm, donor eggs, gestational carriers, genetic testing of embryos, additional transfers, storage of embryos and medications, which can run into the $1000 range.
PATIENTS ARE UNDER FINANCIAL STRESS

- An added level of psychological strain and potential marital strain.
- Need for cost-conscious decision-making.
- Every treatment failure is a waste of precious financial resources.
- May be a set up for risky pregnancies.
- May make psychological intervention unavailable.
- If insurance coverage available, don’t know when to stop.
SUMMARY

Fertility Patients experience significant emotional distress which includes:

- Profound grief
- Self-esteem challenges
- Loss of control
- Marital strain
- Loss of social support and
- Financial strain
SUMMARY

- Pre-existing psychological conditions, marital issues and family issues exacerbate this distress.

- Pre-existing trauma, anxiety disorders and depression are re-triggered.

- Psychological intervention can alleviate some of the suffering and facilitate medical treatment.
A QUICK MEDICAL PRIMER

- World Health Organization (WHO Revised Glossary on Assisted Reproductive Technology)… “A disease of the reproductive system defined by the failure to achieve a clinical pregnancy after 12 months or more of regular unprotected sexual intercourse.”

- Treatment is advised after 6 months for women between 35 and 40 and after 3 months for women over 40. ASRM

- Mitigating factors: AGE, MEDICAL HISTORY, PHYSICAL FINDINGS

- WHO (December 2012) estimates that 25% of couples in developing countries experience some infertility.
CONTEXT AND INFERTILITY

- Infertility is defined by social role—Infertility is not significant unless (future) parenthood plays an important role in one’s identity and/or one desires to be a parent.

- Infertility is a condition of the couple, no matter whom has a diagnosed condition. In LGBT persons or single persons, treatment occurs where no “medical condition” exists.

Greil, Slauson-Blevins, and McQuillan (2010)
THE ABC’s OF ART

• **ART**: Assisted Reproductive Technology or **MAR**: Medically Assisted Reproduction
  Infertility treatment that may include testing, medication, surgery or third party reproduction.

• **Third party reproduction**: The use of sperm donors, egg donors, embryo donors or gestational carriers.

• **RE or REI**: Reproductive Endocrinologist or fertility doctor
THE ABC’s OF ART

- **IUI**: Intrauterine Insemination or **AI**: Artificial Insemination—the mechanical insertion of a semen sample into the uterus at the time of ovulation. Medication may be used to stimulate ovaries to produce additional mature egg cell.

- **DI**: Donor Insemination—the use of an anonymous or known sperm donor.

- **DE**: Egg donation—the use of an anonymous or known egg donor.
IN VITRO FERTILIZATION (IVF)

• Suppress regular ovarian function with oral contraceptives or other medications.

• Stimulate ovaries to maximize production of mature egg cells. 8-12 days of injections.

• Trigger shot of hCG and surgical egg retrieval.

• Create pre-embryos *in vitro* by adding semen sample.

• Transfer cleaved embryo at 3 days or blastocyst at 5 or 6 days.
MORE ABC’s OF ART

- **OHSS**: Ovarian Hyperstimulation Syndrome—one potential risk of injectable medications prior to egg retrieval in IVF. Fluid accumulates in peritoneal, pleural or pericardial cavities. 1:300 OHSS patients need hospitalization.

- **ICSI**: Intra-cytoplasmic sperm injection—a single sperm is injected directly into an egg in order to create pre-embryo.

- **PGS or PGD**: Pre-implantation Genetic Screening or Diagnostic. Testing pre-embryos for chromosomal issues prior to transfer.

FROM CDC IVF SUCCESS RATE REPORT 2012
INFERTILITY DIAGNOSES

For women, age 35 and younger…

- 15% have ovulation problems.
- 35% have tubal or pelvic pathology.
- 35% male factor (typically sperm problems)
- 10% unexplained infertility
- 5% other (e.g. congenital abnormalities, cancer)
INFERTILITY DIAGNOSES

For women older than 35…

- 40% have hormonal problems or egg quality problems.
- 30% have pelvic problems.
- 5% have vaginal/cervical abnormalities or failure to have sexual intercourse.
- 25% have male factor
A COLLABORATIVE MODEL

• The more integrated care is, the better the patient care.

• Some infertility clinics employ mental health professionals. MHPs are part of the treatment team.

• Most clinics outsource mental health to practitioners with specialized training in this area.

• Members of the Mental Health Professional Group (MHPG) of American Society for Reproductive Medicine (ASRM).
PSYCHOLOGICAL ASSESSMENT


- Fertility Problem Inventory Newton, Sherrard & Glavic (1999).

FertiQoL

- 36-item online self-report questionnaire for use in clinical and research settings.
- Questions pertaining to absorption by infertility struggles; disruption of social and work life by infertility; psychiatric symptoms; relationship issues; reaction to treatment and satisfaction with medical services.
- 5-point scale ranging from NEVER to ALWAYS.
- Free and available for use by professionals on the website.
COMPREHENSIVE PSYCHOSOCIAL HISTORY OF INFERTILITY (CPHI)

- A format for a structured interview with a patient by a trained mental health professional.

- Four focus areas:
  - Reproductive History—including infertility history, past pregnancy and outcome and history of genetic or medical abnormalities.
  - Mental Status—current and past including use of psychotropic medications.
  - Sexual History—including current frequency and past sexual trauma.
  - Relationship Status—marital, familial, social
Fertility Problem Inventory

Consists of 84 items which are grouped into 5 areas of concern. Self-administered answers of a 6-point Likert scale ranging from strongly disagree to strongly agree. Validity and Reliability studies with large sample of both men and women.

- Social Concern:
  - Sensitivity to comments
  - Reminders of infertility
  - Feelings of social isolation
  - Alienation from family or peers
Fertility Problem Inventory

- Sexual Concern
  - Diminished sexual enjoyment or sexual self-esteem
  - Scheduled sexual relations difficult

- Relationship Concern
  - Difficulty talking about infertility
  - Understanding/accepting sex differences
  - Concerns about impact on relationship

- Need for Parenthood
  - Close identification with role of parent
  - Parenthood perceived as primary or essential goal in life
Fertility Problem Inventory

- Rejection of childfree lifestyle
  - Negative view of childfree lifestyle or status quo
  - Future satisfaction or happiness dependent on having a child (or another child).

- Global Stress
  - Overall infertility-related stress
SCREENIVF

- Developed for Dutch infertility patients to determine risk for treatment distress in anticipation of IVF procedures. Can be used to help determine whether psychological intervention is warranted.

- Available in English.

- 34 item, self-report questionnaire with responses on a 4-point scale from NEARLY NEVER to NEARLY ALWAYS.

- Asks respondents to reflect on how they felt over the past week.
SCREENIVF

- Anxiety (10 items). Assesses both state and trait anxiety.
- Depression (7 items). Uses items 1, 2, 3, 4, 7, 8, & 9 from the Beck Depression Inventory.
- Social Support (5 items). Perceptions of support.
- Cognitions Regarding Fertility Treatment (12 items). Assesses interference of fertility into everyday life, self-concept, and coping.
- Helplessness and Acceptance. Derived from items on other scales.
PREPARATORY COUNSELING

- Typically used more in setting with on-site mental health professionals after patient’s first meeting with physician.

- This model is also used with third-party reproduction. On-site and external MHPs.

- Consists mostly of psychoeducational counseling and support.

- Helps patients anticipate the process of treatment.
PREPARATORY COUNSELING AGENDA

- Validate and prepare patients for emotional roller coaster of infertility.
- Help patients understand recommended procedures and the strange language of treatment.
- Provide patients with bibliotherapy and online resources.
- Provide referrals for adjunct treatments: nutrition, acupuncture, fertility yoga, genetics counselors.
- Facilitate effective communication with staff.
GROUP THERAPY/SUPPORT

- Group counseling is the most effective treatment modality for infertility patients (Boivin, 2003).
- Can be more effective and attract more patients when offered on-site in infertility clinic.
- **Reduces the isolation of infertility.** “They get me.”
- Typically structured as psychoeducational or open-ended support groups.
- Can be unisex or co-ed.
GROUP THERAPY

- Themed Groups
  - Mind-Body Groups—pioneered by Allie Domar—teach relaxation methods, body awareness, cognitive restructuring, journaling, self-nurturing and other coping skills.
  - Donor Recipient Groups—for recipients of egg or sperm donation. Provide preparation and understanding of complex issues in gamete donation.
- Gay/Lesbian Support Groups
- Single-Parent-By-Choice Support Group
SUPPORT GROUP IDEAS

- Unstructured

- Theme of the Month
  - Relaxation Skills
  - Infertility Etiquette
  - Coping With The Holidays
  - Cooking for Infertility Treatment
  - Loss and Trauma
  - The Newlywed Game
  - Supporting Each Other Through Treatment
  - The ABC’s of ART
INDIVIDUAL THERAPY

- Not all Infertility Patients require individual therapy. Some indications for therapy are:
  - Traumatic Loss/Complicated bereavement
  - Pre-treatment Trauma
  - Symptoms of Depression/Bipolar Disorder
  - Symptoms of Anxiety Disorder
  - Isolation/Minimal Support System for Infertility
  - Underlying Personality Disorder
  - Untreated or Relapsed Eating Disorder or Substance Abuse Disorder.
INDIVIDUAL THERAPY

- Individual therapy can also be helpful to:
  - Teach coping/relaxation skills.
  - Provide ongoing support.
  - Work on cognitive restructuring.
  - Assist with decision-making.
  - Emotion regulation.
  - Processing grief.
  - Referral for adjunct therapy.
COUPLES THERAPY

- Indicated where:
  - Partners are discordant on treatment decisions.
  - Partners are unable to support each other through infertility.
  - Prior marital discord exists.
  - Partners need to grieve together about a significant loss.

Some make use of couples therapy when one partner needs assistance but does not respond well to individual therapy.
TREATMENT GOALS

• Griefwork, if needed.

• Improving communication and ability to support each other.
  • Exploring each partner’s motivation for having children.
  • Identifying differences in emotional reactions/coping.
  • Improving ability to support one another.

• Facilitating medical treatment
  • Awareness of implications.
  • Addressing conflict in decision-making.
  • Reducing stress on relationship.
  • Better communication with staff.
SUMMARY

- Infertility is a **Biopsychosocial** phenomenon which includes:
  - Physiological
  - Psychosocial
  - Interpersonal
  - Familial
  - Spiritual
  - Cultural
  - Societal

Patient receives greatest benefit when treatment professionals collaborate and communicate with one another.
The Real Modern Family

https://www.youtube.com/watch?v=JaXNKGIQimM&app=desktop
THIRD PARTY REPRODUCTION

- When a “third party” is involved in reproduction. Typically, this is 2 parents + an **egg donor**, a **sperm donor** or a **gestational carrier**.

- “Third party” reproduction also refers to:
  - the use of a sperm donor by a single woman or lesbian couple.
  - the use of an egg donor + a gestational carrier by a gay male couple or single man.

- Psychology plays a significant and necessary role in the arena of Third Party Reproduction.
American Society for Reproductive Medicine

- ASRM Guidelines strongly recommend the involvement of Mental Health professionals in:
  - Evaluating Egg Donors--Anonymous and Known
  - Evaluating Sperm Donors and Embryo Donors
  - Evaluating Gestational Carriers
  - Assessing/Advising Intended Parents working with Gestational Carriers and Known Donors
  - Advising Recipients of Egg, Sperm, Embryo Donation
  - Coordinating Needs and Expectations of Intended Parents and Donors or Carriers.
WHO IS THE PATIENT?

- Recipient couple/individual?
- Intended Parents?
- Donor?
- Clinic or Agency paying your fee?
- The child who has come into the world with the assistance of parents, donor, clinic, third party?

HERE LIES THE POTENTIAL FOR SIGNIFICANT ETHICAL DILEMMAS AND VIOLATIONS.
Discover in 1952 that sperm can be frozen and brought back to life.

Jerome Sherman, student in Iowa, hobby of freezing his own sperm and finding ways to thaw it so that it would remain viable.

*Nature* 1953 reports first pregnancy produced with frozen sperm.

Sperm banking became practical and available with changes in technology and law. 1977 California Cryobank—first bank for frozen donor sperm.
WHY SPERM DONATION?

- Azoospermia
  - Childhood illness, high fever, adult STI
  - History of cancer, radiation, chemotherapy
  - Congenital obstructions, Klinefelter’s (XXY)
  - Testicular or hernia surgery (complications)
  - Vasectomy that cannot be reversed.
  - Varicocele (potentially can be corrected)
  - Obesity, drug use, high temperatures

- NO SPERM...Single woman, lesbian, transgender
WHY SPERM DONATION?

- Low sperm count, poor motility, poor morphology.
- Ejaculatory Dysfunction.
- Genetic defect likely to result in significant abnormality or disease in offspring.
- Sexually transmitted infection that cannot be eliminated.
- Rh-factor incompatibility between male and female partners.
WHY EGG DONATION?

- Advanced Maternal Age, Diminished Ovarian Reserve, Perimenopause.
- More common in women older than 35. High likelihood in women 40 and older.
- AMH (AntiMullerian Hormone) is a rough indicator of ovarian reserve.
- Obesity—Fat cells are mini-endocrine glands. A 10% weight loss in obese women can improve fertility.
WHY EGG DONATION?

- Eggs have been rendered poor quality because of cancer treatment, other illnesses.
- Hypergonadotropin hypogonadism—sex organs either do not fully develop or are not very responsive to sex hormones. Often from congenital condition.
- Endometriosis or Polycystic Ovarian Syndrome (PCOS) negatively impacting ovaries.
- Unexplained Infertility
CHALLENGES FOR RECEPIENTS OF GAMETE DONATION

- Must separate parenting from procreating. Which is the most important?

- May need to grieve the loss of DNA, which includes family legacies and attributes, pride in heritage. May need to grieve loss of fertility

- May need to deal with loss of self-definition of manhood/womanhood. May bring about sense of inadequacy,

- May face challenges of attachment to children.
CHALLENGES FOR RECIPIENTS OF GAMETE DONATION

- Fears of child one day saying, “You are not my mother/father anyway.

- Fears that family will not accept donor-conceived child—traditional cultures have greater challenge in this arena.

- Managing a family where one child is donor-conceived and another child is genetically related to both parents.
III. Psychological consultation for recipients

The decision to proceed with donor insemination is complex, and patients and their partners (if applicable) may benefit from psychological counseling to aid in this decision. The clinician should strongly recommend psychological counseling by a qualified mental health professional to all donor sperm recipients and their partners. The assessment should include a clinical interview and, where appropriate, psychological testing. The clinician should require psychological consultation for couples in whom factors appear to warrant further evaluation. In cases of directed donation, the potential impact of the relationship between the donor and recipient should be explored, as well as any plans that may exist relating to disclosure and future contact.
RECIPIENT COUNSELING

- Assess readiness for gamete recipiency.
  - History of relationship.
  - History of infertility, including procedures and losses.
  - Mental health history—eating disorders, depression, bipolar, anxiety disorders.
  - Current stress levels and coping resources.
  - Social support network.
  - Family history, pressure to have children and any dynamics which might interfere with family acceptance of donor-conceived children.
RECIPIENT COUNSELING

- Psychoeducation for upcoming decision-making:
  - Review benefits of single embryo transfer.
  - Review risks of multiple pregnancy.
  - Explain procedures that may be offered vis-à-vis multiple pregnancy (multi-fetal reduction) and explore each partner’s feelings about it.
  - Explore each partner’s feelings about pregnancy termination in cases where significant fetal abnormality is revealed.
  - Facilitate determination about disposition of surplus embryos.
  - Assist with donor selection—what is important to couple.
RECIPIENT COUNSELING

- Implications of Shared Cycles
- Anonymity vs. Confidentiality
- Resources for Adult Recipients and Donor-Conceived Children.

Disclosure
- To Children—How and When?
- To Others
ARE THE KIDS ALL RIGHT?

VIDEO: GENERATION CRYO TRAILER

http://www.mtv.com/videos/misc/965118/generation-cryo-trailer.jhtml
ARE THE KIDS ALL RIGHT?

- LOUISE
  https://www.youtube.com/watch?v=M-wD_a_ia_0

- CHANTELE
  https://www.youtube.com/watch?v=uiMcKcg-Kjl

- RILEY
  https://www.youtube.com/watch?v=ayc9PoNutmQ
DONOR ASSESSMENT

The decision to proceed with gamete donation is complex, and individuals may benefit from psychological counseling to aid in the decision. Psychological consultation with a qualified mental health professional is strongly recommended for all individuals considering gamete donation. The assessment should include a clinical interview and, where appropriate, psychological testing. The physician should require psychological consultation for donors in whom there appear to be factors that warrant further evaluation.

ACRM (2012)
SPERM DONOR ASSESSMENT

- SPERM DONOR ASSESSMENT—CLINCS vs. AGENCIES/BANKS.
  - In practice, many sperm banks do not require psychological assessment.

- Known Donor vs. Anonymous Donor.

- Known Donor undergoes psychological interview and, typically, psychological testing and then meeting with recipients. Donors partner is required to be involved.
EGG DONOR ASSESSMENT

- Typically between the ages of 21 and 30. ASRM guidelines permit donors up to age of 34.

- Assess:
  - Family History
  - Reproductive and Sexual History
  - Mental Health History
  - Relationship History
  - Support System and Significant Relationships
  - Current Stress and Coping Skills
EGG DONOR ASSESSMENT

Assess:

- Education and Work
- Financial Circumstances
- Legal Involvements
- Significant Medical History and Medications, Tattoos, Piercings.
- Family and Personal History of Mental Illness, Psychotropic Medication Use and Psychotherapy
- Use of Cigarettes, Alcohol and Recreational Drugs
- Donor candidate’s ability to make good judgments for herself—maturity and decision-making capacity.
EGG DONOR ASSESSMENT

• Psychoeducation Regarding Informed Consent
  • Explore Values and religious beliefs about others undergoing embryo creation, embryo destruction, termination, multi-fetal reduction, nontraditional families.
  • Requirements and procedures of program.
  • Nature of program—shared vs. matched cycle.
  • Anonymity vs. confidentiality.
  • Financial desperation and coercion—payment.
  • What will become of eggs and who will arise from donation.  www.Donorsiblingregistry.com
EGG DONOR ASSESSMENT

- Psychological Testing
  - Personality Assessment Inventory (PAI)
  - Minnesota Multiphasic Personality Inventory-2 or 2RF (MMPI-2, MMPI-2RF).

- Psychoeducation of committed partners
  - Side effects of drugs
  - Procedures
  - Sexual contact during procedures
  - Future genetic offspring of donor
  - Square with their value system
KNOWN DONOR ASSESSMENT

• Imagine sitting down to Thanksgiving dinner with your sister, who donated the eggs from which your children were born.

• Imagine first cousins who are actually genetic half-siblings and their father who knows that his nieces are his wife’s genetic offspring.

• Imagine the aunt (genetic mother) noticing qualities in her nieces (actually her genetic offspring) that she appreciates in herself but that her own children did not inherit.
KNOWN DONOR ASSESSMENT

- Complicated by delicate family relationships, boundaries and family dynamics.
- Requires more complex level of screening.
- Recipient Counseling + Egg Donor and Husband/Partner + Joint Session.
- Expectations and Values need to match.
- Donor must have good boundaries & be really clear & respectful of needs of recipient.
- Partner must be fully on board.
- MUST HAVE LEGAL CONSULT.
HAGAR—A GESTATIONAL CARRIER?
GESTATIONAL CARRIERS

- **Gestational Surrogacy** is an arrangement in which a woman carries and delivers a baby for someone else. The woman who carries the baby is the *gestational surrogate* or *gestational carrier*.

- **Traditional Surrogacy** is an arrangement in which a woman conceives a baby with her own eggs and the sperm of a contracting man (through IUI or IVF). The traditional surrogate is the genetic and gestational mother of the child. Few engage in this practice today.

Surrogacy is permitted, pre-birth orders are granted throughout the state, and both parents will be named on the birth certificate.

- California
- Connecticut
- Delaware
- Maine (as of July 1, 2016)
- New Hampshire
- Nevada
- Oregon
- Rhode Island
GS BY STATE LAW

GREEN LIGHT STATES WITH SOME RESTRICTIONS

- Surrogacy is permitted but results may be dependent
- OR only a post-birth parentage order is available.
- In some birth states additional post-birth legal procedure may be required.
- The state where the baby is born must have a procedure to allow both parents to be named on the birth certificate without action in another state.
GREEN LIGHT WITH RESTRICTIONS

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Proceed with caution. Surrogacy is practiced, but there are potential legal hurdles; or results may be inconsistent.

Alaska
Arizona
Iowa
Indiana
Louisiana
Mississippi

Montana
Nebraska
Oklahoma
Tennessee
Virginia
Wyoming
Statute or published case law prohibits compensated surrogacy contracts, OR a birth certificate naming both parents cannot be obtained.

Washington, D.C.
Michigan
New Jersey
New York
Washington State

http://www.creativefamilyconnections.com/
A “true medical condition” precludes the patient from carrying a fetus. Carrying could result in death or significant harm to mother or baby.

- Absence of uterus.
- Significant uterine anomaly.
- Recurrent pregnancy loss.
- Medical conditions which contraindicate pregnancy.
- Conditions that may be exacerbated by pregnancy or cause risk to fetus.
- Male couple or single male
- Gray areas—endometriosis, poor response to treatment.
INTENDED PARENT (IP) COUNSELING

- Assess readiness for working with GC.
  - History of relationship.
  - History of infertility, including procedures and losses.
  - Mental health history—eating disorders, depression, bipolar, anxiety disorders.
  - Current stress levels and coping resources.
  - Social support network.
  - Family history, pressure to have children and any dynamics which might interfere with family acceptance of donor-conceived children.
INTENDED PARENT (IP) COUNSELING

- Psychoeducation about process:
  - Educate about “my baby, your body.”
  - Educate about communication, confidentiality, emotional impact, involvement in pregnancy, boundaries, hospital arrangements, potential for failed cycles & losses.
  - Review benefits of single embryo transfer.
  - Review risks of pregnancy and multiple pregnancy.
  - Review and document values about multi-fetal reduction, pregnancy termination and surplus embryo disposition.
GC CRITERIA

- Minimum age 21.
- High school diploma or GED.
- Prior deliveries and experience parenting a child.
- Lifestyle that would not interfere with prenatal care and management.
- Cognitive and emotional ability to comply and understand.
- Free of financial or emotional coercion (not on Public Assistance).
- Evidence of altruistic commitment to become a Carrier.
- Psychological testing within normal limits.
GC CRITERIA (cont.)

- No evidence of UNRESOLVED or UNTREATED addiction, child abuse, physical abuse, traumatic pregnancy, labor or delivery.
- No history of major depression, bipolar disorder, psychosis or personality disorder.
- Sufficient emotional support from partner/spouse or support system.
- Current marital or relationship stability.
- No evidence of excessively stressful family demands, without sufficient social support system.
- No evidence of chaotic lifestyle.
GC CRITERIA (cont.)

- Ability to maintain a respectful and caring relationship it Intended Parents.
- Emotional ability to separate from/surrender baby at birth.
- No history of conflict with authority.
- Ability to perceive and understand the perspective of others.
- No evidence of motivation to use compensation to solve own infertility.
GC PSYCHOEDUCATION

- My Body, Your Baby.
- Potential psychological issues and risks of being a GC.
- Multiple pregnancy, Multifetal reduction, Prenatal diagnostic testing, elective termination—all parties must agree on these decisions.
- Relationship with IPs—past, present & future. Respecting boundaries of relationship.
- Risk of attachment to child and GC’s children attaching to child.
GC PSYCHOEDUCATION

- Impact of GC pregnancy on GCs marriage/relationship/employment.
- Balance between GC’s privacy and IP’s right to information.
- Offer of counseling with mental health professional.
- Benefit of separate legal counsel for IPs and GC.
- Inform GC of source of gametes.
JOINT SESSION

All parties to the agreement (IP couple and GC couple) should be sitting in the same room for discussion.

- Re-emphasize “My Baby/Your Body” and complicated nature of surrogacy.
- Review decisions/values/information discussed in prior (separate) sessions.
- Facilitate relationship between couples.
- Open channels of communication.
LGBT FAMILY BUILDING

- Conscious choice to become parents.
- It is not infertility but need to use medical, infertility treatment. Adds time and expense to treatment.
- Some areas, clinics, physicians are not LGBT-friendly. May be dismissive on non-birth mother in lesbian couples or of gay and transgender.
- Insurance (if available) does not cover medical treatment for those that are not infertile.
LESBIAN FAMILY BUILDING

DECISIONS:

• Home vs. Clinic Insemination.

• Who will carry?
  • May be determined by age, desire to be pregnant, current life circumstances, family genetic history, employment, insurance, BMI, role in the couple.
  • Each partner may carry one child.
  • One partner carries embryo created with donor sperm and other partner’s eggs using IVF.
LESBIAN FAMILY BUILDING

- **SPERM:** Sperm Bank or Known Donor—either Friend or Family Member of non-genetic mother.

- Use of known donor is complicated by desire for parental rights or role in parenting and relationship with the recipient parents.
  - Known donor sperm quarantined for later testing. Delay.
  - Feelings change after a baby is born.
  - Sperm banks are expensive.
GAY MEN & FAMILY BUILDING

- Must use an Egg Donor and a Gestational Carrier.
  - Known Donor or Anonymous Donor
  - Known Carrier or Agency Carrier.

- COST: Clinic, Egg Donor, Agency, Carrier Fees can run over $100,000.

- May encounter specific prejudices about two men wanting to have children. Some carriers refuse to work with gay male couples.
Most transgender persons are not counseled about future family-building prior to beginning their transition.

If they are counseled, family-building might be the last thing on their minds at this very vulnerable time in their lives.

Transgender people who have not had reproductive organs surgically corrected can access their own gametes in order to create embryos. BUT they must stop hormone treatment. It can be psychologically devastating to revert back to a mismatched gender.
PSYCHOLOGICAL COUNSELING OF LGBT FAMILY BUILDING

- Decision-making.
- Guidance and resource materials.
- Facilitate positive interactions with treatment team.
- Reassurance that healthy children grow from healthy couples—gay, straight, lesbian, bisexual, transgender and single.
- Psychoeducation about disclosure.
- Referral to attorneys.
SINGLE MOTHERS & FATHERS

- Discuss motivation to parent and decision to parents as a single.
- Explore social support network.
- Decision-making and how to proceed.
- Educate on research and talking to children.
- Connect with resources.
ETHICAL PITFALLS

We live in a Brave New World of reproductive possibilities.

- We can retrieve eggs and sperm
- freeze them for later use
- combine them in a laboratory
- test them for diseases
- transfer someone’s embryo to another person’s body.

Has anyone ever misused this technology?
THE WILD WEST

- Designer Babies
- Sex Selection by abortion
- The Octomom
- Single 50 year old Dad with 48 year old GC carrying triplets.
- Indian gestational birthing homes for surrogates.
- The real anchor babies
THE WILD WEST

- Single, wealth man in his 50’s finally comes to decision to have a child. Creates embryos, contract with GC, transfers. GC 36 weeks pregnancy with twins and he realizes he does not want children.

- Sherri Sheppard Case

- Theresa Erikson case

https://www.youtube.com/watch?v=DigZkthAH3A
PSYCHOLOGY’S ROLE IN MAT

- Support and assistance for grieving and traumatized patients.
- Creating group support for patients feeling alone and isolated.
- Facilitating greater understanding of upcoming treatment decisions.
- Facilitating better relationships with treatment team.
PSYCHOLOGY’S ROLE IN MAT

- Screening and assessing third party participants.
- Intervening in difficult or troubling third-party situations.
- Enhancing the knowledge and treatment experience of LGBT and single-parent families.
- Facilitating ethics in treatment and, hopefully, reducing the likelihood of abuses in treatment.
REFERENCES

New Frontiers In Family Building: The Role of Psychology in Medically Assisted Reproduction


