AN EXPLORATION OF THE
PSYCHOLOGICAL EXPERIENCES OF
COMMISSIONING GESTATIONAL
SURROGATE COUPLES

Submitted by
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Submitted in partial fulfilment of the requirements for the award of Doctorate
in Psychology (Counselling Psychology) at Swinburne University of
Technology

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DECLARATION

I declare that this report does not incorporate without acknowledgement any material previously submitted for a degree in any university, college of advanced education, or other educational institution; and that to the best of my knowledge and belief it does not contain any material previously published or written by another person except where due reference is made in the text. I further declare that the ethical principles and procedures specified in the Faculty of Life and Social Sciences for Social Research Statement on Research Ethics have been adhered to in the preparation of this report.

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Signed: Date:
ACKNOWLEDGEMENTS

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FOREWORD

This thesis was written during the time when the law relating to altruistic gestational surrogacy arrangements within the State of Victoria was changing. While the experiences of the participants in this study are not altered by this, it is acknowledged that some of the issues raised, that caused them difficulty, will not be experienced by commissioning couples in the future. The process of research, interviewing, and data collection for this project began in 2006. The provisional results from early analysis of the data were compiled into an Executive Summary which was then forwarded by request to the Victorian Law Reform Commission in April 2007. The Executive Summary was then presented by the Victorian Law Reform Commission to the Department of Justice Victoria.

During the time period from 2006 to 2008 the current laws governing altruistic gestational surrogacy in Victoria, chiefly that it was virtually impossible for anyone to undertake, were reviewed and in December 2008 the Assisted Reproductive Treatment Act 2008 received assent in the Victorian Parliament. The Act will come into effect from 1 July 2009 until 1 July 2010 and supersedes the Infertility Treatment Act 1995. The new Act makes provision for altruistic gestational surrogacy arrangements in Victoria to be conducted through licensed infertility treatment clinics, where such arrangements are deemed medically necessary in order for commissioning couples to have children.

At the time of writing this thesis the Assisted Reproductive Treatment Act 2008 had, as yet, not come into effect and it was unclear as to how new legislation was going to impact upon commissioning couples who had attempted altruistic gestational surrogacy under previous legislation. Although the new law now permits this type of gestational surrogacy within the State of Victoria, for couples applying for the process after 1 July 2009, the difficulties of legal parentage and of the issuing of birth certificates to commissioning couples who had children prior to this date has not been completely resolved.
The psychological experiences of, and the emotional impact on, the commissioning couples who took part in the current study cannot be negated by the introduction of new laws, and it was the analysis of these experiences that led, at least in part, to the proposed law reforms. The following thesis investigates the psychological impact on the eighteen commissioning couples within the state of Victoria who agreed to take part in the current study concerning their experiences of altruistic gestational surrogacy in order to have children under the previous *Infertility Treatment Act 1995*. The data presented hereafter, and the findings and interpretations offered, are important to consider as they explore the personal narratives of commissioning couples whose experiences contributed to law reform within the State of Victoria. Further to this, the current thesis also continues to raise questions about such matters as legal parentage and the financial commitments experienced by the commissioning couples who took part in this study; this is of particular importance as it is as yet unclear as to how new legislation will be of benefit to commissioning couples who underwent altruistic gestational surrogacy arrangements prior to 1 July 2009.

As a further note to the reader, the text of this thesis has been retained in the past tense. It has been written in this way as at the time of writing the former law was still operative. Appendix A has been included and provides information about the new law as it stands, during its inception between July 2009 and July 2010, and at the time of the final submission of this thesis.
ABSTRACT

It is estimated by the World Health Organisation (2007) that approximately one in ten couples worldwide is affected by infertility, experiencing either primary or secondary infertility difficulties. Established research indicates that as many as one in six Australian couples are unable to conceive, and therefore seek out available infertility treatments in order to have children. Medical technology has advanced at a rapid rate in the area of assisted conception, but for some couples Assisted Reproductive Technology (ART) is not enough to help them to conceive. A growing number of Australian couples are now looking to altruistic, non-commercial, gestational surrogacy arrangements, where medical technology allows surrogate mothers to gestate other people’s children until full term, giving couples and individuals access to family life that had previously seemed impossible. This qualitative study explores the psychological experiences and emotional responses of eighteen commissioning couples in the State of Victoria in their quest to have families through the process of altruistic gestational surrogacy. All were in heterosexual relationships and were unable to either conceive naturally or to carry to term due to medical problems or multiple medical conditions. Couples were interviewed at length and their responses were tape recorded and then transcribed ready for analysis. An established process of Interpretative Phenomenological Analysis was used in analysing the data, and themes and concepts were broken down into Units of Psychological Meaning and Interpretative Labels. The major findings of the study indicated that all the couples, regardless of what stage they were at in the process of altruistic gestational surrogacy, were positive, determined, and resilient in the face of many legal and procedural obstacles. The main frustrations and negative experiences appeared to centre on a lack of consistent information, the prohibiting of access to treatment for surrogates, and the subsequent need for interstate travel, and the extensive cost of the whole process. Findings showed a consistency in those aspects of the current processes and laws that couples wanted to change in order to improve the process and make it safer for others. Several psychological themes are discussed and recommendations are made for clinical application.
PERSONAL STATEMENT

The interest in this study initially began with a question about the relevance and role of social support in infertility treatment. I had wondered for some time whether a couple’s openness about fertility or sub-fertility problems, including sharing information about treatment attempts, might result in a more positive support network by both friends and family, and whether there might be some connection between these levels of positive social support and successful treatment outcomes. I had considered that two of the factors related to success might be a more tenacious attitude in not giving up if rounds of treatment failed, and secondly, that a more positive psychological position might lead to a susceptible physiological state in response to treatment undertaken, this latter variable, however, is difficult to prove.

In 2006, I approached Associate Professor Cook, Coordinator of Counselling Psychology at Swinburne University of Technology to begin supervision and to discuss whether the above hypothesis would be suitable to research as part of my doctoral degree in counselling psychology. I had begun a course of reading that included a consultation paper prepared by the Victorian Law Reform Commission (2003), entitled, Assisted Reproductive Technology and Adoption: Should the Current Eligibility Criteria in Victoria be Changed? At that time the Commission had been instructed by the Attorney-General of Victoria, the Honourable Rob Hulls MP, to inquire into two issues of importance within the community of Victoria: firstly the eligibility for assisted conception through Assisted Reproductive Technology (ART), including eligibility covering surrogacy arrangements through licensed clinics and, second the eligibility to become adoptive parents (p.ix).

In Chapter 6 of the consultation paper, the Commission outlined the specific areas to be examined concerning surrogacy arrangements in Victoria, and in particular highlighted three issues for inquiry:

i. “Are the current eligibility provisions in the [Infertility Treatment] Act [1995] appropriate for application in surrogacy situations, including situations where donor gametes are used?
ii. How should the legal status of the child be clarified?
In subsequent supervision discussions it was decided that I would take on the current research project, entitled, *An Exploration of the Psychological Experiences of Commissioning Altruistic Gestational Surrogate Couples*. Two previous studies in the area of surrogacy had been supervised by Associate Professor Cook; *Carrying Someone Else’s Baby: A Qualitative Study of the Psychological and Social Experiences of Women who Undertake Gestational Surrogacy* (Goble, 2005) and, *An Investigation of the Psychological Experiences of the Partners of Women who Act as Gestational Surrogates* (Young, 2005).

In exploring the emotional impact of gestational surrogacy on commissioning parents I was completing the picture of the psychological experiences of all adult, and in this case, heterosexual, clients involved in the process of altruistic gestational surrogacy. The term ‘altruistic’ is used as commercial gestational surrogacy arrangements are prohibited both under previous legislation and proposed new legislation. The study would also allow me to investigate the impact on commissioning couples of the current laws governing gestational surrogacy in Victoria and, in response to my original proposal; I would also be able to explore the importance of social support during infertility treatment and more specifically during the process of gestational surrogacy.

The following statement on page 117 of the consultation paper was a further major motivation for this current study.

> “These criteria [relating to the difficulties of accessing fertility treatment in surrogacy] are particularly difficult to identify as there has been little research done on surrogacy and its effects. The Commission would like to hear from researchers who have done work in this area.” (Victorian Law Reform Commission, 2003; p.117).

In light of the above request by the Commission and in light of the previous studies conducted in surrogacy at Swinburne, I decided to embark upon the current study, and in part relate it to the aspects of surrogacy already being reviewed by the Commission.
As previously stated in April 2007 the Victorian Law Reform Commission submitted its final report to the Victorian Government concerning eligibility for infertility treatment and adoption protocols in Victoria; I was asked by the Commission to prepare an Executive Summary of my initial findings from my research into the psychological experiences of the commissioning gestational surrogate couples interviewed. This summary was then forwarded by the Commission to the Department of Justice Victoria. The summary can be seen in Appendix B of this report.

At the time of writing this report the findings by the Victorian Law Reform Commission, and the Department of Justice, into gestational surrogacy within the State of Victoria, were considered by State Parliament. On September 9 2008 the Honourable Rob Hulls, MP, Deputy Premier and Attorney-General, and the Honourable Daniel Andrews, MP, Minister for Health, introduced the Assisted Reproductive Treatment Act (Victoria) Bill 2008 to Parliament. The Bill was developed based on recommendations provided to Government by the Victorian Law Reform Commission in March 2007. On the fourth of December, 2008 the Bill received assent and the Assisted Reproductive Treatment Act 2008 was passed. The government indicated at this time its intention to proclaim the Act by the 1 July 2009, pending resolution of implementation requirements. Any remaining sections of the Act that are not in operation by 1 July 2010 would come into final operation by that date. A media release was issued briefly outlining the intended Bill and can be seen in Appendix C of this report.

To date there have been no published systematic accounts of the experiences of commissioning altruistic gestational surrogate couples in Australia. The following thesis offers a detailed analysis of the experiences of commissioning couples in gestational surrogacy arrangements within the state of Victoria, prior to 1 July 2009. It is intended that this research project will provide a clear representation of the complicated process of gestational surrogacy in Victoria. It is further hoped that the reader will develop an understanding of the emotional impact on commissioning couples who embark on the process of gestational surrogacy.
CHAPTER 1  INTRODUCTION

1.1  THE CONTEXT OF INFERTILITY AND INFERTILITY TREATMENT

The US Department of Health and Human Services (US Dept. HHS) defines infertility as the inability to become pregnant after at least one year of attempting to conceive. Women who become pregnant, but have repeated miscarriages are also identified as being infertile. (US Dept. HHS, 2007). Primary Infertility refers to couples who have never been able to conceive, Secondary Infertility (or Sub Fertility) refers to situations where couples have previously been able to conceive, but where the woman is now unable to achieve a subsequent pregnancy.

The Australian Web Site, Fertility-Treatment. Org (2005) lists five factors that are responsible for successful conception, these are:

1. “Healthy sperms should be deposited high in the vagina.
2. The sperms should undergo changes and acquire motility.
3. The motile sperms should ascend through the cervix into the uterine cavity and the fallopian tubes.
4. There should be ovulation in females.
5. The fallopian tubes should be patent.” (Fertility-Treatment.Org, 2005.)

It is widely recognised that in the absence of one or more of these five factors, conception is unlikely to take place. Inhorn (2003) argues that infertility is a, “problem of global proportions” (p.1), affecting eight to twelve percent of couples worldwide. The World Health Organisation (2007) states that infertility is currently affecting one in ten couples worldwide. It is suggested that these couples experience either primary or secondary infertility problems, or both. Jaffe and Jewelewicz (1991) argue that one in eight couples struggle with infertility. ABC Health Matters (2007) go further and suggest that as many as one in six Australian couples experience infertility. Of these couples it is proposed that 35 to 40 percent of infertility can be attributed to male fertility problems, 35 to 40 percent to female infertility, approximately 10 percent to a combination of male and female fertility issues, and a final 10 percent to unknown causes, known as idiopathic infertility. (ABC Health Matters, 2007).

Gallagher (2004) offers similar statistics to the causal breakdown suggested by ABC Health Matters regarding the incidence of infertility. As shown in Figure 1.1, Speroff
et al. provides us with a basic breakdown of the overall incident rate of infertility in western society, showing both the statistics for couples and women.

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**Figure 1.1 Infertility Statistics in Women and Couples**


Smith (2006) suggests that age related factors play an important role in female infertility arguing that the chance of normal conception decreases as women grow older:

“The chances of pregnancy occurring in healthy couples who are both under the age of 30 and having intercourse regularly is only 25 - 30% per month. A woman’s peak fertility occurs in her early 20s. As a woman ages beyond 35 (and particularly after age 40), the likelihood of getting pregnant drops to less than 10% per month”. (Smith, 2006; Department of Obstetrics and Gynaecology, VeriMed Healthcare Network Review).

1.2 MEDICAL CAUSES OF INFERTILITY

Fertility-Treatment. Org (2005) lists several diagnosable medical causes of infertility for both men and women. Appendix D provides a detailed overview of these causes and Appendix E gives explanations of medical terminology. The main diagnosable causes of infertility appear to be dysfunctional reproductive systems in women, including ovarian, tubal and uterine factors, and defective sperm production in men, such as primary testicular failure and conditions such as Oligo-Astheno-Azoospermia, or abnormal sperm shape.
In order to diagnose infertility several examinations or procedures can be used. Non-invasive testing such as body temperature charting, sperm investigation or ultrasonography are common initial investigations performed by infertility specialists. A laparoscopy or hysterosalpingogram are both surgical procedures, performed on the woman, usually under general anaesthetic, which help to identify potential abnormalities interfering with normal conception.

The next step for most couples, after being diagnosed with infertility problems, is to then consider the treatment options available to them. A number of infertility treatments are offered to infertile couples to either promote fertility or circumnavigate around the problem of infertility. The following section outlines several available treatment options.

1.3 AVAILABLE TREATMENTS

Ovulation induction through the use of fertility drugs, such as clomiphene citrate (usual brand name Clomid), or human menopausal gonadotrophin (usual brand name Metrodin) is used for correcting ovulation dysfunction. However, fertility drugs are also used to treat men with primary hypogonadotrophic hypogonadism, a hormone deficiency in the pituitary gland that interferes with sperm production in the testes. Ovulation induction is often attempted prior to any assisted reproductive techniques. A further technique used before assisted conception is reproductive surgery. These surgeries include procedures such as, a laparoscopy or a hysteroscopy to remove scar tissue, treat endometriosis, remove cysts or open blocked tubes.

Intrauterine Insemination (IUI), In Vitro Fertilization (IVF), Intracytoplasmic Sperm Injection (ICSI), and Gamete Intra-Fallopian Transfer (GIFT) are all assisted reproductive techniques used by medical specialists to overcome the problem of infertility affecting natural conception. IUI in combination with Ovulation induction is probably the most basic of the procedures and involves a process of washing the sperm and injecting it directly into the uterus. IVF refers to the process of fertilising oocytes (female reproductive cells) with sperm in a culture dish before placing them back into the uterus. This procedure usually takes place after the woman has taken a ‘cycle’ of fertility drugs to promote optimal ovulation production. Any extra embryos, not implanted back into the uterus may be cryopreserved (frozen) for later use.
ICSI is often used in cases where there are abnormal semen analyses and IVF cycles have not been successful. It involves injecting a single sperm directly into each mature egg using a micro-needle. Finally GIFT refers to a process in which eggs are removed from the ovaries and placed separately with sperm, in one of the fallopian tubes allowing fertilisation to take place inside a woman’s body as opposed to in a culture dish, as in IVF.

In all of the above procedures semen and eggs from the original couple can be used to achieve assisted conception. IVF-Fertility.Com (2005) argues that attempting to have a child who is biological related to only one partner is probably the next step if treatments have failed, or if there is a known abnormality with either the sperm or the eggs from a couple. This would also be an option where it is known that there is risk of congenital disease or abnormalities being passed on through natural conception. In this case couples may consider using donor sperm (for use in donor insemination, DI, or IVF) or donor eggs. Full embryo donation would be the last option for couples where the woman wished to gestate a baby to full term allowing her to be the birth mother of the child. In the event that none of the above treatments or procedures were possible, the final two options for having a child would be adoption or surrogacy.

Traditional surrogacy refers to the process where a surrogate mother provides her own egg, which is then fertilised by the commissioning father, usually by artificial insemination. The embryo develops in-utero and the surrogate (in this case, biological) mother gestates the baby until full term; she then relinquishes the child to the commissioning parents. In gestational surrogacy an embryo is made from the commissioning mother’s egg and the commissioning father’s sperm (or in some cases from donor gametes) and is developed through IVF procedures. The embryo is then transferred into another woman, the gestational surrogate, who carries the baby until full term and then relinquishes it to the commissioning (usually biological) parents who intend to have full custody of the child. This avenue for having a child is often the only option open for couples where the woman has either congenital or acquired uterine abnormalities, or where carrying a baby until full term would greatly jeopardise the health of the commissioning mother and or the child. Both traditional and gestational surrogacy arrangements can be commercial in nature or altruistic. At present commercial arrangements are prohibited against within Australia.
This study is concerned with altruistic gestational surrogacy. Goble (2005) suggests that,

“While there were 4,801 Australian IVF births in 2000, accounting for 1.9% of all births (Australian Institute of Health & Welfare Media Release, 2003)...Data on [altruistic] gestational surrogacy births in Australia are not recorded, but the number is thought to be fewer than 100 in total (Victorian Law Reform Commission, 2003). (Goble, 2005; p.2).

The demand for assistance with infertility is growing (Goble, 2005; Cook, 2002) and gestational surrogacy may provide an option for couples who wish to have their own child, but where the woman partner is unable to carry to full term. The laws governing gestational surrogacy in Victoria have been extremely complicated and until new legislation comes into effect between July 2009 and July 2010 it is difficult to know what its impact will be on the commissioning couples who have entered into surrogacy arrangements under the old legislation. It is one of the aims of this study to show how couples have been, and are being, affected by Victorian law during their gestational surrogacy arrangements.

The current study is representing the psychological experiences of eighteen couples within the State of Victoria. All of these couples were only able to consider altruistic arrangements in Australia and all had to travel interstate as, at the time, this option was also prohibited in Victoria. Very few of the couples chose surrogacy as a first option after the diagnosis of infertility, although some women knew from an early age that this was their only option as their particular medical conditions would prevent them from carrying their babies until full term. In most cases couples only considered surrogacy after a long period of diagnosis and unsuccessful treatment attempts.
1.4 GESTATIONAL SURROGACY IN VICTORIA

1.4.1 THE CURRENT LAWS

In order to understand the complicated procedural steps that were required to be taken by the commissioning couples interviewed for the current study it is first important to return to the original issues for inquiry by the Victorian Law Reform Commission (2003) concerning surrogacy in Victoria prior to 1 July 2009:

i. “Are the current eligibility provisions in the [Infertility Treatment] Act [1995] appropriate for application in surrogacy situations, including situations where donor gametes are used?

ii. How should the legal status of the child be clarified?


It is of equal importance to understand that behind these issues for inquiry were a number of complicated Acts (regulatory laws and governing guidelines) that, as they stood at the time of writing this report, virtually prohibited gestational surrogacy within the state of Victoria and definitely prohibited any commissioning mothers and, in some cases, commissioning fathers from being identified as their biological child’s parents, where that child was born to a gestational surrogate mother. The Acts that I am most concerned with here are the Status of Children Act 1974, the Adoption Act 1984 and the Infertility Treatment Act 1995.

According to the Status of Children Act 1974 any child born is classed as the child of that birth mother, whether the birth mother’s egg was used in the formation of the embryo becoming the child or not. In other words, and of particular importance to the current study a birth certificate would be issued to the birth mother (even in a full gestational surrogacy arrangement) identifying that birth mother as the mother of the child, not the commissioning mother who is the biological mother. However in determining the father of a child born in a gestational surrogacy arrangement, the 1974 Act states that the husband of the surrogate, who has agreed to his wife becoming that surrogate, and who has not provided sperm for the formation of the embryo, can also be identified as the resulting child’s father on the issued birth certificate.
For the commissioning parents interviewed for the current study, it is this paternal determination that appears to be a moving target. The birth mother (the surrogate), under the legislation governing gestational surrogacy prior to 1 July 2009, could identify the commissioning father as the father of his biological child, and therefore this commissioning father could be listed as the child’s father on the birth certificate of his child, but who is born to a gestational surrogate mother. In most cases the participants in this study were issued birth certificates with the surrogate mother’s name and the commissioning father’s name being listed as the child’s parents. At the time of writing this report, in almost all cases the commissioning parents were in the legal process, or had been involved in the legal process, of applying for full guardianship or legal adoption of their own genetically related child.

According to the new Assisted Reproductive Treatment Act 2008 under the new legislation the phrase, ‘Closed Surrogacy’ will appear on the Register of Births for those children born as a result of gestational surrogacy after 1 July 2009, however it is not clear whether birth certificates will be re-issued to those commissioning parents whose names do not (both) appear on their child’s birth certificates. The Assisted Reproductive Treatment Act 2008 further states that commissioning couples in gestational surrogacy arrangements will be able to apply to the Supreme Court of Victoria for full legal parentage of their children as of 1 July 2009.

The Adoption Act 1984 states that couples who wish to adopt must be married or have been in a de-facto relationship for at least two years. The Act also limits ‘known child’ adoption to ensure that people do not make private adoption arrangements. In the case of gestational surrogacy arrangements the Act is unclear and not easy to adapt to this situation. Of the eighteen couples that I have interviewed ten have become parents through gestational surrogacy, in some cases more than once. It appears that these couples have taken several different routes in gaining full custody of their child or children.

At the time of writing this report some of the commissioning couples interviewed have been issued legal guardianship, but only where the gestational surrogate mother is a close relation; some couples have the surrogate and their partner’s name on the birth certificate of their child; other couples have the birth mother and the commissioning father listed; several couples have been told by their lawyers to “wait it out” and see whether law reform allows them to be issued, or re-issued, with a birth
certificate under the new legislation where both of their names appear. In some cases commissioning parents were told not to try and adopt their genetic child as there was a great risk that their child may go to “the next couple on the adoption waiting list” as opposed to being legally adopted by them. Through this study I was given access to couples who have now legally adopted their genetic children, but who stated that they were treated “extremely badly” by adoption authorities and were made to feel that there was a strong possibility that they might lose their children to other childless couples through the process of adoption.

Prior to the Assisted Reproductive Treatment Act 2008 the Infertility Treatment Act 1995 regulated access to Assisted Reproductive Technology (ART) in Victoria. In other words the Act identified who may undergo infertility treatment, and for what reason. Initially the Act required that women who sought out infertility treatment must be either married or in a heterosexual de-facto relationship. The Victorian Law Reform Commission (2003) states that this can no longer be imposed since the successful law suit of McBain versus The State of Victoria (2000). The Act further specifies that in order to receive infertility treatment a woman must be classed medically as unlikely to become pregnant through natural conception or, that natural conception could result in giving birth to a child with a genetic abnormality or that child being born with a congenital disease (Victorian Law Reform Commission, 2003; p. xiii). The 1995 Act also states that commercial surrogacy is completely prohibited in Victoria and that only altruistic surrogacy may be considered as a possibility.

The difficulty for the commissioning couples in the current study, who were attempting gestational surrogacy under the eligibility regulations of the 1995 Act and not the 2008 Act, is that the fertility status of the commissioning mother was not reviewed, only the fertility status of the potential gestational surrogate. That meant that for the gestational surrogates, in this current study, to be allowed access to treatment in Victoria they would need to be assessed as clinically infertile or being at risk of passing on a congenital disease in carrying their own genetic babies to full term. For a gestational surrogate to receive treatment in Victoria under the 1995 Act she would need to have undergone a tubal ligation or other surgery preventing conception, or be clinically infertile due to medical reasons, or due to idiopathic causes. The partner of the surrogate would also need to be infertile, for example, to have undergone a vasectomy. For the commissioning couples in the current study, the couple, the surrogate, and her partner had to find a licensed clinic in Victoria
willing to treat them. At the time of interviewing the participants for the study, and at the time of writing this report, there were no clinics in the metropolitan area willing to do this, and I was aware of one clinic only, in country Victoria, that was willing to carry out IVF between a surrogate and commissioning parents.

Although the 1995 Act states that infertility treatment can be accessed where there is a risk of passing on congenital abnormality or disease, this does not apply in gestational surrogacy as the surrogate’s genetic material is not being used, only the commissioning mother’s eggs and the commissioning father’s sperm (or donor gametes), therefore this makes the surrogate unlikely to pass on abnormalities or disease even though she is gestating a baby until full term.

1.4.2 PROCEDURAL STEPS UNDERTAKEN BY THE COMMISSIONING COUPLES IN THE CURRENT STUDY UNDER THE 1995 ACT

In order for the commissioning couples from Victoria, in the current study, to access infertility treatment for their gestational surrogate they were required to travel interstate to licensed clinics permitted by law to treat people from other states, for example Sydney IVF Clinic and Canberra Fertility Centre. Appendix F is adapted from Goble (2005) and outlines the procedural steps undertaken by Victorian couples prior to 1 July 2009 in order to have a child through gestational surrogacy arrangements. As previously mentioned a significant concept to note, in Appendix F, is that for a surrogate to be considered for infertility treatment, as part of a gestational surrogacy arrangement, they must be classed as clinically infertile within the State of Victoria. Essentially this means that it is the fertility status of the surrogate that is considered in gestational surrogacy and not the fertility status of the commissioning mother.

As can be seen in Appendix F the process of gestational surrogacy in Victoria under the previous legislation could be long and complicated; in most cases taking up to two to three years. As yet commissioning parents are unable to claim the cost of infertility treatment on private medical insurance, thus adding to the already extensive cost of the process. The costs for the participants in the current study, depending on success of treatment, varying legal fees and whether couples moved the process from Victoria to overseas, ranged from approximately $30,000 to $300,000.
1.5 MEDICAL TECHNOLOGY AND THE FUTURE OF ART

1.5.1 STATISTICAL DATA AND TECHNOLOGY

According to the World Report on ART presented in 2002 at the 22nd Annual Conference of the European Society of Human Reproduction and Embryology (ESHRE), 200,000 ART babies had been born around the world in that year. This was presented in comparison with 30,000 babies that had been born in 1989, which was the first year that ESHRE had begun to collect statistical data regarding the number of ART births world wide.

In 2006 ESHRE published a press release stating that to date, more than three million babies had been born throughout the world using ART methods, since the first IVF baby, Louise Brown, was born in 1978 in the United Kingdom, as reported by Edwards, Steptoe and Purdy in 1980.

The International Committee for Monitoring Assisted Reproductive Technologies (ICMART) currently covers over two-thirds of the world’s ART activity. It presented its report, at the 2002 ESHRE Annual Conference, stating that even with the missing data from African and Asian countries; the bureau was still able to estimate that, “the total number of ART cycles in the world can be estimated at one million a year, and the number of ART babies produced at around 200,000 a year.” (de Mouzon, 2002; ESHRE Annual Conference).

1.5.2 THE FUTURE

New technology is being developed at a rapid rate in response to the world wide problem of infertility. ZIFT and or TET are now two further assisted reproductive technologies that can be used during the process of assisted conception. ZIFT, or Zygote Intrafallopian Transfer, involves placing an embryo directly into the fallopian tube. The procedure differs from GIFT as a whole embryo is transferred, as opposed to a mixture of sperm and eggs. TET, or Tubal Embryo Transfer, is a similar process, except that transfer takes place 24 hours after fertilisation at the two to six cell stage of embryo development; versus transfer at the fertilised oocyte stage, usual in ZIFT procedures.
In 2006 ESHRE released a media transcript citing new research reported in the journal, *Human Reproduction*, in June of that year. This new research supported the findings, that in many cases transferring single embryos into the wombs of women undergoing IVF, who are aged 36-39, is just as likely to result in pregnancy and a live birth as it is in younger women. This is important to the current study as many commissioning mothers are often older, especially where other avenues of assisted conception have been exhausted. Senior author, Dr Hannu Martikainen, was quoted as saying,

“What we demonstrated for the first time was that the pregnancy rate, and in particular, the cumulative pregnancy rate, was very similar in the age group 36 to 39 to that obtained previously in younger women. This suggests that embryo quality is the most important parameter in the outcome [of treatment] and that selection for elective single embryo transfer should be based on embryo quality rather than the age of the woman.” (Martikainen, 2006; ESHRE Press Release).

Lucas and Elbarbary (2007) argue that ART will only increase, and that the future therefore lies in continuing to developing more efficient and effective treatments such as, Ovarian Tissue Cryopreservation and Grafts (the ability to freeze ovarian tissue and make it susceptible to successful tissue grafting); In Vitro Oocyte Maturation (the development of immature female reproductive cells outside of the human body); and Pre-Implantation Genetic Diagnosis (a process of diagnosing the ‘health’ of a gamete before it is transferred back into the uterus).

The importance of the above findings to the current study is that in improving the medical procedures involved in Assisted Reproductive Technology, this also improves the chance of success of IVF procedures in gestational surrogacy arrangements. As was previously stated many commissioning couples only consider gestational surrogacy after a long period of diagnosis and unsuccessful treatment attempts. Evidence that egg quality is vital to success in treatment is relevant here as many women are in their mid to late thirties, or older, when gestational surrogacy, using their own eggs, is suggested.
1.5.3 THE CONTEXT OF THE CURRENT STUDY

The importance of this thesis, within the context of the information provided thus far, is that as more and more couples and individuals seek out treatment for infertility the psychological impact of these treatments needs to be understood. Cook (2002) argues that we live within a pronatalist hegemony that values children and the concept and reality of family life. As a former therapist in this area I feel that it is important to understand what motivates a person to be so driven to have a child that they are willing to subject themselves to so many invasive treatments and difficult procedures, as is the case for gestational surrogacy.

In the following section I outline the research goals of this thesis, which is intending to explore the psychological experiences of commissioning gestational surrogate couples.

1.6 RESEARCH GOALS

The project is designed to investigate the psychological experiences of commissioning gestational surrogate couples who have decided to accept an altruistic offer by a woman, usually a close family member or close friend, to act as a surrogate to gestate their child until full term. The project is looking specifically at altruistic gestational arrangements where the commissioning mother is unable to support a normal and safe pregnancy. It can be assumed throughout the reading of this document that wherever gestational surrogacy is referred to, in the context of this study, that altruistic arrangements are being referred to unless otherwise stated.

It is intended that three main areas will be investigated; the psychological experience of gestational surrogacy, the negotiation of guidelines and laws which currently govern infertility treatment and surrogacy arrangements in Victoria, that is the legislation as it stands prior to 1 July 2009, and the negotiation of relationships with all involved in the surrogacy process. This latter area will include investigating the immediate relationship between the individuals in a commissioning couple.

Overall it is hoped that this research may help the reader to understand the emotional impact of gestational surrogacy and the complications that couples may have to face in their decision to have a child in this way. It is further hoped that the findings of this study and the interpretations of these findings may provide the following benefits:
• A systematic investigation of the psychological experiences of commissioning gestational surrogate couples. To date there are no published investigations into this area in Australia.

• Provide legislators with important data during the process of moving from the Infertility Treatment Act 1995 to the Assisted Reproductive Treatment Act 2008.

• Provide data for the legal fraternity to improve understanding and reduce negative experiences for commissioning couples.

• Provide data for health and medical and allied professionals in improving the services offered to commissioning couples.

• Provide information for commissioning couples in Australia in order to improve the process and experiences for these couples.

1.7 THESIS OUTLINE

In concluding this introductory chapter an outline of how the remainder of this thesis will be presented is offered. In chapters two through to four, I will follow the recognised plan of reviewing established research pertinent to the topic under study.

Chapter Two looks at grief and loss models appropriate to the area of loss of fertility, and at the stress and coping models that may be adopted by people in dealing with the psychological impact of this loss. Chapter Three investigates the impact of social support during times of crisis, such as when dealing with, and attempting to cope with, the sometimes difficult experience of gestational surrogacy. The final literature review chapter of this thesis looks specifically at some of the concerns relating to gestational surrogacy such as attachment and exploitation. The three chapter topics have been carefully chosen to give a detailed overview of specific aspects of gestational surrogacy in assisted reproductive technology. A second rationale for choosing to study these aspects is that they loosely represent a time line of the process of gestational surrogacy. Chapter Two looks at the emotional impact of loss of fertility before entering into gestational surrogacy; Chapter Three investigates support during the process; and finally Chapter Four looks predominately at the experiences after surrogacy arrangements. These chapters then form the basis for interpretation and discussion concerning the before, during and after experiences of the couples who took part in the study.
Chapter Five focuses on the methodology that supports this thesis. It offers the reason for adopting a qualitative approach and presents the theoretical rationale for the particular research paradigm used in analysing the collected data. The chapter also outlines how the research was performed and how the methods used helped to overcome some of the recognisable difficulties in working in the area under study. The chapter outlines the structure and style of the interviews carried out and explains in detail the processes underpinning data collection, analysis, presentation of findings and subsequent interpretations and discussion.

Chapters Six through Eight offer the results, interpretation and discussion section of the thesis. Chapter Six looks at the impact of the psychological experience leading up to making the decision to enter into a gestational surrogacy arrangement. Themes such as loss of fertility, anxiety, determination and commitment and philosophical acceptance are explored. Chapter Seven investigates the experiences during the process of the treatment phase of gestational surrogacy, looking at such issues for inquiry as, vulnerability, the positive experience of support, frustration and anger and financial stress. Chapter Eight explores the themes that are apparent in the post treatment phase of the IVF procedure in gestational surrogacy, such as attachment, public opinion, a desire for change, disappointment, desperation and hopelessness.

Finally in Chapter Nine I offer a summary of the findings from this study and discuss their implications, especially the clinical implications for professionals working in the area of gestational surrogacy, or in the review of its processes. I also discuss the limitations of the study and make suggestions and recommendations for further research in the light of the new legislation governing gestational surrogacy in Victoria, coming into affect between July 2009 and July 2010. I conclude with final comments about the study and its impact on those involved.
Chapter 2  Models of Grief and Stress in Infertility

2.1 Introduction

In this chapter I discuss several models of grief and stress that could be used to explain the psychological impact of infertility on commissioning couples in gestational surrogacy arrangements. Conway and Valentine (1988) describe the ‘grief’ in infertility as, ‘reproductive losses’ (p.43), and Baram and Tourtelot et al. (1988) discuss the need for ‘psychological adjustment’ (p181) in attempting to deal with reproductive loss. After presenting an overview of the traditional grief work hypothesis, I offer three interpretations concerning loss, grief and bereavement, and then briefly discuss the theory that there is a possible gender difference in processing the grief associated with infertility. I then explore two models of stress and coping and further discuss their application to the area of gestational surrogacy. In conclusion I offer the theory that an integrated continuous model of bereavement and coping best fits the psychological impact of gestational surrogacy on commissioning heterosexual couples, as opposed to a model offering a linear processing of grief, assumed by stage models of bereavement. I propose that such a model allows for the emotional responses of both individuals in a couple to be considered.

2.2 Traditional Grief Work Hypothesis and Its Application to the Experience of Gestational Surrogacy

McCabe (2003) defines grief as being concerned with, “injury, suffering, trouble, or disaster; the injury or suffering is a result of [that] trouble or disaster.” (p.17). In terms of bereavement, Freud, in 1917, defined the injury as, “the loss of a loved person, or something else that has taken the place of a loved person.” Parkes (1986) and Bowlby (1980) describe the aetiology of grief as being a response to object loss, whether the object is real or imagined. These definitions are significant in understanding the grief that may be associated with the loss of fertility and the need to enter into a gestational surrogacy arrangement to have a child. The object lost can either be the loss of the ability to conceive naturally, or the disappointment associated with failed treatment attempts during the process of gestational surrogacy.
The origins of the concept of grief work can be traced back to the early research of Freud (1917) who argued his theory of trauерarbeit, or the need to be willing to work through a grieving process. Later Bowlby (1980) discussed his attachment theory and the need for detachment, from the person who has been lost, in order to be able to reorganise attachment bonds.

Stroebe and Schut (1999) argued, that based on their research of grief work, grief can be described as,

“A cognitive process of confronting a loss, of going over the events before and at the time of death, of focusing on memories and working toward detachment…fundamental to current conceptions is the view that one needs to bring the reality of loss into one’s awareness as much as possible and that suppression is a pathological phenomenon”. (Stroebe & Schut, 1999; p.199).

Bound up in the theory that an individual needs to process their grief in a formulated way are traditional models that propose a stage process for working through the psychological impact of bereavement. McCabe (2003) offers us a representative schema of prominent grief stage and phase theories, seen in Table 1. This schema illustrates the traditional research postulations concerning loss and grief. The models are important to consider within the context of the current study as they illustrate the potential feelings of grief that could be associated with the loss experienced in infertility or unsuccessful treatment attempts in gestational surrogacy.

Table 1  models of grief

<table>
<thead>
<tr>
<th>Theorist</th>
<th>Stage or Phase</th>
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<tbody>
<tr>
<td>Lindemann (1944)</td>
<td>Shock &amp; Disbelief</td>
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<td></td>
<td>Acute Mourning</td>
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<td>Resolution</td>
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<td>Developing Awareness</td>
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<td>Restitution</td>
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<td>Resolving the Loss</td>
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<td>Idealisation</td>
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<td>The Outcome</td>
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<td>Pollock (1961)</td>
<td>Shock</td>
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<td></td>
<td>(Acute Stage)</td>
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<td>Grief</td>
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<td>Separation</td>
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<td>(Chronic Stage)</td>
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<td></td>
<td>Reparation</td>
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<tr>
<td>Averill (1968)</td>
<td>Shock</td>
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<td></td>
<td>Despair</td>
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<td></td>
<td>Recovery</td>
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<td>Kubler-Ross (1969)</td>
<td>Denial &amp; Isolation</td>
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<td></td>
<td>Anger</td>
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<td>Bargaining</td>
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<td>Depression</td>
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<td>Acceptance</td>
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<td>Parkes (1971)</td>
<td>Numbness</td>
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<td>Searching &amp; Pining</td>
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<td>Depression</td>
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<td>Recovery</td>
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<td>Yearning &amp; Searching</td>
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<td>Disorganisation &amp; Despair</td>
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<td>Reorganisation</td>
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<td>Bowlby (1980)</td>
<td>Numbness</td>
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<td>Yearning &amp; Searching</td>
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<td>Disorganisation &amp; Despair</td>
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<td>Reorganisation</td>
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<td>Rando (1984)</td>
<td>Avoidance</td>
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<td>Confrontation</td>
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<td>Sanders (1989)</td>
<td>Shock</td>
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<td>Awareness of Loss</td>
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<td>Conservation-Withdrawal</td>
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<td>Healing</td>
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Stroebe and Schut (1999) argue that there are many shortcomings of traditional grief work theory and its associated models. Their main criticisms are the “lack of clarity” in the definition of grief work (“is there a clear definition of ‘grief work’ decided upon in established research?” p.200); the quality of explanation of the actions of grief in empirical studies (for example, “what does ‘yearning and pining’ look like?” p.200); the absence of evidence to support these actions in their linear progression, and the lack of application of these models across belief systems and cultures.

The most obvious criticism from the point of view of the current study is that none of the above models allow for a continuous process of grief during a continuing reoccurring loss, as in the loss of fertility and the losses associated with ineffectual treatments, including failed attempts at IVF procedures in gestational surrogacy. In the process of entering into and being in gestational surrogacy a decathexis (Bowlby, 1980), or gradual process of withdrawing energy from that which is lost, is not possible for many couples as they face the next cycle of treatment or the next procedural hurdle. However, the above models are not designed to cope with or even be adapted to the loss of fertility except perhaps in cases where miscarriage occurs during the process of surrogacy, and or when a commissioning couple make the decision to stop treatment altogether.

Despite their obvious shortcomings there is merit in applying the above models to the area of loss of fertility in gestational surrogacy. Although McCabe (2003) does not label the verbs used by the theorists as such, the language used in Table 1 could be characterised as either Interpretative labels or Units of Psychological Meaning as described in the methodology section of this report. In the remaining sections of this chapter I will take the time to look at several models of grief and loss, and of stress and coping that have been developed from the traditional models and that give us a foundation on which to build an understanding of the psychological impact that gestational surrogacy has on commissioning couples.

2.3 Models of Grief and Loss

Following are three models of loss and grief that could be applied to the area of loss in infertility. Although loss in infertility is often clear, for example, through the loss of a baby in miscarriage, loss in gestational surrogacy is often more subtle. This loss usually centres around the initial reasons for entering into the process, and the grief experienced as a result of failed treatment attempts involving a third party.
2.3.1 THE MEANING RECONSTRUCTION MODEL

Gillies and Neimeyer (2006) propose A Model of Meaning Reconstruction in Bereavement, in which grieving individuals reconstruct meaning in response to loss through a process of sense making, benefit finding and identity change. This could be termed as the constructivist meaning reconstruction model as constructivist refers to the view in psychology that individuals learn through a process of accommodation and assimilation. Accommodation is a process of reframing a mental representation of the world to fit a new experience. Assimilation refers to the ability to be able to integrate the new experience into an already existing framework. Constructivists argue that in describing human cognition and associated pedagogic approaches, accommodation and assimilation allows us to “learn by doing”. Gillies and Neimeyer (2006) propose that bereaved individuals question, find and make sense of their bereavement in order to understand their experience of grief; and that bereaved persons accommodate and assimilate the new experience of loss through learning how to deal with the new reality of loss and grief in their previously “assumptive worlds” (p.37).

Gillies and Neimeyer (2006) describe sense making as the need for grieving individuals to “strive to find reasons for what has happened” (p.37) in order to restore routine, security and predictability and as a way of protecting themselves from the pain of loss and grief. The authors propose that benefit finding is a way of “building new meaning structures” (p.37) founded on incorporating the raw experience of the actual loss. These new meaning structures allow the grieving individual the opportunity for “reappraisal” of self and life, especially where some months or years have passed since the loss. However, it is stated that this kind of self actualisation is, “likely dependent on a host of maturational, personal and social resources.” (p.37). Lastly the authors describe identity change as the process of reconstructing the self in new roles.

The connection between Gillies and Neimeyer’s model, illustrated in Figure 2.1, and the potential loss associated with gestational surrogacy, is that the model assumes the case for the need to continue to function and learn from the grief experience. In the model, and in gestational surrogacy, neither party can be so psychologically impacted by the loss that it causes them to stop functioning or learning. This would have a deleterious effect as the goal, in this case a healthy baby, would never be achieved.
Figure 2.1  Model of Meaning Reconstruction Pathways in Response to the Loss of a Loved One

Gillies and Neimeyer describe their model as a model of post traumatic growth. Tedeschi et al. (1988) also argue this and further suggest that a phenomenon of “post traumatic growth” occurs in individuals who respond to loss and bereavement in an adaptive way. This adaptive processing allows for the bereaved person to develop a changed sense of self, becoming more emotionally resilient and independent. In positive identity change the individual might also take on new roles and develop an increased capacity for empathy. Tedeschi (1988) terms this as becoming, “sadder but wiser.” (p.38). In the process of infertility treatment in gestational surrogacy, individuals, and couples, can learn from each treatment attempt how to protect themselves better from negative psychological impact, therefore becoming sadder, but wiser with each subsequent attempt.

The appropriateness of Gillies and Neimeyer’s (2006) model to the area of bereavement in gestational surrogacy also lies in its narrative approach. The above model and representative diagram have only been developed by the authors through their dialogue with bereaved individuals, through a process of semi-structured interviews similar to the data collection method chosen for the current qualitative study. Gillies and Neimeyer argue that it is the re-telling of the narrative that allows the individual to assign meaning to their bereavement experience,

“Constructivist theories commonly frame human experience in terms of our life stories because “we live in stories, not statistics.” (Gilbert, 2002). We continually author our own life stories as we reflect, interpret and reinterpreted what happens in our lives, and we tell and retell our stories to other people and ourselves. Meaning then, is embedded in our life stories, and can be evoked by accessing people's stories in their own word.” (Gillies and Neimeyer, 2006; p.38).

As was previously mentioned the problem with adapting any model of loss and bereavement to the area of loss in infertility and gestational surrogacy is that it does not recognise the continuous experience of loss in the process. A further criticism of the model, and models similar to it, is that it could be said to be based on a behavioural cognitive approach with very little emphasis being assigned to the psychodynamic or interpersonal aspects of loss and bereavement, such as the pain of separation and severed ties with the lost object, in the case of the current study, the desire to have a child.

In the next section I outline the Two Track Model of Loss and Bereavement which is a model that incorporates both cognitive behavioural and psychodynamic approaches.
2.3.2 THE TWO TRACK MODEL OF BEREAVEMENT

Rubin (1999) argues that there are two major approaches to the concept of loss and bereavement. The psychodynamic interpersonal approach, first postulated by Freud (1917), stated that, “Separation from the deceased [is] the heart of the response to loss.” (published in Rubin, 1999; p.683). According to this approach a loss signified the weakening of the connection between the bereaved and the deceased and in the absence of a return to normal pre-loss functioning, the bereaved individual was almost certainly at risk of developing psychological dysfunction.

The second approach suggested by Rubin is based on a behavioural cognitive model, experienced as a “biological, behavioural, cognitive and emotional process fundamentally similar to the response of individuals in situations of crisis, trauma and stress.” (p.228). In this second approach researchers and theorists are less concerned with talking about severed bonds suffered by the bereaved and are more concerned with assessing behavioural impact on daily functioning pre and post loss. This is similar to Gillies and Neimeyer’s model, but the overall two track model allows for dual involvement because of its concern with the psychodynamic interpersonal approach as well as with the bio-behavioural. Stroebe and Schut (1999) refer to this dual model as a psychosocial model (p.209). The relevance of Rubin’s two track model to the potential loss experienced in gestational surrogacy is that it concentrates on daily functioning ‘pre’ (as in the lead up to the need for gestational surrogacy) and ‘post’ (as in failed treatment attempts). It also recognises the dual involvement of bio-behavioural and interpersonal responses that could potentially seen in response to failed medical interventions in gestational surrogacy arrangements.

In his article, ‘The Two Track Model of Bereavement: Overview, Retrospect and Prospect’, Rubin (1999) argues that a combination of the psychodynamic interpersonal and cognitive behavioural approaches, offering a bifocal approach to bereavement and loss, allows us to consider the impact of separation in bereavement, and assess that impact on psychological, emotional, physical and spiritual functioning.

“In the attempt to bring the study of trauma and loss into alignment, an approach that emphasises a continuing relationship to the deceased, while remaining attentive to the indicators of functioning that are disrupted, has particular value. Under varying conditions of stress, bereavement and trauma, and at any time, we can choose to examine how functioning, and or the relationship to the deceased are proceeding.” (Rubin, 1999; p.684).
As a result of published studies offered by Rubin (1981, 1982, 1984a, 1984b, 1985), the author proposed his Two Track Model of Bereavement. Rubin (1999) argued that a bereavement response occurs along two main axes and that these axes are themselves multi-dimensional. He argued that the first axis deals with how individuals would normally function and how this functioning is affected by the life changing event of loss. According to Rubin the second axis is concerned with how the individual is involved in, “maintaining and changing their relationship to the deceased.” (p.684). This axis appears to be dealing with how people cope psychologically and emotionally. Rubin argues that the implications of the model are relevant to theory, research and clinical interventions as, “One can always ask to what extent the bereaved’s response along each of the tracks of the model is addressed and understood?” (p.685). This is important within the context of gestational surrogacy as the loss experienced in failed treatment attempts needs to be balanced against the whole impact of the loss of fertility. Finally Rubin suggests that the bifocal nature of the model means that in clinical work a focus can be placed on both functional and relational aspects of loss and grief work. The author argued that this is important in grief counselling. In the area of gestational surrogacy this would also be of particular importance as couples could be continuously facing loss.

Figure 2.3 outlines Rubin’s (1999) two track model of bereavement. It would appear that this is a useful model to explore in the context of the current study as it looks at the need to maintain life function whilst also attending to the function of grieving. In gestational surrogacy arrangements commissioning couples must attend to daily functioning, including treatment, as well as attending to any sadness relating to initial diagnosis and or unsuccessful treatment attempts.
<table>
<thead>
<tr>
<th>Track I</th>
<th>Functioning</th>
<th>Track II</th>
<th>Relationship to the Deceased</th>
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<tbody>
<tr>
<td>• Anxiety</td>
<td>• Imagery &amp; Memory</td>
<td></td>
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<tr>
<td>• Depressive Affect &amp; Cognition</td>
<td>• Emotional Distance</td>
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<td>• Somatic Concerns</td>
<td>• Positive Affect vis-à-vis Deceased</td>
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<td>• Psychiatric Symptoms</td>
<td>• Negative Affect vis-à-vis Deceased</td>
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<tr>
<td>• Familial Relationships</td>
<td>• Preoccupation with Loss &amp; the Lost</td>
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<td>• General Relations</td>
<td>• Idealisation</td>
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<td>• Self Esteem &amp; Self Worth</td>
<td>• Conflict</td>
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<td>• Meaning Structure</td>
<td>• Features of Loss Process (Shock, Searching, Disorganisation &amp; Reorganisation)</td>
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<td>• Work</td>
<td>• Impact upon Self Perception</td>
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<td>• Investment in Life Tasks</td>
<td>• Memorialisation &amp; Transformation of the Loss and the Deceased</td>
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Rubin’s (1999) model allows for a dual process of grieving that can occur in the loss of fertility and failed treatment attempts in gestational surrogacy. The alignment of both the functional and relational aspects of grieving that occurs in a continuous loss is particularly pertinent. During the potential roller coaster ride of gestational surrogacy, candidates often face years of near successful attempts at IVF, failed cycles, miscarriages, distressing diagnoses, and the unpredictability of costs, along with the previously inconclusive laws regarding legal parentage if a child is born. Track I sub areas such as anxiety would be apparent and Track II sub areas such as, preoccupation (with lost fertility) and impact on self perception (at failure to conceive) would almost certainly fit within Rubin’s model.
Although the two track model comes closer to giving us an understanding of the process of loss and grief involved in gestational surrogacy, we still require a model of continuous loss to help us to fully comprehend bereavement in the loss of fertility and the subsequent choice of a gestational surrogacy arrangement. In the next section I outline the Keening Syndrome of Infertility-Specific Grieving Model. As its title suggests it is a specific model that looks at the psychological impact of the loss of fertility and therefore could be applied to the impact of gestational surrogacy.

2.3.3 THE KEENING SYNDROME OF INFERTILITY-SPECIFIC GRIEVING MODEL

“Infertility involves grief and loss whether it is a profound distinct loss at the onset of treatment or a gradual accumulation of losses over time. The losses of infertility may involve the loss of individual and or couple’s health, physical and psychological well-being, life goals, status, prestige, self-confidence, and assumption of fertility, loss of privacy and control of one’s body, and anticipatory grief at the possibility of being childless.” (Covington & Burns, 2006; p.1).

Sharon Covington and Linda Hammer Burns (2006) propose the Keening Syndrome of Infertility Specific Grieving Model. As can be seen from their quote there is an assumption that the loss of fertility is experienced in an incremental progression. It would also appear that the impact of this loss can be seen over several functional areas.

Within the context of infertility specific grieving, the authors propose that keening refers to the, “Traditional Irish custom of grieving in which women weep...and men watch in sombre silence.” (p.18). Covington and Burns suggest that this might be an appropriate model for grief in loss of fertility as,

“The keening syndrome of infertility refers to the way in which many couples grieve the losses of infertility: Women weep and men watch, often emotionally distancing themselves from the couple’s shared loss. This phenomenon can result in husbands becoming the ‘forgotten mourners’ because the husband is less verbal and expressive with his grief or unable to express it in the same open manner as his wife.” (Covington and Burns, 2006; p.18).

Covington and Burns (2006) argue that not only is this keening model moving toward a more appropriate model of grief in loss of fertility, but it also takes into account the gender differences in responding to the problem of infertility, and attempting to deal with the continual losses associated with unsuccessful treatment.
The authors argue that grief in infertility is a disenfranchised grief in that, “infertility is a loss that can lead to intense grief, although others may not recognize it, or perceive it as minor.” (p.19). The three aspects of disenfranchised grief suggested here that form the foundation of the keening syndrome model are; that the grief can be perceived by others as having no legitimacy and is socially unrecognised; that the grief is seen as insignificant by others; and that the griever is not recognised as having suffered a loss.

In addressing the gender difference in the grief associated with the loss of fertility, the authors argue that this has a long term impact on a couple’s ability to move forward and make decisions about how to build a family, especially as the woman in a couple may well be assuming the role of the primary griever, while the male stands by assuming the role and responsibility of stoicism and control.

“In many ways, this approach highlights not only gender differences in grief and mourning but also how women often assume the role of primary mourner, bearing an unequal share of the emotional burden of a couple’s grief. Some have suggested that this is because women are proportionately more distressed than men, while others argue that it represents a common marital or cultural pattern in which women assume greater responsibility for the couple’s emotional well-being and expressiveness.” (Covington and Burns, 2006; p.20).

The similarity between Covington and Burn’s model and the two track model of bereavement is that apart from considering areas of functioning (Track I); the authors also look at Track II features such as, shock and negative affect, for example, blame or shame. Other psychological or relational aspects listed by Covington and Burns are grief responses such as, “disbelief, anger, blame, shame and guilt, loss of control, diminished self esteem, anxiety and depression.” (Covington & Burns, 2006; p.1).

Established research by Abbey, Andrews and Halman (1991) supports the view that individuals question the control that they have over their bodies in infertility. Bryson, Sykes and Traub (2000) include studies on lowered self esteem in infertility and Cook (1987) and Ulrich and Weatherall (2000) discuss the, “growing isolation and separateness from peer groups and friends.” Cook (2002) offers further empirical studies that outline the impact on both men and women of the grief at the loss of their fertility and failed treatment attempts. Unruh and McGrath (1985) support the notion of chronic bereavement in infertility identifying the chronic infertility-specific grief model, which suggests that, “infertility-specific grief may never be completely mourned, transcended, or fully integrated.” The authors
further argue that, “even after parenthood has been achieved or childlessness accepted, infertility can, and often does, periodically reemerge only to be remourned from a different perspective.” (p.20).

Cook (2002) further discusses the concept of pronatalist hegemony in society, making it, ‘exceptionally difficult’ for infertile couples, and women in particular to accept their loss of fertility. This is due to the pronatalist ideological belief that a woman's worth is tied to conceiving and bearing children. This pronatalist view is considered to be the controlling or dominating influence, the hegemony underpins the society in which we live (Dennerstein & Morse, 1988; Fiske, 1997; Golumbok, 1992). Cook argues that for couples who have constructed meaning for their lives that includes parenthood, the involuntary childlessness can be, ‘psychologically devastating’. The author further argues that the intrapersonal responses by women to their loss of fertility are similar to the grief and loss, and bereavement experience. Cook looks at the three aspects of disenfranchised grief, mentioned by Covington and Burns (2006), and describes Anderson and Alesi’s (1997) view of grief in infertility. These researchers state that, “there is no tangible loss and no discrete event”; the infertility is, “not regarded as significant by those who have no experience of it” and that due to technological advancement and the hope that a treatment will work, “the loss is uncertain and the grieving cannot proceed.” (Anderson & Alesi, 1997; p.251).

The relevance of Covington and Burn’s (2006) model to the context of gestational surrogacy is that it specifically deals with the grief and loss that might be experienced in infertility. The model also proposes that there may be a gender difference in response to infertility. This is briefly discussed in the next section, and is important within the context of the current study, as it points to the need for establishing a model that takes into account the emotional responses of both parties in a heterosexual couple.

2.4 GENDER DIFFERENCES

As has been stated, the aim of this study is to explore the psychological experiences of commissioning couples entering into gestational surrogacy arrangements. The process of this analysis is a complicated one as we are looking at individual responses, but from within a heterosexual couples’ relational framework. Although there is not the space here to analyse the gender difference in grief responses in extensive detail, it would be remiss not to pay some attention to the fact that established literature clearly states that men and women grieve differently and that
this difference is apparent in the loss of infertility. Research suggests that models of stress and coping are more likely to be relevant to grieving men, than models of loss and grief, and that it is a stressor-specific framework that men work within when coping with loss (Stroebe & Schut; 1999 & Cook; 2002). These assumptions do not necessarily negate the models of loss and grief previously discussed, but point more specifically to the difference in gender when coping with loss.

Cook (2002) argues that the research output in the area of gender difference in response to grief and loss in infertility, and in particular in the area of men’s personal responses, is small and tends to include men, “only as those who are companions of the women being treated.” (p.35). He suggests that earlier research such as Woollett (1985) and Matthews and Matthews (1986) assume and conclude that men are similarly affected to women in their intrapersonal responses in the area of fertility loss and infertility treatment. Cook further cites Callan and Hennessey (1989) who argue that these earlier reports, along with studies by Tarlatzis et al. (1993) and Glover, Abel and Gannon (1998), “Initially seemed to adopt a model of grief and bereavement which worked well for explaining women’s responses.” (p.37). Cook suggests that these studies assumed that if women’s grief in infertility could be explained by traditional models of grief and bereavement then so could men’s.

Stroebe and Schut (1999) argue that current grief work hypothesis does not take into account preferred masculine ways of coping with loss and grief, which appear to be less confrontative of emotional responses and less likely to present as distress and depression than in women (Stroebe, 1998). The authors further argue that although the male grief response is now beginning to receive some attention, the emphasis has been very much on the assumption that men and women grieve in a similar fashion. Stroebe and Schut postulate the idea that the grief work hypothesis has been derived from largely female samples and that the results from these studies may not be generalisable to a male sample. They ask the question, “Is what we have at present a female model of grieving.” (p.204).

Cook (2002), whose research dealt specifically with the losses experienced by infertile men, cites further studies that show that men may respond differently to women in their responses to infertility, especially in male infertility. Support for this suggestion comes from Kedem, Mikulincer, Nathanson and Bartoo (1990) who reported that infertile men are more likely than fertile men to have lowered self esteem and suffer from anxiety. Glover, Gannon, Sherr and Abel (1996) found that infertile men feel guilty and at fault concerning their infertility; Irvine and Cawood (1997) reported
findings that infertile men have feelings of being inadequate, both personally and sexually; and van Balen, Trimbos-Kemper and Verdurman (1997) found that infertile men are not likely to talk to others about their problems, preventing them from experiencing the Social Buffer highlighted by Stroebe, Stroebe and Schut (2001) which suggests that, “High levels of social support protect individuals against the deleterious impact of stress on health.” (p.72).

Band, Edelmann, Avery and Brinsden (1998) found that infertile men were more at risk of depression and anxiety and less able to access social and medical support than fertile men. An explanation offered by Cook (2002) for the development of these characteristics was that, “Infertile men are not so much grieving for a loss, but anticipating and experiencing a threat...this threat is perceived as diminishing men’s sense of their masculinity.” (p.38).

Stroebe, Stroebe and Schut (2001) found that in coping with spousal bereavement men were freer to engage in their preferred style of coping as they were not prevented from doing so by the same external constraints as women, for example, attention to family and domestic tasks. Ultimately this leads to men possibly suffering more as they did not necessarily attend to both the functioning and relational aspects of the so called grief work, but engaged in management rather than confrontative grief. (de Ridder, 2000; Folkman & Lazarus, 1980; Porter & Stone, 1995, in Stroebe et al. 2001). The authors cite further studies that show bereaved men exhibited health benefits when they were taught in counselling to confront emotions and deal with any secondary stressors associated with loss and grief; likewise women who were taught to be less emotional and more problem orientated also showed major health benefits (Schut, Stroebe, van den Bout & de Keijser, 1997).

A clear picture emerging from the studies investigating the experience of the emotional impact of infertility is that women grieve and men stoically cope. It is this quiet coping that gives rise to the theory that men may well be working within models of stress and coping rather than traditional models of loss, grief and bereavement. The following section outlines two models of stress and coping and discusses their application to the area of gestational surrogacy.
2.5. MODELS OF STRESS AND COPING

Below I discuss two models of stress and coping and offer an explanation of how these models may well be more appropriate frameworks for coping with the loss of fertility and the experience of being a commissioning parent in a gestational surrogacy arrangement.

2.5.1 COGNITIVE STRESS THEORY

Lazarus and Folkman (1984) were the first exponents of Cognitive Stress Theory. The authors postulated that, “Stress is experienced by an individual when the demands of a given situation are seen as taxing or exceeding resources, which endangers well being and health.” (p.312). According to cognitive stress theory, cognitive appraisal processes operate to determine whether a situation should be perceived as challenging or stressful. Stroebe and Schut (1999) argue that in line with the model, coping processes manifest themselves in two ways. Problem-focused coping is directed at managing and altering the problem, which is perceived by the individual as being able to be changed; and emotion-focused coping, refers to the individual managing the resulting emotion of being in a challenging or stressful situation. The authors further argue that emotion-focused coping tends to be relied upon more when the individual perceives the situation as being out of their control.

Stroebe and Schut (1999) argue that for a stress and coping theory to be applied well to a specific area or stressor, the model needs to be able to deal with three things; the characteristics of the stressor, the coping process and the outcome. In applying cognitive stress theory to the area of coping and the loss of fertility in gestational surrogacy we would need to examine its appropriateness in the light of these three markers.

The characteristics of the stressor under immediate study are the emotional and psychological responses of the individuals in a heterosexual couple to the loss of fertility and to the feelings associated with failed treatment attempts in gestational surrogacy arrangements. From the studies cited thus far it would appear that men cope with bereavement by engaging in problem-focused coping and women in emotion-focused coping. Although it would seem that cognitive stress theory could be applied to the area of emotional response to loss and grief in infertility, Stroebe and Schut (1999) argue, that in the context of bereavement, it is not the life event of the loss that is the main stressor, but it is the grief that this event elicits. The authors ask the question, “How, then, does one deal with this distressing emotion [grief] in
an emotion-focused versus problem-focused way, given that emotion-focused coping incorporates the control of emotions as well as the expression of them?” (p.206). This is similar to Rubin’s (1999) two track model which looks at the relationship between the emotion of loss and the control of the emotion of loss which in turn contributes to daily life functioning. This exploration of the processing of the psychological impact of a loss is also the main issue for inquiry in the current study.

Aldwin (1994) and Aldwin, Sutton and Lachman (1996) introduce a Deviation Amplification Model of Coping with Chronic Stress. The possible application of this model to the area of individual grief response in infertility and failed treatment attempts is that it does not presume a single episode of stress, (for example, Bolger, 1990, Folkman & Lazarus, 1985), or an episodic interlude of stress over a discrete period of time (Gottleib, 1997), but presumes a coping process for dealing with ongoing chronic stress associated with elicited grief as described by Stroebe and Schut above and as suggested by Rubin (1999). This model then is appropriate for application within the context of infertility and gestational surrogacy as it deals with chronic continuous stress.

2.5.2 THE DEVIATION AMPLIFICATION MODEL OF STRESS AND COPING
The initial development of the Deviation Amplification Model of Stress and Coping was based in part on Maruyama’s (1963) modification of systems theory that accounted for change and growth and homeostasis in dealing with the long term effects of stress, reworded here as the ‘stress of grief’ (Gottleib, 1997). Maruyama proposed that there were two processes by which a system either maintained homeostasis or promoted change. A deviation countering process or deviation countering process loop, seen as a negative feed back loop that prevented change and maintained the status quo; and a deviation amplification process or deviation amplification loop, seen as a positive feed back loop serving to promote and magnify change.

In stress and coping theory this deviation and amplification model was seen by its designers as having the potential to result in either adaptive (positive) or maladaptive (negative) spirals, both of which could result in things remaining the same or changing in either a negative or positive direction. Aldwin and Stokols (1988) hypothesised that the characteristics of stressors were likely to lend themselves to either deviation countering processes or deviation amplification processes.
The authors argue that the direction of the spirals was dependent on components such as personality characteristics and access to coping resources. A further argument is made that in a negative spiral, “low levels of coping resources may contribute to a further depletion of resources which results in increased vulnerability to future stress.” (p.842); and in positive spirals, “High initial levels of resources may result in the development of further resources, which increase resilience to future stress.” (p.842).

**Interpretative Labels**

**Adaptive Spiral**
- A Desire for Change
- Determination & Commitment
- Excitement & Hope
- Gratitude
- Philosophical Acceptance
- Positive Experience & Support
- Strong Relationship with Partner

**Maladaptive Spiral**
- Anxiety
- Confusion
- Desperation & Hopelessness
- Disappointment
- Disempowerment & Lack of Control
- Exhaustion
- Financial Stress
- Frustration & Anger
- Guilt
- Isolation
- Stress
- A Traumatic Experience
- Vulnerability

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**Figure 2.3** A Deviation Amplification Model for Grief in Infertility


**Figure 2.3**, adapted from Aldwin and Stokol’s (1988) model, shows a possible deviation amplification model for coping in the process of grief in infertility. Possible interpretative labels of psychological meaning, relevant within the context of gestational surrogacy have been suggested in the place of adaptive spirals and maladaptive spirals.
The deviation amplification model of stress and coping could be adapted to the area of grief and stress and coping in infertility, especially as the model concentrates so heavily on mastery and building self esteem allowing for both an adaptive problem-focused and emotion-focused result. The relevance of this within the context of gestational surrogacy is that an adaptive problem-focused response is required in order to continue to deal with the practicalities of the treatment process, and an adaptive emotion-focused response is required to deal with the psychological impact of such treatments.

It would appear, from the evidence given, that cognitive stress theory and the deviation amplification model can be applied to the current study as they both provide for problem-focused and emotion-focused responses, allowing for the gender difference in response to loss and grief in infertility. However, there are two problems that might exist in trying to force the concept of grief and loss in infertility and grief and loss in failed treatment into these models. The first problem is that even if we have a totally clear picture that women grieve and men stress and cope, there is little published evidence to suggest that in the area of loss in infertility and failed treatments that men specifically adhere to stress and coping models and women specifically comply with models of bereavement loss and grief. The second problem is that both of the above stress models highlight the cognitive and almost evolutionary response to grief and stress without really taking into account the psychodynamic component. As we learned from Rubin’s (1999) model this psychodynamic and interpersonal approach is extremely significant in the experience of bereavement and loss especially in the area of counsellor understanding.

In summarising all of the models represented in this chapter so far, it could be said that each might be adapted to the context of infertility and gestational surrogacy and that most, if not all of the models, could be applied to the area of gender specific emotional responses. Although it would appear that men and women may engage in grief work from differing perspectives, this does not mean that men, who are dealing with the grief associated with the loss of fertility and failed treatment attempts, automatically fit into a cognitive stress theory model of coping or a deviation amplification model. The complication here for me is that I am left with questions about whether the response to the loss of fertility and the difficulties of gestational surrogacy has been inappropriately labelled as grief, when perhaps it could be better understood if it were labelled as something else, such as, grief and stress. It also needs to be considered as to whether there is a differing gender response to loss and
grief in infertility depending on whether there are male or female contributing factors to that infertility. Further research would be useful in this area, but is not the main aim of the current study.

In returning to the initial definitions described at the beginning of this chapter I am reminded that grief has been understood in established research as, ‘injury and suffering’ in response to ‘trouble and disaster’ and as the emotional response to, ‘object loss’ whether ‘real or imagined’. In keeping these definitions in mind it could be said that anyone who has experienced the loss of the real object, that is fertility; and the loss of the imagined object, children and family life could be described as grieving and stressed.

As this study is not designed to investigate this possible intricate distinction between grief and stress it would seem to be appropriate to look for a model that best incorporates bereavement, loss and grief, and stress and coping across both genders, and that can then be applied to the area of grief and stress in loss of fertility and incremental loss in failed treatment attempts in gestational surrogacy. In the final section of this chapter I describe a dual process model of coping and bereavement and discuss its applications to the area of gestational surrogacy.

2.6 THE DUAL PROCESS MODEL OF COPING AND BEREAVEMENT TOWARD AN INTEGRATED MODEL

Neimeyer (2002) argued that the Dual Process Model of Coping and Bereavement (DPM) focuses specifically on, “the aspect of confrontation and avoidance, the positive and negative valence of the emotion or situation being confronted or avoided, and its effects on coping with loss.” (p.56).

The developers of the DPM, Stroebe and Schut (1999), identify two stressors within the framework of their model, loss orientation and restoration orientation (p.212). Neimeyer (2002) describes loss orientated coping as a process concerned with concentrating on, and working through aspects and issues of the loss experience, for example yearning for and crying about the person lost (p.65). Stroebe and Schut (1999) argue that restoration orientated coping is more concerned with mastering new tasks and roles, dealing with reorganising life, and the development of new identities. The authors further suggest that a stressor is not an outcome variable, but a secondary source of coping with stress:
“When a loved one dies, not only is there grief for the deceased person, one also has to adjust to substantial changes that are secondary consequences of loss. In many bereavements these additional sources of stress add considerably to the burden of loss and cause extreme additional anxiety and upset.” (Stroebe & Schut, 1999; p.214)

Neimeyer (2002) and Stroebe and Schut (1999) give examples of these additional complications such as, taking on the financial responsibility of the household, being a single person in a friendship circle predominated by established couples, or the selling of the family house in order to reorder life and avoid financial complications.

The relevance of the DPM within the context of the current study is that commissioning couples in gestational surrogacy arrangements must also attend to loss orientated and restoration orientated coping. As previously mentioned, couples involved in gestational surrogacy need to attend to the potential burdens of being involved in the process, such as travelling interstate at short notice. They also need to attend to daily life functioning, and to the grief that they may be feeling at the loss of their fertility and the need for surrogacy arrangements.

Stroebe and Schut (1999) suggest that loss and restoration is similar to the concepts discussed by Parkes in his 1971 article, entitled Psychosocial Transitions. Here the author describes the balance between grief and loss through death and between personal gains in terms of positive changes for the bereaved individual over time. However the authors state that what is missing from Parkes’ model and other models of bereavement and coping are the cognitive processes regulating attention to either loss or restoration. Oscillation is therefore proposed by Stroebe and Schut and described as a dynamic mechanism that allows for an inclusion of cognitive appraisal, emotional response and psychodynamic processing. It refers to,

“The alternation between loss and restoration-orientated coping, the process of juxtaposition of confrontation and avoidance of different stressors associated with bereavement. At times the bereaved will be confronted by their loss, at other times they will avoid memories, be distracted, or seek relief by concentrating on other things. Sometimes there may simply be no alternative but to attend to the additional stressors...” (Stroebe & Schut, 1999; p.216).
This juxtaposition can be referred to as a cognitive process and a regulatory mechanism that comes from confrontation versus avoidant coping strategies. Oscillation within the DPM is described by its developers as a ‘*dynamic back and forth process*’ which allows the bereaved individual optimum chance for healthy adjustment. This is achieved within the model by acknowledging the benefits of denial and avoidance (for example when a bereaved person takes time off from grieving whilst attending to tasks) allowing the individual to regroup before confronting the emotional impact of the loss. Optimal adjustment is seen when a bereaved person is able to oscillate between loss orientated and restoration orientated fields and is cognisant of the processes involved in doing so. It is predicted by Stroebe and Schut that through repeated exposure and ‘confrontation’, habituation takes place, and that this habituation in the context of ‘*taking breaks*’ allows for the ultimate recovery from grief and promotes the healthiest and most cognisant (being aware of the process) form of coping.

The Dual Process Model of Coping with Loss Pathways, presented in Neimeyer (2002) provides us with a clearer picture of how individuals grieve and cope with loss on a daily basis by cognitively reconstructing meanings from their experiences. The application of this DPM to the current study is that it provides us with a framework for understanding grieving and coping. The individual can move backwards and forwards between the two orientations without having to totally move away from that which is lost, or that which is causing them grief. In infertility and in choosing treatment pathways the individual or couple is not free to process grief or stress in a linear progression but deals daily with decisions such as, “*Do I take a break from treatment and start a new job?*” (restoration), Or, “*Do I engage in this next treatment cycle and cope with the grief and stress that it brings, whilst maintaining the status quo in other areas of my life?*” (confrontation).

*Figure 2.4* illustrates Neimeyer’s 2002 model which clearly shows the relationship, or oscillation between, loss orientated and restoration orientated responses to loss and grief showing the relationship between restoration and confrontation.
In its application to the current study the DPM is perhaps the most appropriate model that we have for a number of reasons:

1. It explains how individuals and couples can ‘take time off’ from thinking about and having to deal with the loss of fertility and the stress of being involved in gestational surrogacy. Stroebe and Schut refer to this process as *dosage*.

2. Couples can be educated about loss-orientation and restoration-orientation and can recognise the need for denial and avoidance, and confrontation and engagement.

3. In the ongoing process of treatment in gestational surrogacy, cognitive appraisal and reappraisal in examining the stressors, looking at the process of dealing with grief and coping, and understanding that men and women deal with the situation differently may improve a couple’s experience and lessen discord between them.
4. The model promotes meaning construction and reconstruction at varying points, which is particularly important in situations of ongoing or cyclical loss as is often the case in infertility and failed treatment attempts.

5. The model does not presume a linear progression and allows individuals and couples to re-enter with each new loss and work towards restoration or the next step in attempting to build a family.

2.7 CONCLUSION

It is apparent from the studies presented in this chapter that individuals who suffer a loss also suffer from a sense of bereavement and need to find a way of coping with the impact of their grief. It may well be that women are more loss orientated and emotion-focused than men in attempting to deal with their feelings of loss, as per models of loss and grief, and that men are more restoration orientated and problem-focused, perhaps focusing less on the absence of a child and more on the anticipation and experience of how this will be perceived and how this will continue to impact their lives, as in models of stress and coping.

For the time being the dual process model of stress and coping offers us a framework to understand how individuals cope with the synonymous tasks of dealing with grief, the stress of that grief and their daily life functioning. In the context of the current study this may explain how commissioning couples cope with the sadness of their initial diagnoses whilst also attending to the stress of treatment, unsuccessful treatment attempts and daily life events.

In the next chapter I look closely at the impact of social support during the process of gestational surrogacy and suggest that the grief, loss and stress associated with the loss of fertility and the need for gestational surrogacy can be better managed and coped with within the context of a positive and supportive social network.
CHAPTER 3  THE IMPACT OF SOCIAL SUPPORT DURING GESTATIONAL SURROGACY

3.1  INTRODUCTION

In this chapter I discuss the importance of social support during the process of gestational surrogacy. I give several definitions of social support, as they relate to areas of health and health promotion, and offer a brief description of the assessment tools used in analysing social network morphology. I offer three hermeneutic models of coping which rely heavily on psychosocial support as the basic tenet of their theories, and discuss their relevance to the area of infertility treatment in gestational surrogacy. I then examine several studies designed to investigate the psychological impact of social support and its effect on well-being during health crises; I also examine studies that look particularly at the impact of social support during IVF treatment. Finally I discuss the models and studies as they might pertain to the impact of social support during the process of gestational surrogacy.

3.2  DEFINING SOCIAL SUPPORT IN CONTEXT

Within the context of the current study social support might be perceived, by commissioning couples, as being either positive or negative. Golombok et al. (2006) argue that criticisms of the process of gestational surrogacy have arisen from religious, moral and sociological backgrounds. The main concerns appear to centre on public lack of understanding regarding the actual process of gestational surrogacy, especially altruistic surrogacy, and fears that parties may be exploited in attempting to create a healthy child. Other concerns point to the possibility of lack of attachment and bonding by either parent or child due to birth origins. These concepts are discussed more fully in the next chapter. For commissioning couples undergoing surrogacy there could be the potential for individuals within their social network to have concerns, due to their own lack of understanding about the process. The distinction between negative and positive social support, as it can be applied to specific areas, is a topic for study in its own right. For the purpose of the current study social support is assumed to have the potential for positive impact, whereas a lack of social support, or inability to access it, is assumed to have a deleterious effect.
Pearson (1986) suggests that it is extremely difficult to arrive at a consensus (p.390) on what exactly social support is. Having extensively investigated both the definitions and measurement of social support, Pearson argues that,

Research indicates that socially supportive relationships and effective social networks have therapeutic value in mental and physical health. It is now widely believed by counsellors and psychologists that social support facilitates coping. (Pearson, 1986; p.390).

One of the classic definitions given to explain the concept of social support is offered by Sidney Cobb in his presidential address of 1976 in *Psychosomatic Medicine*,

“Social support is defined as information leading the subject to believe that he is cared for and loved, esteemed, and a member of a network of mutual obligations...It appears that social support can protect people in crisis from a wide variety of pathological states: from low birth weight to death, through arthritis to tuberculosis to depression, alcoholism, and the social breakdown syndrome. Furthermore, social support may reduce the amount of medication required, accelerate recovery, and facilitate compliance with prescribed medical regimens.” (Cobb, 1976; p.300).

In attempting to analyse Cobb’s definition, and in the search for a consensus, Pearson (1986) argues that Cobb is identifying three components of social support: firstly, the information that the individual perceives that he is loved and cared for, (“succour, nurturance and affiliation”), secondly, information that the individual is valued and esteemed, (“recognition and respect”), and thirdly, information that the individual belongs to a network of mutual obligation, (“group membership”) (p.390).

Gore (1973) conceptualises social support as the, “...attributes of socially legitimate roles which provide for the meeting of dependency needs without loss of esteem.” (p.16). Gore argues that social support is an asset to coping which facilitates striving for love, security and sexual satisfaction, and self expression, recognition and belonging. (p.25). Pearson highlights Gore’s conceptualisation of social support as falling into two pathways; the first being the pattern of interpersonal relationships and the second being facilitation of the performance of social roles which help to meet both interpersonal and intrapersonal needs.

For the sake of having a foundation from which to begin, it would appear that social support can, at least at its most basic level, be defined as the network of relationships that support, and possibly even mould, the individual, offering an opportunity for love, esteem, and communication, being based upon either positive mutual obligation or the need of a particular individual. During this chapter I will be
concentrating more on the support offered by social networks than on the support offered by organisations staffed by professionals. The topic of the impact of organised social support is a large one, and the focus in this study has been directed more specifically toward the impact of social support from informal sources.

Below are several definitions that define social support in specific life or health contexts, and offer some insight into how individuals utilise social support. It is hoped that this may help to give the reader a deeper understanding of what role this psychosocial phenomenon plays before extrapolating to the area of infertility and gestational surrogacy.

### 3.2.1 Defining Social Support in Women’s Health

Hurdle (2001) suggests that the concept of social support was first articulated by Cassel (1974) and Caplan (1974), and argues that there is an importance in, “social ties [that help in] coping with crises, life transitions and deleterious environments.” (p.73). Hurdle, a researcher and social worker by profession, states that one of the first social work definitions of social support was offered by Ell (1984), as “...the emotional support, advice, guidance, and appraisal, as well as the material aid and services, that people obtain from their social relationships.” (p.73). This is an important definition as up until this point I have concentrated more specifically on definitions of social support that look more at the psychosocial benefits than at the material gains that an individual might perceive as being just as important, or perhaps even more so, in receiving social support. For example, paying for a taxi to drive a woman’s children to school, where that woman has just undergone embryo transfer in a gestational surrogacy arrangement, might be perceived by her as being much more socially supportive than listening to her narrative of the experience.

Hurdle (2001) argues that the importance of relationships to women of all ages might explain the strong link between social support and the effect on female health. Gilligan (1982); Miller and Stiver (1997); Surrey (1991) and Hurdle (2001) all investigated the self-in-relation to psychological development and ethic-of-care in moral development. The studies concluded that for females of all ages, and stages of development,

...the need for connection and relationships with others is a primary motivation that determines cognition, affect, and behaviour...therefore the influence of social relationships may assume a more primary role for girls and women and influence the decisions they make and their feelings about health issues. (Hurdle, 2001; p.74).
In summing up her definitions of what social support looks like relating to the issue of women's health, Hurdle (2001) discusses studies by Spiegel et al. (1989) and Roberts et al. (1994), both of which illustrate the impact of social support in women newly diagnosed, and women with end stage, breast cancer respectively. In the initial study, by Spiegel, newly diagnosed participants reported that psychological well-being and stress levels were dependent on their perception of available social support; in the second study, by Roberts, participants were found to live longer and have improved emotional health when they participated in a support group of women facing similar difficulties.

As a further definition Hurdle discusses the concept of social support in relation to pre-natal health in young mothers. Here the author argues that studies show (for example Barrera and Ball, 1983) that social support and size of social network positively influenced whether birth complications occurred and also played a role in the health of newborn infants.

From the explanation given in this section, the definition of social support takes on yet another dimension to those previously outlined; that is, the influence of psychosocial support on health behaviours and outcomes. What is apparent is that a sense of well-being can be related to the experience of positive social support. In the current study I am looking particularly at the impact of positive social support and how it is accessed and utilised by commissioning couples in gestational surrogacy arrangements.

In the next section I look at the definition of social support as it relates to the connection between self-esteem and the ability to access positive social support. Although there are many studies which explore the connection between social support and coping, there are few which investigate more specifically the impact of social support on the development of self-esteem in marginalised individuals. The study explored in this section looks particularly at the experiences of gay men in a culture where homosexuality is all but prohibited. The rationale for including this study is that it offers the best example of an investigation of the relationship between self esteem and the personal ability to access social support. As has been previously mentioned there is little established research available in the area of the psychological impact of gestational surrogacy on commissioning couples, including the impact of social support on self-esteem; for this reason I am required to extrapolate from established research. The application of the research, cited in the next section, to the current study is that social support, and the ability to access it,
can greatly improve health behaviours, including the psychological well-being, of individuals potentially disenfranchised from their social group due to major life events, life decisions, or due to health crises. The study provides us with a foundation for exploring the development of self-esteem within the context of a socially supportive environment and is pivotal to understanding the importance of this within the context of infertility. This specific area is discussed further in Section 3.5.1 of this report.

3.2.2 SOCIAL SUPPORT AND SELF ESTEEM

Elizur and Mintzer (2003) argue that, "romantic relationships evolve within a social network, and social support is a consequential aspect of that context." (p.414). The authors further argue that in conceptualising or defining social support, it can be described as a, "resource that promotes the attainment of goals and the resolution of life tasks, as well as offering protection against risk factors that are associated with adversity." (p.414).

Elizur and Mintzer (2003) suggest that within the context of their research they expected to find that family social support and acceptance would play a significant role in the lives of gay men and would therefore have an impact on the quality of the romantic relationship between gay partners. The research took place within Israeli culture, where family ties and religious and socio-political components promote a more pro-heterosexual environment than in other western cultures. In measuring social support, the researchers distinguished between support providers, and between global support, and a variety of social domains. Contextual variables such as self-acceptance, acceptance as context for attachment security and social support were considered in the study. The authors found that, contrary to what might have been expected, the influence of family on the quality of gay relationships was less salient than the influence of friends in the social network. Kurdek (1988) argued that, "friends usually fill the empty space that is created when gay youth hide their sexual orientation and are [therefore] distanced from their families." (p.504). Elizur and Mintzer (2003) postulated that the influence of friends might be greater in their study, as within the culture in which the research took place, there is very little room for the endorsement of gay relationships, therefore for gay men to have a network they need to rely more heavily on non-familial social networks.
The purpose for including Elizur and Mintzer's conceptualisation of social support in the current discussion is because like Hurdle, they also extend the definition of social support. As can be seen in Figure 3.1, Elizur and Mintzer describe social support in, perhaps, its more pure psychosocial sense; that self-definition, self acceptance, attachment security, relationship durability, and friends' support and friends' acceptance are intertwined and co-dependent on each other. In other words they postulate the idea that social support can promote relationship quality, but that self-esteem may contribute to the ability to be able to access and interact with social support. This is an important factor to consider within the current study as couples undergoing treatment for infertility can feel disenfranchised from their social support network, but their ability to be able to voice their difficulties can impact their ability to access that support thus leading to better psychological well-being.

Figure 3.1  A conceptual path model for the prediction of relationship qualities with self-system variables as Mediators

As can be seen from the Figure 3.1, social support is depicted as a circular process of reaction to self and to others. In applying this model to the current study it is possible that, as for the marginalised group in Elizur and Mintzer’s study (2003), commissioning couples need to develop a strong sense of ‘self definition’ and ‘self acceptance’ in order to cope with the trials and tribulations of the current system of gestational surrogacy in Victoria, prior to the establishment of new legislation in July 2009.

3.3 ASSESSING SOCIAL SUPPORT
Although the current study relies on a qualitative methodology it is useful to mention quantitative measurement tools in assessing social support as social support questionnaires were reviewed in establishing the style of questions to be posed in the current study. Pearson (1986) provides a comprehensive overview (see Appendix G) outlining several measurement tools used for social support. She suggests that the most promising of these tools is Dean et al.’s (1981) Social Support Scale (SSS) and Norbeck, Lindsey and Carrieri’s (1981) Norbeck Social Support Questionnaire (NSSQ), more commonly referred to as the SSQ. Pearson argues that the SSS has been subjected to rigorous item analysis, and alpha coefficients show high internal consistency; the scale has been further validated against sociodemographic variables and measures of life transition and anxiety and depression (Dean et al., 1981; Lin, Dean & Ensel., 1981). Sarason et al. (1981), Mullis (1987), and Gigliotti (2006) provide support for the SSQ stating that it is a valid and reliable measurement of assessing social support.

3.4 MODELS OF SOCIAL SUPPORT
Three models of social support are presented; Coping Facilitation Theory (Pearson, 1986); the Path Model of Emotions and Adaptation (Swanson, 2000) and the Social-Contextual Model of Coping (Berg et al., 1998).

3.4.1 COPING FACILITATION THEORY
As previously mentioned there are many studies which discuss the impact of social support on coping however, one of the classic investigations which explores the specific relationship between social support and facilitating coping is Coping Facilitation Theory. Pearson (1986) argues that there is little doubt that, “social support buffers the effects of stressful events and life changes.” (p.391). Dean et al.
(1981), Kaplan et al. (1977) and Nuckolls et al. (1972) further support this theory of social support as a buffer. Andrews et al. (1978), on the other hand, discuss the protective functions of social support in strengthening coping abilities and promoting healthy adjustment to life changes. It is this recognition, that social support facilitates coping, (Cobb, 1976; Cohen, 1978; and Roskies & Lazarus, 1980), which Pearson refers to as, Coping Facilitation Theory. The author suggests that within the interactions in a social support network, individuals can begin to increase a repertoir of coping behaviours. She argues that as well as using individuals within a network for a cathartic release of emotions, thereby reducing anxiety and stress; there is also evidence that the cognitive guidance function of social support seems to be, “significantly related to indexes of mental health and adjustment.” (p.391).

Gottlieb (1978) divides socially supportive behaviours that facilitate coping into four categories:

a) Emotionally sustaining behaviours = emotional support
b) Problem solving behaviours = information and intervention
c) Indirect personal influence = being available
d) Environmental action = social advocacy.

The theory of coping facilitation appears to be circular in nature; the four categories that might facilitate coping are also dependent on the individual’s ability or circumstances in accessing any of the categories. A positive by-product of an ability to access the four categories of social support is that an individual may become more confident and skilled in assessing stressful situations and coping with them, thereby appearing more competent and attractive within their social network, thereby perhaps being more likely to be helped.

Within the context of infertility and gestational surrogacy, it is perhaps more likely that the individual who has a good self-esteem and an ability to research the possible avenues for help will receive positive affirmation and assistance, whereas the individual who lacks social skills and is unable to access assistance may continue to feel disenfranchised from their social group and socially unsupported. The challenge for mental health specialists here, including IVF counsellors, is that it is these latter clients who have the greater need for social support and the teaching and the development of skills to access it.
3.4.2 A PATH MODEL OF EMOTIONS AND ADAPTATION

Swanson (2000) designed a study intended to investigate women’s depressive symptoms post miscarriage. As part of this study the author developed and tested a theory-based path model of emotions and adaptation. The model was based on Lazarus and Folkman’s (1984) Cognitive Stress Theory and is referred to here by Swanson as “Meaning Assessment” (p.192). The theory states that when a potentially stressful situation occurs, as in the case of miscarriage, the individual makes a primary appraisal of what is at stake for them. A benign response arises when the situation is perceived as neutral or irrelevant and a stressful response occurs when the situation is appraised as harmful or significant and the individual also senses that they do not have the capacity to deal with it. These perceptions are set within the context of the social support network.

Swanson (2000) developed a five stage model designed to investigate a number of constructs. Stage I investigated contextual variables, in this case gestational age, number of miscarriages, number of children, maternal age, perceived professional support and family income. Stage II examined interceding variables; perceived social support, emotional strength and subsequent successful pregnancies. Stage III looked at the primary appraisal of meaning, that is, the personal significance of miscarrying, which might not be centred around one issue or concern, but on many. Stage IV considered secondary appraisal, that is, active or passive coping, and Stage V investigated emotional response, that is, depressive symptoms. Swanson argued that his findings supported the findings of Lazarus and Folkman (1984) in that the participants in the study appeared to go through a process of meaning assessment, or meaning appraisal, in responding to the personal impact of their circumstances.

As with all research, the path model requires further testing and investigation, however in terms of its implications for infertility and gestational surrogacy, the model does provide a framework in which individual responses to infertility and failed IVF treatments in gestational surrogacy can be better understood. In Stage I an added contextual variable, would be method of conception; the availability of a gestational surrogate and the embryo transfer part of the treatment into that surrogate. Further contextual variables would be cost to the commissioning couple and number of embryos available for implantation. In Stage II of the model, additional interceding variables might be fear that the surrogate would be unable to undergo further embryo transfers. In Stage III the personal significance of the miscarriage in gestational surrogacy may be further complicated by many issues of significance including the commissioning parent’s inability to conceive either
naturally or by normal IVF means. In Stage IV active or passive coping might be further complicated by the fact that a commissioning couple in gestational surrogacy may feel disenfranchised from the process as it occurs in the surrogate’s body. Finally, in Stage V symptoms of depression may be compounded by failed IVF in gestational surrogacy. High cost, surrogate availability and reduced options may cause commissioning couples increased depressive symptoms, more so than in normal conception miscarriage.

3.4.3 THE SOCIAL-CONTEXTUAL MODEL OF COPING

Berg et al. (1998) proposed a social contextual model of coping with everyday problems. Stress appraisal is conducted by the individual, as for the path model, but the stress is conceptualised at a variety of levels, ranging from sole appraisal through to integrated and shared appraisal by the social network. Subsequently coping efforts range from sole effort through to collaborative efforts. Berg et al. suggested that the process within the social-contextual model is a dynamic one in which, “microdevelopmental change across a current coping situation and macrodevelopmental change across the lifespan” (p.239) constantly interweave with each other.

The model under study here has its origins in the Social-contextual Model of Everyday Problem Solving. This original model discusses the concept of an activated life space, that is, a person’s potential individual and contextual features, and the role that those features play in dealing with major life events. Berg et al’s. (1998) model, the Social Contextual Model of Coping with Everyday Problems across the Lifespan looks at the established research offered by Berg and Klaczynski (1996). The newer version of the model is more concerned with how individuals cope with daily hassles, without being impacted by physiological difficulties, and whilst employing individual and contextual constructs. The model also looks at how the individual anticipates everyday life problems and copes with them in relation to others, whether the problems are interpersonally focused or competence focused, that is, difficulties with others versus a problem perceived to be more mechanical and apparently related only to self.

The relevance of the social contextual model to the current study is that commissioning couples are required to cope with everyday problems and ‘hassles’ as well as the life changing event of gestational surrogacy arrangements, whilst also employing individual and contextual constructs. For example a commissioning couple required by law to travel interstate, at short notice, and for potentially several
trips, if IVF attempts fail, has to cope with the logistics of such a process, but within the context of the whole gestational surrogacy arrangement, which the couple desperately hopes will give them a baby.

### 3.4.4 IMPLICATIONS FOR INFERTILITY AND GESTATIONAL SURROGACY

The models presented in this chapter thus far illustrate that there is a process of appraisal and coping that occurs when an individual is subjected to potentially stressful situations. Coping facilitation theory argues that behavioural thought impacts upon action and that these thoughts and actions can be influenced by social support prior to execution. The path model of emotions and adaptation proposes that individuals work within a framework of cognitive stress appraisal set against the background of social support. Finally the social contextual model looks at ways in which individuals appraise stress and then cope either in isolation or as part of a social collaboration. It is evident from the models and theories outlined in this chapter that social support has an impact on coping with major life events and everyday problems. The models and theories also show that social support can provide a large component of what is needed by the individual when developing and employing coping strategies. The most obvious implication for the current study is that commissioning couples need social support when entering into gestational surrogacy arrangements in order to have improved coping abilities. In the next section I look at the impact of social support during potential health crises and IVF treatment.

### 3.5 THE IMPACT OF SOCIAL SUPPORT DURING CRISIS

In the following sections it is my intention to present studies which examine the impact of social support during health crises. The first sub section deals with specific health crises that may be impacted upon by the positive experience of social support. My rationale for including studies, such as recovery from hospitalisation and illness is that it allows for reasonable extrapolation in exploring the impact of social support during a major health crisis and life event such as the diagnosis and treatment phase of gestational surrogacy. I then examine the impact of social support during infertility treatment which allows for a more specific extrapolation to the current study. As has been previously mentioned there is little research into the area of the psychological impact on commissioning couples in gestational surrogacy; it is intended that an exploration of the following studies might give some insight into the positive impact of social support during this specific major life event.
3.5.1 THE IMPACT OF SOCIAL SUPPORT DURING HEALTH CRISIS

Nosek et al. (2004) and Cobb (1976) each discuss the relevance and impact of social support during health crises. Cobb (1976) discussed immediate crises with long term effects; hospitalisation and recovery from illness, respectively. This study, although not modern, is regarded as relevant as its outcomes revolutionised post-hospital care at the time. It is still considered useful today as its findings are consistently supported by newer investigations designed to explore the positive impact of social support on illness recovery. Nosek et al. (2004) examine the impact of social support in long term disabilities in women. The rationale for including this study is that it deals with long term and ongoing potential health crises, such as can be the case in gestational surrogacy arrangements where diagnoses and treatments are drawn out over long periods of time.

In his presidential address in the September edition of *Psychosomatic Medicine* (1976), Sidney Cobb discussed the impact of social support on individuals during hospitalisation, and recovery from illness. Cobb argued that, “[The] association of cooperative patient behaviour with various components of the social support complex is one of the best established facts about the social aspects of medical practice.” (p.306). Cobb presented a study concerning two groups of surgical patients; one group were given special supportive care by their anaesthetist and the second group had the usual limited contact prevalent at the time. The surgeons were blind as to which patient fell into which group and results showed that those given supportive care by their anaesthetist were more likely to have an expedient recovery from their surgery than the control group, and be released from hospital up to three days earlier. Cobb states that both findings were statistically highly significant (p.305).

Cobb (1976) further postulates that corroboration for the social support argument can be seen in the work of Holmes et al. (1961). The researchers found that when using the Berle index (1952), (a clinical scale to determine prognosis in stress disease), when treating, “a disease of social isolation”, that is tuberculosis, patients scored the lowest on the Berle index, predicting slower recovery rates than patients allowed and encouraged to have social contact with friends and family during recuperative periods. In studying the interaction of social support with life change with respect to steroid therapy in adult patients with asthmatic conditions, Holmes et al. (1973) found that patients with a supportive network instituted high life change scores which correlated with lower steroid use scores indicating the, “protective effect
of support”. This finding is similar for the 2001 Hurdle study, who found that women engaged in health promoting behaviours as a result of interacting with other women in their social support network.

Nosek et al. (2004) studied the impact of social support on women with long term disabilities. As stated the rationale for including this study centres on my understanding that for many couples infertility is not a short term medical crisis, but a long term, protracted condition that can often play out over many years.

Nosek et al. (2004) found that five key content areas emerged from the results of semi-structured interviews with women with long term disabilities. First the women interviewed associated perceptions of health with functional capacity; secondly they acknowledged that outlooks and attitudes played a role in health promoting behaviours and wellness. Thirdly, and of most importance to the current chapter, that social support, including the attitudes of others affected health outcomes and feelings of wellness. Fourthly, the women interviewed stated that there is a relationship between health behaviours, functional capabilities and disability related barriers. Finally, the women expressed concern over their relationships with health professionals, citing the impact of negative relationships on health outcomes.

In discussing the third key area in more detail, Nosek et al. (2004) suggested that the women interviewed indicated that having a healthy support network counterbalanced the everyday problems that they faced living with disabilities. In most cases the women relied more heavily on friendship networks as opposed to family, and most of the participants were either divorced or had never married; none mentioned marriage as a component of social support.

The two studies briefly outlined here show that there is a relationship between social support and coping, between social support and protective effect and, finally, between social support and the ability to counterbalance against the problems of everyday life. Dealing with the issues associated with infertility can be for many a trying and desperate experience. In this next sub-section I look at several studies that highlight the importance of social support during the process of IVF treatment.

3.5.2 THE IMPACT OF SOCIAL SUPPORT DURING INFERTILITY TREATMENT
Lechner et al. (2007), Verhaak et al. (2005) and Fouad and Fahje (1989) have conducted studies into the effect of social support on women and or couples during IVF treatment cycles. Lechner et al. (2007) investigated the dissatisfaction in men and women with their social support networks in making their decision to cease
active infertility treatment and accept definite involuntary childlessness. 116 participants (87 females, 29 males; 17 complete couples) responded to questionnaires designed to examine coping styles post acceptance of childlessness status. The validated Utrecht Coping List (UCL) was used to investigate both active coping style (active approach) and passive coping style (passive reaction approach). The researchers hypothesised that women would experience more distress than men; that distress would decline over a period of time; that a positive relationship between passive coping and distress, and a negative relationship between active coping and distress would be evident; and that a positive relationship between being dissatisfied with social support and levels of distress would exist, and finally, that the relationship between coping styles and distress would be impacted by the level of dissatisfaction with experienced social support.

Lechner et al. (2007) argued that they expected to find a protective effect, and that they would produce results that were comparable with previous studies such as, Silver and Wortman (1980), Holahan and Moos (1981), Mindes et al. (2003), and Verhaak et al. (2003) in Verhaak et al. (2007). However, the authors found that on this occasion, there was only an association between passive coping style, dissatisfaction with social support and health complaints associated with increased levels of distress, such as, anxiety, depression and complicated grief. The results confirmed that more dissatisfaction with experienced social support strengthens the association between passive coping and health complaints. In other words if individuals perceived that they were not being supported by those in their social networks then they were more likely to attempt to cope in isolation, but this in turn negatively impacted their perception of their health complaints.

A second phenomenon highlighted by Lecher et al. (2007) was that there was a possibility that the same social support is perceived differently by people depending on whether they are still undergoing active IVF cycles or in the process of accepting childlessness. Lechner found that social support was perceived as increasing by couples as the period of involuntary childlessness continued on. Lechner (2007) suggests that, “possibly, in the longer term, involuntary childless people have learnt how to deal with their childlessness and how best to involve their social environment in their situation.” (p.292).
The Lechner et al. (2007) study points once again to the relationship that exists between perceived social support, and the development of coping styles. The circular nature of the phenomenon highlights the link between health and wellness, coping strategies and the ability to access support. If social support is seen to be readily available and perceived as positive then this in turn has a positive impact on coping and health. The significance of this within the context of the current study is that for individuals undergoing diagnosis and treatment in gestational surrogacy arrangements coping styles may well be influenced by the availability of social support, and just as importantly by the ability to access it and perceive it as positive.

Verhaak et al. (2005) ran a longitudinal study examining personality characteristics, pre-treatment meaning of fertility problems and social support in adjusting to unsuccessful IVF treatments. 148 women and 71 partners completed self-report questionnaires containing items designed to investigate anxiety, depression, personality traits, understanding of fertility issues, coping and social support. The results from the study showed that women, but not men, had increased levels of anxiety and depression after failed IVF attempts; but that by six months, post final cycle, less than 20 percent of these women showed subclinical forms of mental illness. In assessing the responses to the questionnaire items, Verhaak et al. (2005) argued that women who had higher levels of anxiety and depression and reduced networks of social support prior to beginning IVF cycles were more likely to be in the sub-clinical cohort. The authors further concluded that women who had had unsuccessful IVF attempts, who had been assessed as emotionally stable with a good understanding of fertility problems, and who had satisfactory social support adjusted well to failed treatments. Women without these protective factors in place were still at risk six months after unsuccessful treatments.

Fouad and Fahje (1989) investigated the effect of self-esteem, depression, locus of control and social support as these factors related to feelings about self and emotional response to infertility. The authors proposed that social support is negatively correlated with depression and positively correlated with self-esteem. They further propose that self-esteem is positively correlated with internal locus of control and that depression is negatively correlated with internal locus of control.

In response to the hypothesis that social support is negatively correlated with depression, Fouad and Fahje (1989) found that the more depressed the participants were, the more social support they needed and the less satisfied they were with the support that they received. In response to Hypothesis Two, that social support is
positively correlated with self-esteem, the authors found that high self-esteem lead to being happier with levels of social support, but that high self-esteem correlated with less need for social support.

For Hypotheses Three and Four it was found that the lower the self-esteem and the higher the levels of depression, the more the women felt that external forces were in control of their lives. The findings for all four of these hypotheses support the notion that women undergoing treatment for infertility are likely to face risk factors such as anxiety, depression, low self-esteem and a feeling of disenfranchisement from their social network.

The findings by Fouad and Fahje (1989) are similar to those of Elizur and Mintzer (2003), previously mentioned. The evidence from both studies suggests that there is a strong link between the development of self-esteem and the impact of social support during major life events. Both studies point to the possibility that social support is vital for potentially disenfranchised individuals to develop coping skills. This is significant for the current study as gestational surrogacy presently affects only a small number of individuals or couples within Australia. The potential for these individuals to perceive themselves as disenfranchised is a distinct possibility and has implications for the professional understanding of the link between positive social support, self-esteem and mental health during the process of gestational surrogacy.

3.6 IMPLICATIONS FOR GESTATIONAL SURROGACY

The models presented in this chapter were the facilitation coping model, the path model of emotions and adaptation and, the social contextual model of coping with everyday problems across the lifespan. The common component of these models is that they recognise the relationship between social support and the development of coping skills in response to everyday crises and major life events. The studies presented in Section 3.5 further support the idea that social support helps individuals to deal with difficulties arising from potential health crises or from the issues associated with infertility. It would seem that from all of the evidence presented thus far there is a correlation between self-esteem, depression, social support and the ability to access that support. The area of gestational surrogacy is a complicated area of infertility as commissioning parents are not only trying to cope with the impact of their own infertility, but must also rely on another women’s body to respond well to IVF cycles, whilst coping with the anguish of potential childlessness, unpredictability
of treatment outcomes, laws, and slow reform and rising costs, and in Victoria, prior to July 2009, the complicated process of completing cycles interstate as a way of negotiating state legislation.

The relevance of the evidence presented in this chapter to the current study is that social support appears to have a positive impact on coping skills needed for both daily life events and major life, health or decision making crises. As has already been established a significant factor for commissioning gestational surrogate couples in accessing social support is feeling disenfranchised from their social group. If a link does exist between self-esteem and the ability to access social support then this is important for health professionals working in the area to understand.

### 3.7 CONCLUSION

In this chapter I have discussed the impact and significance of social support during health crises and I have explored ways in which this might be applied to the area of infertility and gestational surrogacy. From the evidence presented it is apparent that social support can be a double edged sword; it is almost always required by all of us to be able to function, especially during major life crises. However, it would also seem that to be able to access social support and enter into a supportive and sometimes reciprocal network individuals need to possess the personal capabilities and characteristics that enable them to avail themselves of all that a social network can offer. The implications of this for the current study are that individuals attempting to cope with any grief and stress that might be associated with infertility and the subsequent need to enter into gestational surrogacy may not be able to access social networks, especially if they or others perceive their grief as disenfranchised, thereby emotionally separating them from their social groups.
CHAPTER 4      GESTATIONAL SURROGACY: ATTACHMENT
AND OTHER CONCERNS

4.1 INTRODUCTION
In this chapter I examine several public perceptions or misperceptions concerning altruistic gestational surrogacy. An intended issue for inquiry in this study is to investigate the psychological impact on commissioning couples of their relationships with others during their surrogacy experiences. I am interested to explore whether the couples were aware of any public opinion concerning gestational surrogacy during their own experiences, and whether these opinions were perceived by the couples as being either positive or negative social influences. I would further hope to explore whether the commissioning couples in this study faced any criticisms for doing something that might be considered to be substantially different from the norm, and whether this discouraged them or made them more determined in their efforts to have children.

In the following sections I examine the three most common stereotypical beliefs about gestational surrogacy, as outlined in Golombok (2006), chiefly that attachment and bonding are compromised when infants are not gestated by their biological mothers; that exploitation of surrogates is commonplace; and finally, that the treatment options available to commissioning couples in gestational surrogacy arrangements places them in a position of orchestrating nature or of ‘playing God’ in the formation of their families. These two latter beliefs are explored first as they rely heavily on new opinion pieces and non-evidentiary research, but still add to the overall important picture of public perceptions. Evidence regarding attachment theory and gestational surrogacy is also new, but tends to be from recognised published sources.

An explanation of secure attachment is offered and the alternatives are also briefly discussed. Evidence is then offered from three consecutive longitudinal studies which are suggestive of secure attachment patterns being formed between parents and their children in gestational surrogacy arrangements in the United Kingdom. A further UK study is also discussed which supports these findings. A case study is then presented from Australia which also supports the idea that attachment is not
compromised in gestational surrogacy. A section is then presented regarding attachment in the atypical situations of adoption and step families. A social network model is then suggested, as an alternative to the dyadic models of attachment, as being more appropriate within the context of a society where traditional methods of conception and birth are not the only means of building a family. Finally I conclude that secure attachment patterns can develop in atypical circumstances, such as in gestational surrogacy.

4.2 GESTATIONAL SURROGACY AND HUMAN EXPLOITATION

Since the development of assisted reproductive technology in surrogacy began sociologists and philosophers have questioned whether surrogacy is exploitative and a violation of human rights and dignity. Ozolins, at the 1998 World Conference of Philosophy in Boston, argued that a surrogate is merely a means to an end. The relationship between her and the ‘putative’ commissioning couple would undoubtedly become ambiguous and harmed, and would therefore become exploitative and ‘immoral’ and only in favour of the commissioning couple and not their surrogate. Wilkinson (2003) argues that even regulated commercial surrogacy is, ‘morally objectionable’ (p.169). Further to this, he raises the question as to whether commissioning parents may also be the unwitting victims of exploitation due to their desperate circumstances. Ciccarelli and Beckman (2005) use the term, ‘contractual parenting’ to describe surrogacy. Golombok et al. (2006) state that, ‘Much of the criticism of surrogacy has arisen from religious, moral and sociological standpoints.’ (p.213) and that society is nervous about situations where economically disadvantaged women are paid to have babies for women who are, ‘more affluent than themselves.’ The Melbourne based agency referring to themselves as WISE, ‘Women’s Issues and Social Empowerment’, present the argument, in a non published paper entitled, ‘Surrogacy: Why Women Lose’ that surrogacy arrangements reduce the surrogate to an inhuman object,

“The term surrogate mother reduces women’s status to that of a disembodied uterus in which man’s seed can then reproduce. She is an inanimate object, an incubator, a receptacle, rented property, plumbing, a kind of hatchery, or alternative reproduction vehicle...” (Szikla, 1996; p.3).
Public opinion pieces appear to focus on the assumed socially and economically disadvantaged status of surrogates. ‘Feministe Blog’ presents a heated debate between those who do and those who do not support the idea of surrogacy. One contributor argues that,

“We cannot act as though these are autonomous decisions because these women are oppressed by class and gender. A large number of women’s choices are constrained choices because of class and gender. How do we decide which choices we or they get to make?” (Akeeyu, Feministe Blog; 2008).

It may well be that the public perception of surrogacy is that only rich women can afford to have babies using the bodies of poorer women. There may also be the perception, or misperception, that even in altruistic arrangements the surrogate is somehow coerced into invasive procedures resulting in her giving up her uterus for nine months with nothing to show for it after giving birth. It is interesting that Wilkinson (2003) raises the question about the possible exploitation of the commissioning parents. There are few public opinion pieces which paint the surrogate as the tough, business women selling a commodity to her desperate buyers. One contributor in Feministe Blog (2008) actually applauds women who rise above their economic circumstances using surrogacy and suggests that it is, ‘self-righteous’ to inform women in poorer nations that they may not use their bodies to improve their situations. In response to this comment another reader argues that, in regard to third world labour, if we are happy to outsource manufacturing and discuss its merits in improving third world economics, whilst also improving Western economics, then it is morally wrong to say that only Western women can act as paid surrogates.

Another consideration in the exploitation argument appears to be in regard to the children born in gestational surrogacy arrangements. Successful arrangements; to date there have been about a dozen in Victoria; have the potential to draw little media attention unless the commissioning parents choose to share their experiences. However complex arrangements where communications have broken down, or where aspects of the process have become confused, are inevitably reported upon. Coney (1999) argues in her tabloid piece, ‘Surrogacy Issues Unresolved’, that where family members gestate for their relatives, ‘Sisters are mother’s aunts’, thereby confusing the natural order of family relationships. In 2008 a case was reported on which caused widespread concern. A twelve day old baby girl born to an Indian surrogate mother, through using the commissioning father’s sperm and donated eggs (from an
unknown Indian egg donor) was in 'legal limbo'. The Japanese commissioning couple had separated and the wife (not the biological mother) no longer wanted the baby. The commissioning father (also the biological father) did want the baby. The complexity began because Indian law, which has only just prepared a draft bill by the Indian Council of Medical Research, does state that single men may not adopt children, even their own biological children born in surrogacy arrangements. The potential risk for all parties, including the child, in this case, to be exploited was very real.

Although the purpose of this study is not to argue about the personal circumstances of those who act as gestational surrogates, or about the outcome of such arrangements, it is important to consider public perceptions about these aspects. As was previously mentioned, an issue for inquiry in the current study concerns the relationships between the commissioning couples and those in their social networks. It will be interesting to explore whether the couples in this study experienced strong, or even subtle, public opinion about the exploitation of surrogates, and others involved in surrogacy, during their gestational surrogacy arrangements.

4.3 GESTATIONAL SURROGACY: ORCHESTRATING NATURE AND PLAYING GOD

Ber (2000) argues that the introduction of assisted reproductive technologies, including surrogacy, deleteriously separates the natural acts of sex and procreation. The author takes the argument to an extreme extent and asks the important question about whether gestational surrogacy is a form of living organ donation, and whether women who are in persistent vegetative states could be used to gestate other women’s babies, if they had left permission in writing prior to their ‘deaths’. Ozolins (1998) argues that even ordinary cases of surrogacy are, ‘morally wrong’ as, 'human flourishing cannot be separated from one’s relationships with others and any circumstance which is destructive of such relationships [such as surrogacy] must be considered immoral.’ (p.1). Szikla (1996) proposes the idea that, in relation to surrogacy, either commercial or altruistic, what needs to be understood is that, ‘Desire is not a biological need, it is a want.’ The author further argues that there is a chasm of difference between rights and wants and that only moral rights are grounded within a framework of, ‘inalienable conditions which are basic to the well-being of all humans.’(p.6).
Further research into perceptions and misperceptions concerning gestational surrogacy illustrates that public opinion can be loosely segregated into three categories. There are those who endorse surrogacy and argue its merits in helping couples to build families where all other options are closed. There are those who openly admit that they have not really considered it, and are cautious about making a stand on such a complicated ethical area, although many in this category question why couples would spend money on surrogacy instead of adopting. This in itself is a common misperception; that commissioning couples actively choose gestational surrogacy over adoption. Finally there are those who describe the process as anti-natural and argue that surrogacy is against God and against natural laws. A word that appears over again in opinion pieces from this latter group is, ‘immoral’.

The sixteenth chapter of the book of Genesis in the Bible also makes many appearances in literature denouncing surrogacy. Moralists argue that when Hagar was coerced, by nature of her being Sarai’s servant, into being a surrogate for Abram and Sarai, the result was devastating. Even before the child was born, Hagar was said to, ‘despise her mistress’ (verse 4). When Hagar gave birth to her son, Ishmael, years of conflict followed as the nation was split when Sarai, now Sarah, fell pregnant and gave birth to her own son, named Isaac. The passage tells that God himself had to instruct Abram, now Abraham, to bring Ishmael to live in the family home as for the first thirteen years of Ishmael’s life he lived with Hagar and not Sarah.

It is of interest to note that anti-surrogacy comments based on apparent religious principles predominately use this passage to argue against gestational surrogacy. The ‘immoral’ practice of a man having intercourse outside of marriage to impregnate another women with his child, which will then be forcibly relinquished and given to the man and his wife to raise, somehow gets confused into arguments against regulated commercial or regulated altruistic gestational surrogacy. This is significant as it potentially highlights an important possible misperception about surrogacy, that is, that it can only result from extra-marital relationships, and that gestational surrogates are always the biological mothers of any children born.

It is of further interest to note that none of the published articles considered for these sections on exploitation and playing God, (Ciccarelli & Beckman, 2005; Wilkinson, 2003; and Ozolins, 1998) or the public opinion pieces, such as Szikla (1996) or Singer (2006) mention the ethical-medical issues involved in gestational surrogacy as being
controversial or morally wrong. As the author of this report I am constantly questioned about the fate of unused embryos in gestational surrogacy arrangements, and have dealt with my own experiences of public perceptions or misperceptions concerning this point. One woman ‘of faith’ stated that she would not be able to condone the actions of others who choose gestational surrogacy as an option as they would be, ‘playing God’ deciding the fate of their embryos, she also doubted my own integrity as I had accepted the unenviable task of writing about commissioning parent’s experiences.

Sharon LaMothe, the co-founder of Infertility Answers, Inc. and two time gestational mother, discusses similar experiences. She reports that in her first act as a surrogate the commissioning couple’s house keeper angrily announced that she, LaMothe, was ‘playing God’ and preventing a needy adoptee child from having a home with the couple in question. LaMothe states that from an early point she had to form her own public perception regarding God and surrogacy:

“So here are my views on the God issue. Surrogates are not playing God. Egg donors are not preventing adoptions from taking place. Reproductive endocrinologists and embryologists are NOT pretending to be God (although some may act God-like). We are all using the gifts that God gave us...and what about all the other medical marvels in the world? Heart transplants? Kidney donations? Bone marrow donations? How about blood transfusions? Are these not prolonging life, enhancing life? And doesn’t a very much wanted baby make a life complete for those parents who desire to enhance their own existence...” (LaMothe, 2008 Blog).

In her article in the Herald Sun, entitled, 'Moralists Cry Out on Conroy Surrogacy: Rocking the Cradle', Singer (2006) attempts to educate her readers about the terminology surrounding gestational surrogacy. She makes the distinction between commercial and between altruistic surrogacy very clear. The author also points out that Senator Conroy and his wife, the commissioning parents of their new daughter, Isabella, do not have a ‘surrogate child’, they have a ‘real child’. Singer argues that a surrogate child is what she herself has, a cairn terrier named, ‘Agnes’. Although Singer is obviously supporting Senator Conroy and his wife, she also writes that the Senator’s Catholic priest did not approve of Isabella’s origins. The author goes on to discuss the merits and pitfalls of surrogacy, and finally highlights the sad tale of a paid surrogate in the US who died during the childbirth of her surrogate baby, leaving her own child motherless and the commissioning couple devastated. The surrogate mother’s own parents want commercial surrogacy to be totally banned.
As for the issue of possible exploitation in gestational surrogacy, it is not the purpose of the current study to present an argument for or against the religious or moral views concerning surrogacy. It is however, important to illustrate that these opinions exist in order to explore whether the commissioning couples who took part in this study experienced similar opinions from their social networks to those presented here.

Golombok et al. (2006) argues that one of the biggest fears concerning gestational surrogacy is the area of attachment and bonding between the child and the commissioning parents and that, ‘From a psychological perspective, concerns have been raised about the potentially adverse consequences of surrogacy for the resultant family.’ (p.213). In the following sections I will briefly discuss secure and insecure attachment and explore the evidence which suggests that secure attachment is possible in the atypical circumstance of gestational surrogacy.

4.4 SECURE ATTACHMENT AND THE ALTERNATIVE

The concept of Attachment Theory began with John Bowlby and later with Mary Ainsworth (Ainsworth & Bowlby, 1965). An extension of Bowlby’s maternal deprivation hypothesis, that is, that children from families where mothers were absent or ineffectual almost automatically developed anti-social behaviour, was Ainsworth’s formulation of Patterns of Attachment (Ainsworth & Bell, 1970, Ainsworth et al, 1978 & Ainsworth, 1982). Here Ainsworth emphasised the quality of the carer-child relationship and proposed that the behaviour of the primary care giver, usually the mother, would predict the type of relationship into which the mother-child dyad would develop, and would further predict the type of relationships and attachment patterns that the adult child would engage in with others. She postulated the concept of the mother’s sensitivity, arguing that a mother who is more “sensitive, responsive, accessible and cooperative” (Cowie, 1995; p.14) during their child’s first twelve months of life is more likely to have a child who develops a secure attachment and has feelings of self worth and self confidence when exploring new friendships and developing new and lasting relationships, including the forming of intimate relationships during late adolescence and adulthood.
The significance of these findings within the context of the current study is that neither Ainsworth, nor Bowlby, discussed the concept of pregnancy and gestation as a foundation for secure attachment; instead much more emphasis was placed on the interaction between the infant and parent once the child had been born and was in direct relationship with others.

Ainsworth (1970) and her colleagues developed the Strange Situation study in which infants were separated from their mothers for short periods and the reunions were then assessed. Upon detailed analysis of their results from over fifty studies, Ainsworth and her colleagues proposed that there are three basic attachment types or patterns. The most common response of the children was to cry during separation from their mothers, but to then be relatively easily consoled upon reconciliation. These children actively sought and maintained contact with their mothers during reunion and showed obvious signs of preferring them to the strangers they had been left with during separation episodes. This pattern was termed by Ainsworth as a secure attachment pattern, known as Type B.

In contrast to the above attachment pattern, some children shunned contact with their mothers during reunion episodes or were anxious and avoidant in their responses when their mothers re-entered the room. The stranger was also treated this way by the infants. Ainsworth termed this as an insecure pattern of attachment and labelled it the anxious/avoidant type of attachment or Type A. A further insecure pattern was identified. Here these children combined resisting contact with some proximity seeking behaviours, often showing anger toward their mothers upon reunion, and giving the impression of ambivalence directly after a separation episode had occurred. Ainsworth termed this the anxious/ambivalent type or Type C. In 1990 Main and Solomon added a further insecure type most commonly seen in families where there is parental psychopathology, high social risk or child abuse. The type here is labelled disorganised attachment pattern or Type D and is characterised by the child appearing dazed and confused with no apparent or coherent system for dealing with separation or reunion.
4.5 SECURE ATTACHMENT IN GESTATIONAL SURROGACY

In this section several studies are presented, three of which form a longitudinal study over the first three years of children’s lives born in gestational surrogacy situations. An article by Maggie Kirkman, the first commissioning mother in Australia, is also explored. The intention is to show that early published findings and personal accounts provide supporting evidence that secure attachment patterns can develop between commissioning parents and their children in gestational surrogacy arrangements. This is an important aspect of surrogacy to explore as, it was previously mentioned, one of the most poignant public perceptions, or misperceptions, of gestational surrogacy is that children born in these situations will not securely attach and bond with their commissioning biological parents.

MacCallum and Lycett et al. (2003) interviewed 42 couples in the UK within the first year of their children’s lives post gestational surrogacy arrangements and post obtaining legal parenthood of their children. The study was designed to investigate the parent’s experience of gestational surrogacy and of the first twelve months of parenthood. The mean age of the mothers in the study was 35 years and the mean age of the fathers was 40 years. The socioeconomic status of the families was measured using the Registrar General’s Classification for Employment (UK). 76 percent of families were classed as professional and managerial, with the remaining 24 percent being split between skilled manual and non skilled manual categories. The participants were interviewed and their responses were tape recorded and later transcribed for analysis. Five areas were investigated; motivations for surrogacy, details about the surrogate mother, experience of surrogacy during pregnancy, experience of surrogacy after birth and, openness about surrogacy.

The findings from the study indicated that all of the couples interviewed had opted for gestational surrogacy due to infertility problems and in many cases (reported by 43 percent of couples) due to repeated IVF failures. 69 percent of couples did not know the surrogate mothers prior to the gestational surrogacy arrangements, 17 percent of surrogates were family members of the commissioning mother and the remaining 14 percent were friends of the commissioning couples. 62 percent involved partial gestational surrogacy (using donor gametes) and 38 percent involved full gestational arrangements. 95-98 percent of commissioning mothers rated their relationships with their surrogate mothers as harmonious, depending on the time period, and 86-90 percent of fathers indicated similar feelings to their partners and
toward their surrogates. 93 percent of commissioning mothers and 97 percent of commissioning fathers said, after the experience of surrogacy, that they would recommend the process to others, and all 42 couples stated that they planned to tell their children about the surrogacy when their children were old enough to understand. All 42 couples reported the experience and the subsequent twelve months after surrogacy as positive. The authors concluded that at one year post birth there did not appear to be negative affect on attachment and relationships between parents and their children or on parental well-being. A non significant trend towards emotional over involvement amongst surrogacy families was found, but this was found to have disappeared by the time families were revisited one year later.

Golumbok and MacCallum et al. (2006) and Golombok and Murray et al. (2006) are two further studies that were carried out which continued to investigate the relationships between the commissioning parents and their offspring from the MacCallum and Lycett (2003) study. Golombok and MacCallum interviewed 37 surrogacy families along with 48 egg donor families and 68 natural conception families at two years post birth. Each family were assessed for parental psychological state, parent-child relationships and children’s psychological development, Appendix H shows the statistical findings for comparisons of parental functioning between family types. The authors found that for parental functioning commissioning mothers appeared to show more positive representations of their children than did the natural conception parents, and commissioning fathers showed lower levels of stress associated with parenting than the natural conception fathers in the same study. The authors acknowledged that the commissioning parents may have been motivated to present a positive picture of parenthood in counter attack to criticisms of surrogacy, but that this was accounted for through the use of validated measures such as the Parent Development Interview (Aber et al., 1985 & Slade et al., 1999).

Additional findings showed that the children’s psychological development in the surrogacy families did not differ from the natural conception children with respect to socio-economic and cognitive development. However exceptions were for variables relating to parent competence and child affection. Here the commissioning mothers rated higher than their egg donor family counterparts. Golombok and MacCallum et al. (2006) argue that for commissioning parents the road to parenthood is often long and paved with enormous difficulties. The authors suggest that, ‘thus a strong desire for a child among surrogacy parents may result in more positive representations of
the relationship and a higher quality of parenting than among parents whose children were naturally conceived.’ (p219). The significance of these findings, within the context of the current study, are that early investigations concerning attachment in gestational surrogacy suggest that children born in gestational surrogacy arrangements are no less likely to be securely attached to their parents than are children born through natural conception, and that parenting quality may be even higher in surrogacy families.

The final study conducted by Golombok and Murray et al. (2006) investigated the consequences for the same families, where still available, as the MacCallum and Lycett et al. (2003) study and the Golombok and MacCallum et al. (2006) study, but at three years post birth. Again parent-child relationships and the psychological well-being of mothers, fathers and children were explored, Appendix H shows the statistical findings for the study. As for the two year study, the parents in the surrogacy families rated either within the normal range, or higher than the expected normal range, for positive relationships with their children. The authors again concluded that the absence of a gestational link between parents and their children does not have a negative effect on parent-child relationships or on the psychological well-being of mothers, fathers and children at aged three. The authors of both studies did however suggest that more research would be needed as children in surrogacy families continued to grow and develop.

The significance of all of these studies, again within the context of the current study, is that the findings directly show that the attachment between children, in their pre-school years, and their parents in gestational surrogacy arrangements was not deleteriously impacted because of gestational origins.

In a similar investigation to the longitudinal studies outlined above, van den Akker (2000) measured the responses of 29 women, aged between 29 and 47 years who had been trying to conceive naturally for between one and twenty five years. The reasons for considering surrogacy ranged from failed IVF or failed adoption through to wanting to have a genetic link with their child and surrogacy being the only option, as in full gestational surrogacy, or a partial genetic link, as in donor gamete gestational surrogacy. As is the case in the current study, most of the participants interviewed in the van den Akker study were unable to conceive for medical reasons, such as, gynaecological conditions or diseases, or congenital abnormalities, for example,
being born without a uterus; 52 percent of van den Akker’s participants fell into this category. Of all the women studied 100 percent stated that they had negative feelings about their infertility or sub-fertility, however almost all of the women expressed that they felt positive about entering into gestational surrogacy arrangements as, ‘a way of resolving their infertility.’ (p.1852).

Van den Akker (2000) found that for the women who were able to use their own eggs, and in most cases their partner’s sperm, the significance of their child being biologically linked to them, despite being gestated by a surrogate mother, was seen as important. Those who were unable to use their own genetic material were less adamant about the importance of their child being genetically linked. Van den Akker describes these findings and the subsequent finding, that nearly 60 percent of participants would have considered adoption, as a, ‘cognitive dissonance’; as the majority of the group that identified a genetic link as important, also felt that adoption, where there was no genetic link, was a viable option for creating a family.

Van den Akker (2000) concludes that in the formation of families, individuals and couples are willing to overcome infertility and raise their children no matter what the origins of these children’s births. In terms of attachment within the context of gestational surrogacy this once again points to the possible willingness of commissioning parents to parent their children, despite and perhaps because of the proceeding gestational process; it further poses questions about whether commissioning couples are more ready to be parents then in natural conception situations as they have had to strive to create their families and invest so much, both emotionally and logistically, into the process of becoming parents.

The article prepared by Maggie Kirkman (2002) gives the perspectives of some of the individuals involved in making her daughter, Alice’s, birth possible. At the age of thirty, in 1978, Kirkman underwent a hysterectomy due to fibroid tumours. Ten years later, in 1988, Kirkman’s sister, Linda gave birth to Kirkman’s daughter, Alice, as a result of Kirkman’s egg and donor sperm being used in an IVF procedure as part of a gestational surrogacy arrangement. Alice was the first child in Australia to be born of such an arrangement. The most poignant part of this article is the recollections by Kirkman of her child in her early years. Kirkman says of her infant,
“I am a fortunate mother to have an alert and collaborative child. Alice was a demanding baby, but responded to what I did for her, rewarding my efforts to fulfil her needs. We were amazed, when Alice was only about 20 months old and before she was articulate, by evidence of her relationship and communication skills. She was upset about something, and threw an impressive archetypal tantrum...I said that I would stay nearby until she felt better...Alice soon got up from the floor, mimed that she was ready for me to comfort her, and lay down to resume the tantrum. When I picked her up she immediately quietened and relaxed. Alice has always been an impressive human being.” (Kirkman, 2002; p.141).

Of her husband, Sev, Kirkman writes that she warned him that their story had been leaked to the media, and that it was likely that their names would be discovered. In reply to this Sev stated, “We’re going to have a live baby and that’s all that matters.” (p. 142). Kirkman continues to write,

“He seemed truly unconcerned. If public knowledge of his sterility was the price to pay for fatherhood, he was happy to pay it. He never wavered from that view.” (Kirkman, 2002; p.142).

In her part of the article Alice poses the question to herself, “Do you think that you are special because of the way you were born?” (p.144). In response she replies,

“No. Some people are born through IVF; some people are born because a man and a woman get very drunk; or when a man and a women love each other; or when a man and a woman hire a scientist. There are many different ways of being conceived. Mine was just one of them.” (p.144).

Although attachment in gestational surrogacy arrangements is yet to be studied in Australia, it could be inferred, at least from the Kirkman family experience, that within the context of child acceptance of gestational surrogacy there is as much potential for secure attachment as there is in ‘normal’ conception. Obviously further study is required as to the link between children’s acceptance of their conception methods and their resultant attachment patterns with their parents.

While every child that has been born, and will be born, as a result of gestational surrogacy, is not the child of a highly trained psychologist, well versed in an understanding of attachment theory and child development, as is the case for Alice Kirkman, it is hoped that the reader of this report will be open to the idea that it is the richness of early relational experiences that lead to secure attachment and not the method of gestation.
Although only four published studies, and one case study, are presented here early findings, and one longitudinal experience, suggests that secure attachment is possible between commissioning parents and their children in gestational surrogacy arrangements. As was previously stated, both Bowlby and Ainsworth (1965) postulated that it is the child’s early relational experiences that help them to form secure attachment patterns; gestational experience for the child is not mentioned as a factor. It will be of interest to note whether the commissioning couples in the current study were aware of the criticisms surrounding gestational surrogacy and attachment and whether this had any psychological impact for them during their experiences.

4.6 ATTACHMENT IN ATYPICAL CIRCUMSTANCES: ADOPTION AND STEP FAMILIES

The rationale for including information about adoption and step families in this next section is to further show that secure attachment is possible in atypical circumstances. If it is the case that secure attachment patterns can develop in adoption and in blended families, then it is reasonable to assume that it is also possible in the circumstance of gestational surrogacy. Some of the public misperceptions concerning the ease of adoption, that it is a readily available alternative to gestational surrogacy, are also addressed.

According to the Australian Bureau of Statistics (ABS) and the Australian Institute of Health and Welfare (AIHW) (2007, website), from 1971-1996 there were 10,466 adoptions within Australia. During the time period 1995-1996 of the 491 children adopted by non-relatives within Australia, 56 percent of these children had been born overseas. 80 percent of these overseas born children were under the age of five during the period of the adoption process and 66 percent of any Australian born children, to be adopted at this time, were also under the age of five.
Figure 4.1 shows the pattern of both relative and non-relative adoptions in Australia from 1980-1996.

![Figure 4.1 Relative and Non-Relative Adoptions, 1980-81 to 1995-96](image)

After 1996, adoption statistics for Australia were held by the judicial system for each individual state. According to the 2004 statistics database held by the Victorian State Government, Department of Human Services (DHS) only ten infants were placed in adoptive homes for the 2003-2004 period, and 100 overseas adoptions took place with children older than twelve months (DHS, website, 2007). Both the Australian Bureau of Statistics and the Department of Human Services in Victoria state that the number of adoptions has dramatically decreased throughout Victoria and Australia wide over the past thirty years due to, improved contraception and availability of pregnancy terminations, and the increased acceptance of single parent families, with the introduction of monetary benefits for these families. The ABS further states that advancement in infertility treatment has reduced the demand for adoption. The significance of this data for the current study is that adoption is not an easy and readily available process for childless couples in attempting to have children.

As was previously stated, Golombok (2006) argues that one of the major perceptions, or misperceptions, concerning gestational surrogacy is that attachment between the commissioning parents and their infant will be compromised because the commissioning mother has not gestated her baby. Singer et al. (1985) used the data from two separate samples using the Ainsworth (1965) strange situation paradigm to
assess the quality of attachment relationships in adoptive and non-adoptive mother-infant dyads. Infants were between 13 and 18 months at the time of the study. Findings indicated that there were no differences in mother-infant attachment between non-adopted and intra-racial adopted subjects, or between intra-racial and inter-racial adopted subjects, although inter-racial adoptive mother-infant pairs did show a higher incidence of insecure attachment in comparison to non-adoptive pairs. No relation was found, however, between quality of mother-infant attachment and either perceived social support, infant developmental quotient, infant temperament, number of foster homes experienced by the infant, or infant’s age at the time of adoption placement. The authors suggested that the established research which points to higher incidence of psychological problems found in adoptees in middle childhood and adolescence cannot be necessarily explained in terms of insecure attachment relationships during the infancy years.

The Department of Humans Services (DHS, Melbourne) Training Manual for Adoption and Permanent Care (2008) provides potential adoptive parents with published literature concerning attachment in children in care. Several themes are addressed including the nature of secure and insecure attachment styles and the type of parenting skills to be employed by adoptive parents in helping their new children to become more securely attached. Two significant concepts are addressed; firstly that it is not always the youngest children needing permanent homes who will be the less scathed by their experiences, often children post infancy show the potential for secure attachment styles if their early experiences with a consistent care-giver have been positive. The second concept addressed is that it is possible to ‘rehabilitate’ children and provide them with opportunities to develop secure attachment patterns within their permanent families, and that their experiences prior to their joining their new families are not always indicative of their behavioural outcomes later in life.

Golding (2007) provides an overview of the clinical implications of using attachment theory in helping carers to help foster children who are likely to be placed for relative, or in some cases non-relative, adoption. The author argued that children with poor early interaction experiences present a, ‘considerable challenge’ for those who will eventually care for them (p.2). Golding continues to argue that the only way forward in helping children from dysfunctional backgrounds to learn secure attachments is to offer therapeutic options that emphasise the role of the carer, and that the carer is
taught how to offer a basis for secure attachment through being educated about attachment theory.

A current study being conducted into attachment and adoption is the *Adoption and Attachment Representations Study*. The study is longitudinal in nature and is being carried out as a joint venture between the Coram Family Institute, The Anna Freud Centre and the Great Ormond Street Hospital in London. In 1995 a group of 63 children considered to be, ‘hard to place’ due to histories of maltreatment and neglect were contrasted with a second group of 48 children, who were adopted before their first birthday, but who were between the ages of 4 and 8 years at the start of the project. The study was designed to show a comparison between late versus early adoption.

The study is using measures such as the Adult Attachment Interview (AAI) developed by Main et al (1985) and Story Stems (Hodges, 1995) where children are asked to respond to story dilemmas designed to measure their expectations and perceptions of family roles and interactions and relationships, thereby giving detailed insight into their internal working models. Parent Interviews designed to capture the parent’s representation of the child at differing time points in the study, enabling the researchers to track the process of developing attachment from the parent’s perspective, are also being used.

The second phase of this study is currently being carried out and the children in both groups are now in early adolescence. The researchers from the three institutes involved have reiterated that this follow up phase is again to be based on the philosophical assumptions of attachment theory, with a specific focus on internal working models of relationships and the subsequent effect on the formation of new relationships. Using a process of interaction observation and interviewing, and of measured questionnaire responses, this current phase of the study is designed to assess the participant’s current attachment relationships to family and peers. It is further designed to investigate how adolescents behave, and how they internalise and externalise behaviour problems, their self esteem, psychosocial functioning, cognitive skills, negotiation skills and academic performance.
Although the above study is not due for completion for some time, it is predicted that the findings will indicate that the earlier a child is given a strong and stable base for developing a secure attachment pattern the more likely it is that the child will be able to go on to continue to form healthy relationships and interactions. Although this finding may be in contrast to the other studies presented in this section, that children older than infants when adopted can eventually form secure attachments, it is significant for the current study as it argues that the younger the child, the more likely the secure attachment.

The suggestion here, based on the material presented, is that if secure attachment is possible in adoption, then it is possible in gestational surrogacy. This suggestion further raises the question about whether the potential for developing secure attachment patterns is reliant on gestational experience or on early relational experiences. As has been previously mentioned attachment theory recognises the importance of relationships post birth, in attachment and bonding, and not on the relationships built between mother and child during gestation. In time, further studies would be useful in comparing attachment styles in adoptive and in gestational surrogacy adolescents and adults.

Although there exists a plethora of published research concerning attachment in adoption, public opinion appears to have less to say about this topic than attachment in gestational surrogacy. A possible public perception here may be that adoption, even commissioned open adoption, of a genetically unrelated child, is nobler than commissioning another human being to carry a child containing your own DNA. As was highlighted, LaMothe (2008), two time surrogate mother, and previous surrogacy agency owner, was questioned about her own integrity in acting as a surrogate and met with the strong opinion that she was preventing a homeless child from entering an adoptive family. One commentator on Feministe Blog postulates the following:

“Fertility treatment, legal expenses, the carrier's health insurance, the carrier's fee, the agency fee etc...That's a whole lot of money. Imagine how good it would do if the parents adopted a child and put all of that money towards the child's well-being, education, etc...Or if they adopted a child and donated a hunk of that money to the foster care system.” (QLH, Feministe Blog; 2008).
This comment again highlights the possible public opinion that commissioning parents have actively chosen gestational surrogacy over and above adoption. Childless couples have to meet stringent criteria in order to be placed on any local or overseas adoption waiting lists. As can be seen from the statistical information presented in this section adoption figures have decreased dramatically in the past three decades within Australia. Out of the one in six couples facing fertility problems here many will be unable to be placed on waiting lists as they do not meet the criteria. It will be of interest to explore whether the commissioning couples in this study considered adoption as a first choice in overcoming childlessness.

Statistics for step and blended families in Australia are, like the figures for adoption, provided by the Australian Bureau of Statistics. The ABS defines a step family as containing a natural child (or children), aged 0-17, of one partner in a couple, but not the other (meaning that two children in a family may be unrelated biologically). The ABS further defines a blended family as containing two or more children, aged 0-17, of whom at least one is the natural child of both parents, but other children in the family are natural to only one or other of the parents, having been children from previous relationships. This means that two children in a family may share the genetic composition of one parent, but may be biologically unrelated to the other, as is the case for half siblings. The ABS states that the term natural also applies to children who have been legally adopted, and where there is no biological link to either parent in either a step or blended family.

According to the ABS Family Characteristics Survey (2003-2004), there were 7,640,200 households in Australia in 2003, 5,532,400 of these households were made up of families. Of this figure, 176,700 families were classified by the Family Characteristics Survey as step or blended families.

Ruschena and Prior (2004) conducted a longitudinal study of adolescents during family transitions. The authors discuss the concept of Australia as being the, 'lucky country', and argue that in terms of secure, or insecure, attachment patterns, 'most families are doing OK'. The authors further argue that much of this success is due to Australian factors such as the emphasis on children’s welfare during family discord or break up, and they postulate that factors such as, “enforced child maintenance, might mitigate the hardship of family breakdown”. (Ruschena & Prior, 2004; p.538).
The authors further suggest that:

“There is overwhelming evidence that what damages children is not the break-up but conflict. If parents behave well, remain co-operative and keep children’s welfare to the forefront, generally children do well. Those who don’t do well often had problems that pre-existed the break-up.” (Prior, 2004; p. 539).

Ruschena and Prior (2004) state that in terms of the attachment patterns of the adolescents in the study, all of the participants were dismissive of suggestions that parental break up had detrimentally affected their school work, arguing that, “divorce was not the single defining moment of their lives.” (p.540).

The implication of the above investigation for the current study is that the children from separated and divorced families did not automatically fall into patterns of insecure attachment and maladjusted behaviour as a result of parental break up, especially where there were no signs of these psychological disturbances prior to the break down of the families. Again the implication and significance of this finding for the current study is that secure attachment can prevail in atypical circumstances such as in the forming of blended families. As for adoption, it is reasonable to assume that if secure attachment patterns are possible between parents and children and between step-parents and children in situations of families reforming after separation and divorce, than it is possible for parents and children to form strong secure attachments in gestational surrogacy arrangements.

In view of the research presented concerning secure attachment in adoption and in blended families it would appear that it is what happens post-birth that matters in children and parents forming healthy bonds and attachments. In her review of studies conducted in parent-infant bonding, Goldberg (1983) postulates that early post-birth contact between children and parents does not predict the type of relationships that will subsequently develop, and that in cases of difficult births, prematurity and perinatal medical complications, ‘success or failure does not hinge on a few brief moments in time.’ (p.1379). This argument is significant in the case of early child-parent attachment in gestational surrogacy as it contributes to dispelling the misperception that a non-gestational mother is less likely to be able to help her child to form secure attachment patterns than a gestational mother.
4.7 THE SOCIAL NETWORK MODEL

Presently there is not enough published research available concerning the impact of attachment in surrogacy and it may be that attachment theory needs to be re-thought in its application to this area. As Belsky and Nezworski (1988) argue we need to be cautious in assuming that the principles of attachment theory can always be applied in every circumstance:

“In general, we need to be constrained in the predictions that we make from attachment theory. There are those who will some day count the number of “hits” and “misses,” disregarding the precision of theoretical derivation. If we want to adequately test the theory and contribute to its evolution, our empirical efforts need to be thoughtfully guided.” (Belsky & Nezworski, 1988, p.28).

In terms of secure attachment, within the context of gestational surrogacy, I would like to propose a social network model as this builds upon initial dyadic attachment models, but also recognises the polytrophic attachment figures present in a child’s life. It is possible that, without negating the importance of the early interactions between mother and baby, positive levels of support in gestational surrogacy situations are so great that children born into this network automatically receive a plethora of social data which strengthens their internal working models and representations in developing secure attachment styles. In the words of the ancient African proverb, “It takes a village to raise a child.”

Lewis (2005) proposes the Social Network Model arguing that this is a polytrophic model that recognises the role of multiple attachment figures. Bronfenbrenner (1986) discusses the concept of the ecology of development, which states that the infant is born into a world filled with networks, the most significant being the family, but which allows for the interconnected networks outside of the immediate family arena to be included in the child’s development. Lewis proposes that these interconnected networks can form larger social bands, such as clans, social classes or religious groups.

Lewis (1987) and Lewis and Feiring (1981) describe the social network model as being defined as a matrix in which,
“different social objects (e.g. mother, father, peers) typically satisfy different social needs or functions, including protection, caregiving, nurturing, play, exploration and learning, and affiliation.” (Lewis, 2005; p.12).

The matrix represents the possible individuals present in the child’s social network. Lewis (2005) suggests that through the process of systems analysis, families can be characterised by a set of, ‘interrelated elements.’ (p.20). Here it is argued that the child establishes their relationships, thereby forming their style of attachment, within a network of already existing relationships. An example given is that the mother of a child does not bring only herself into influencing her child’s behaviour or personality, the mother is also influenced by the social network around her, and those that influence the mother in that network are themselves within further indirect networks which may ultimately influence the child in its original family.

The implications of this for the current study are that any children born in gestational surrogacy arrangements are born into established social network patterns that will ultimately influence these children and direct their development. The social network paradigm does not necessarily negate the role, or the importance, of the mother-child relationship; it merely suggests that there is more. As was previously mentioned, it has been suggested that children born in gestational surrogacy arrangements may potentially be more likely to develop secure attachment styles than children born in normal conception situations. This may be due to the personal efforts of their parents in having to take such complicated routes to have their children. It will be of interest to explore in the current study whether the commissioning couples interviewed are part of supportive social networks eager for success and keen to support parents in raising their long awaited for children, thus supporting the principles of the social network matrix.

4.8 CONCLUSION
It has been shown in this chapter that there are many public attitudes or public perceptions, or misperceptions, concerning gestational surrogacy arrangements, chiefly that the process should be viewed with suspicion and caution, as it is potentially exploitative, unnatural, and interferes with normal emotional development.
Whilst this study is not designed to investigate the personal circumstances of surrogate mothers or to make an assessment of the morality of gestational surrogacy, these have been important concepts to present. The extent to which public opinion influences commissioning couples is an important issue examined in this thesis.

From the evidence presented in this chapter it could be said that the early signs are that attachment is not deleteriously affected in gestational surrogacy arrangements. As the children born in Australia in gestational surrogacy arrangements become adolescents and adults it will be important to open discussions with them about their experiences. Although a detailed investigation of attachment theory in surrogacy is not within the remit of this study, the perceptions about this area by others are important to investigate. Social support, and the psychological impact that relationships had on commissioning couples, are essential aspects to explore in trying to understand how couples were influenced in making their decisions to enter into surrogacy arrangements. It is also important to look at how these relationships shaped the whole experiences of surrogacy for the couples who took part in the study.

The next chapter of this thesis offers a detailed methodology of how the current study was conducted and how the material collected was analysed. The results and discussion chapters following this methodology explore in detail the experiences of the eighteen couples interviewed and relate these experiences back to the models and theories discussed in chapters one through to four of this thesis. It is my intention that the reader will be able to draw many conclusions from this report, not withstanding that the children born to commissioning couples have the potential to form secure attachment patterns in early relationships with their biological parents and their wider social networks.
CHAPTER FIVE  

METHODOLOGY

In this chapter I offer the rationale for adopting a qualitative method to study the psychological experiences of commissioning gestational surrogate couples. I describe the specific type of qualitative approach used and discuss the issues needing to be addressed in adopting this paradigm. This chapter also outlines details concerning the method and procedure used in conducting the interviews with the participants and how the principles of the qualitative approach were applied to the analysis of the data collected.

5.1. A QUALITATIVE METHODOLOGY: BACKGROUND & RATIONALE

As the psychological experiences of commissioning gestational surrogate couples were being studied, I wanted to take the opportunity to understand in a detailed way the impact on these couples regarding their decision to embark upon gestational surrogacy; I also wanted to investigate how they had been, or how they were currently being, affected by the process. As yet there is so little known about the experiences of commissioning couples in gestational surrogacy arrangements that it is difficult to formulate specific hypotheses. It was felt that a qualitative approach would allow for a respectful drawing out of the rich data, which this potentially highly vulnerable group had to offer, without reducing the interviews conducted into clinical fact finding missions.

Smith and Osborn (2003) argue that we can answer many important research questions through formal surveying and data analysis, but that this is limiting when attempting to investigate the psychological responses to specific life events. The authors suggest that:

“...Phenomenological psychological research aims to clarify situations lived through by persons in everyday life. Rather than attempting to reduce a phenomenon to a convenient number of identifiable variables and control the context in which the phenomenon will be studied...In other words phenomenological analysis seeks the psychological meanings that constitute the phenomenon through investigating and analysing lived examples within the context of the participants’ lives.” (Smith & Osborn, in Smith, 2003; pp.26-27).
There are very few established studies available which discuss the psychological impact of gestational surrogacy on commissioning couples. Van den Akker (2007) argues that, “Virtually all studies [in surrogate motherhood] have used highly selected samples, making generalisations difficult.” (p.53). However, as previously mentioned, MacCallum et al. (2003) have conducted a similar study to the present study, with 42 couples recruited through the United Kingdom Office for National Statistics (ONS). A record was made of all successful surrogacy arrangements post commissioning couples being granted legal parentage of their children. The chief method used for this investigation was tape recorded semi-structured interviews, as is the case for the current study.

Further studies into the effects of infertility on individuals and couples, such as, Cook (2002) and Abbey, Andrews and Halman (1994) also used semi-structured interviews in collecting data and analysing phenomenological experience in this area. Goble (2005) and Young (2005) used this method for assessing the psychological experiences of surrogate mothers and their partners, respectively, involved in the gestational surrogacy process.

Similar to Smith and Osborn’ comments above, Cook (2002) argued that he did not want the richness of his participants’ experiences to be lost in statistical summaries when exploring the effect that male infertility had on the men in his study,

“I did not want to lose the valuable subtleties of the men’s responses by applying statistical techniques which use approximations and averages and submerge individual data under that of the group...I did not want [the participants] to think that their discussions of some of the most personally difficult matters would be diminished or handled dismissively by a researcher whose agenda was reflected in the use of data gathering techniques which could not respond to the subtlety of felt responses.” (Cook, 2002; p.86).

Bannister et al. (1995) argue that the qualitative researcher focuses on the context and the integrity of the material and will never build an account of phenomenological experience using only quantitative methods. I have chosen to use a qualitative approach which would best represent the participants’ phenomenological experiences and to help develop an understanding of the psychological and emotional impact of gestational surrogacy on commissioning couples. In the next section I describe in detail the specific approach used; my purpose in doing this is to provide a step-by-step account of how the data from participants in this study was handled and interpreted in readiness for discussion.
5.2 INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS: TOWARD A METHODICAL STUDY

I have chosen an Interpretative Phenomenological Approach (IPA) throughout this study as it is defined by Giorgi (1985) and by Moustakas (1994). The main appeal of this approach for me was that it has a methodical step-by-step process of collecting and analysing data that does not diminish the importance or phenomenology of the lived experience, but at the same time offers a scientific way of working with qualitative material.

5.2.1 AN EXPLANATION OF HERMENEUTICS AND PHENOMENOLOGY

Hermeneutics refers to the scientific process of interpreting the psychological meanings of a text, particularly where common themes can been seen across similarly lived experiences. Fischer (2006) further defines the hermeneutic circle (p.185), widely accepted in qualitative research (Denzin & Lincoln, 2005; Smith, 2003; Rubin & Rubin, 2005; Moustakas, 1994), as the continuous reformulation of the evolving understanding of psychological meanings of parts of texts. It is understood that the circle offers a rejoining point each time a deeper or clearer understanding is reached about a particular aspect of text. The hermeneutic circle also acknowledges that the researcher and his or her own lived experiences also play a part in understanding and interpreting data.

Phenomenology is a philosophy developed by Edmund Husserl in the early 1900’s. The basis of this philosophy was Husserl’s belief that psychology could help to make discoveries about the experiential world in psychologically significant ways. Giorgi (1985) argues that the guiding theme of phenomenology is to adopt Husserl’s basic premise of going, ‘back to the things themselves.’ Or to, ‘go to the everyday world where people are living through [a phenomenon in] actual situations.’ (p.8).

Below is outlined the four step process designed by Giorgi (1985) for specific data analysis using the IPA approach. The sub-section that follows from this looks at the writings of Moustakas (1994) relating to the philosophy that forms the foundation for Interpretative Phenomenological Analysis.
5.2.2 A FOUR STEP PROCESS IN THE INTERPRETATIVE PHENOMENOLOGICAL APPROACH

Giorgi (1985) argues that once an investigator has recorded the narrative of the participants living through the phenomenon four steps need to be applied to the transcribed text of the narrative in order to be able to assign psychological meaning and offer interpretation:

1. Establish a sense of the whole. This refers to the process of reading and re-reading a transcript as a whole to ensure that the researcher has understood the basic tenets of the text.

2. Discrimination of meaning units, or labels, within a psychological perspective and focused on the phenomenon being researched. This step constitutes reading the text again, but this time from a psychological perspective. In this study I have chosen to adopt an IPA approach. Keeping this in mind I would read through a particular transcript and highlight any part of the text that helped me to understand more about a participant’s emotional responses to the lived experience of contemplating or entering into gestational surrogacy. I would then assign interpretative labels to the highlighted text, such as, ‘confusion’.

3. Transformations of the participant’s expressions into psychological language with emphasis on the phenomenon being investigated. In this step the researcher assigns units of psychological meaning to the interpretative labels from step two that best describes the particular psychological response. For example, ‘confusion...about conflicting information’ and ‘confusion...about the lack of information’ were items transcribed from the interviews clustered together under the overall interpretative label of ‘confusion’.

4. Synthesis of transformed meaning units into a consistent statement. Giorgi argues that the role of the researcher in this final step is to, ‘synthesise and integrate the insights into a consistent description of the psychological structure of the event.’ (p.19). The place to present this synthesis would be in the discussion section of this thesis, where interpretations would be offered and similarities of participants’ experiences might be compared and explored.

Smith and Osborn (2003) argue that in IPA a two stage process or double hermeneutic, or two-fold way of understanding exists; an empathic hermeneutic, as presented by the researcher based on the involvement of their own experiences and a questioning hermeneutic, the researcher trying to extract information about the
participant’s response to a particular life event; ‘The participants are trying to make sense of the world; the researcher is trying to make sense of the participants trying to make sense of the world.’ (p.51).

In interpretative qualitative research it is recognised that the researcher’s interpretations of the shared narrative cannot help but to be based in part on their own assumptions and life experiences. Smith and Osborn (2003) refer to this as, ‘insider perspective’. Since it is not possible to approach qualitative study as a removed human being it is accepted that the interpretations offered are a synthesis of the experience that occurred between the participant and the researcher during the course of the interview period as well as a synthesis of the participant’s experience of the phenomenon being studied.

Moustakas (1994) builds upon Giorgi’s four step plan of understanding phenomenological experience whilst also including a process for recognising the researcher as an individual bringing his or her own experience into the arena.

5.2.3 PHILOSOPHY OF INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS

Moustakas (1994) argues that:

“Evidence from phenomenological research is derived from first-person reports of life experiences. In accordance with phenomenological principles, scientific investigation is valid when the knowledge sought is arrived at through descriptions [by the researcher] that make possible an understanding of the meanings and essences of experience.” (Moustakas, 1994; p.84).

Moustakas (1994) discusses his notions of Epoche, Phenomenological Reduction, Imaginative Variation and Synthesis. An explanation is offered of each of these below:

1. The Epoche. Like Giorgi (1985), Moustakas (1994) begins with the work of Husserl stating that ‘freedom from suppositions’ (Husserl, 1931, 1970), when attempting to understand another’s experience is to rid ourselves of, ‘the biases of everyday knowledge.’ (p.85). Moustakas labels the ability to suspend preconceived ideas and judgements as The Epoche. The Epoche is a Greek word meaning to abstain or stay away from. In phenomenological inquiry the researcher working within this philosophical stance is called upon to take a naive starting point free from preconception and professional knowledge. I attempted to do this by asking as many open ended questions as possible during the interviews. This allowed for the participants to openly
discuss their experience of gestational surrogacy without confining their responses to conveying a catalogue of chronological facts and figures.

2. **Phenomenological reduction.** Refers to the continuous process of looking and describing and then continuing to look and describe until all perceptual possibilities are exhausted. The implications of this method for the current study would be to read through each transcript from each interview as many times as it took to extract as much meaning from the texts as possible. Within phenomenological reduction the researcher is asked to do four things; *bracketing*, which refers to the process of placing the topic of study in a mental bracket whilst reading the transcripts and only look at the psychological experience as it relates to this topic. *Horizonising*, which refers to initially giving equal value to all statements that describe the psychological experience in relation to the topic being studied. *Clustering the horizons into themes*, similar to Giorgi’s application of units of psychological meaning and *organising the horizons and themes into a coherent textural description*. This refers to the oral or written presentation of the themes allowing the reader to be able to understand the participant’s experience knowing that as clear as possible a picture has been offered by the researcher.

3. **Imaginative variation.** Moustakas (1994) argues that the steps involved in Imaginative Variation include:

   - ‘Systematic varying of the possible structural meanings that underlie the textural meanings’. That is an acceptance by the researcher that another may have a different perspective on an interpretation offered. One researcher may perceive a statement as angry whereas another may perceive the same statement as disappointed or depressed.

   - ‘Recognising the underlying themes or contexts that account for the emergence of the phenomenon’. The implication for the study here is that I need to recognise that the units of psychological meaning that I have applied to the text account for the phenomenon being studied, that is the commissioning parents’ psychological experience of gestational surrogacy.

   - ‘Considering the universal structures that precipitate feelings and thoughts with reference to the phenomenon, such as the structure of time, space, bodily concerns, materiality, causality, relation to self, or relation to others.’ Here Moustakas is asking the researcher to consider why a participant might have a particular psychological response. In other words to look deeper than just the surface.
• ‘Searching for exemplifications that vividly illustrate the invariant structural themes and facilitate the development of a structural description of the phenomenon.’ In the current study this would mean paying particular attention to any cross referencing that exists between the participant’s experiences. The more examples that can be given that show the similarities between psychological responses, the more it can be shown that a particular phenomenon is creating a particular affect.

4. Synthesis of Meanings and Essences. Like Giorgi (1985), Moustakas (1994) recognises the need for the researcher to make a decision about any interpretations reached and then present a statement that offers these interpretations. Moustakas quotes Husserl in concluding that:

> “Every infinite property draws us on into infinities of experience, and that every multiplicity of experience, however lengthily drawn out, still leaves the way open to closer and novel thing-determinations; and so on infinitum”. (Moustakas, 1994; p.100).

5.3 Issues for the interpretative phenomenological approach to address

As is evident from the rationale given above, I believe that the best qualitative method for this study is IPA, however any approach, whether qualitative or quantitative, has its limitations and the onus is therefore on the researcher to try to overcome these difficulties in order to produce a methodical and scientifically processed study, with clear procedures and productive outcomes. In this next section I outline some of the issues raised and discuss how they were dealt with.

5.3.1 Scientific control & validity

One of the major concerns of any researcher is scientific control. Quantitative methods in research are often presumed to be more scientific because the data appears to be quantifiable and responds well to parametric statistical analyses, including computer software analyses. This type of analysis can make the reader feel more comfortable with results, as it is presumed that parametric statistical analysis controls for human error and contamination of any data, but as it has already been highlighted a quantitative methodology would not have been the appropriate method to use for the current study.
Fischer (2006) argues, in relation to running focus groups for identifying Psychoeducational HIV/AIDS interventions in Botswana, the data collection from the population being most affected by the disease would be difficult to process using a quantitative method, as the participants targeted needed to narrate their experience of contact, contraction, and living with HIV/AIDS in order for the medical community to be able to understand where to begin to educate; a living example of the need to practise psychology from the perspective of The Epoche. Fischer states:

“Qualitative research strategies often are used to obtain phenomenological and existential information about the human condition that, by the very nature of the data, would be difficult or nearly impossible to acquire through quantitatively orientated or conventional statistical means”. (Fischer, 2006; p.385).

Cook (2002) argues that, ‘The decision about how to proceed with any research inquiry rests on the goal of the inquiry.’ (p.90). The goal of the inquiry of this study was to gather and synthesise the psychological experiences of commissioning gestational surrogate couples. This was so that the emotional impact and psychological experiences of such couples undertaking this controversial form of infertility treatment could be better understood.

Yardley (in Smith, 2003) offers three broad principles for assessing the validity of qualitative research. Following is an outline of these principles and an explanation of how I paid close attention to them whilst conducting the research and analysing the subsequent data in the present study:

1. **Be sensitive to context** by showing an awareness of existing literature relating to either the topic under study or to the methodology adopted in the study. Also consider how well the unfolding argument is evidenced by material drawn from the participants, especially in regard to the relationship between the researcher and the participants. Finally look at the socio-cultural climate in which the study takes place. I have highlighted the need for this study due to the lack of published systematic research in the area of the psychological experiences of commissioning couples in gestational surrogacy. I have further formed a rapport with each of the participants which has resulted in the sharing of detailed experiences that allow for the unfolding argument concerning their experiences to be evidenced.

2. **Show commitment, rigour, transparency and coherence.** Yardley argues that this refers to a committed, ‘thoroughness of the study, in terms of the appropriateness of the sample to the question in hand and to the completeness of the analysis undertaken.’ (p.54). As is outlined below in the specific analysis
section of this chapter, I have attempted to replicate the principles of Interpretative Phenomenological Analysis as laid down by Smith (2003), Giorgi (1985) and Moustakas (1994), as closely as possible. Yardley (2003) further argues that transparency and coherence refer to, “How clearly the stages of the research process are outlined in the write-up of the study” and to, “the fit between the research carried out and the underlying philosophical assumptions of the approach being followed”. (p.54). I have attempted to offer a clear and concise write-up of all of the parts of this study in accordance with the principles of Interpretative Phenomenological Analysis, believing that this method was the best ‘fit’ for the research, as I wanted to convey to the reader a systematic analysis of the psychological experiences of the participants involved. Yin (1989) suggests that an important way to check the validity of research is to file all of the data in such a way that the next researcher could follow the chain of evidence and check through the ‘paper trail’, analyse the data and produce similar results and interpretations. As is clear from my write-up of both the procedure and the specific analysis I have attempted to be conscientious. I have also included knowledge and personal disclosure of the researcher to allow the reader to assimilate my own experience into their own understanding of the participants’ experiences.

3. **Consider impact and importance.** Yardley argues that a **key test** of the validity of a piece of research is, does it tell us anything that is important or that ‘makes any difference?’ (p.55). As there are no published systematic studies of the psychological experiences of commissioning gestational surrogate couples in Australia and, as specific aspects of surrogacy were under review by the Victorian Law Reform Commission and the Victorian Government during the writing of this thesis, it is hoped that this study will be able to add important and relevant information to the field of the study of infertility treatment, especially gestational surrogacy and its emotional impact on its clients.

A fourth consideration not outlined by Yardley is to incorporate participant feedback. Through sending participants completed transcripts of their interviews and inviting them to read and re-read what was written the data was then checked, and re-checked, from their perspectives.
5.3.2 KNOWLEDGE AND PERSONAL DISCLOSURE OF THE RESEARCHER

It was important to me that each interview yielded as much information as possible in order for that information to be methodically analysed and presented in such a way that the reader clearly understood the salient and common psychological themes being investigated. I also felt that there was significant value in using a narrative approach which encouraged self-disclosure by the interviewee and took the focus off the interviewer. I was inspired by Denzin and Lincoln (2005) who argue that:

“Narrative inquiry can advance a social change agenda. Wounded storytellers can empower others to tell their stories...collective stories can form the basis of a social movement. Telling the stories of marginalised people can help to create a public space requiring others to hear...” (Denzin & Lincoln, 2005; p.642).

My own experience of infertility and sub-fertility differs from the participants in the study as I was never faced with the decision about gestational surrogacy. I am recording the information that I shared with participants here as it forms some of the basis of my conversations with several participants during the course of interviewing them.

My husband and I married twelve years ago and were unable to conceive for a period of approximately two years. I underwent surgical investigation and was told that I had a small amount of endometriosis. This was apparently not enough to interfere with conception, but as that left my infertility unexplained I was given three courses of clomiphene and became pregnant with our son who is now eight. My husband and I were advised not to leave a large time gap if we wanted subsequent children and fifteen months later we had our second son who is now seven.

Three years later I underwent further investigative surgery as I was again unable to get pregnant. At this stage I was told that I would require IVF to conceive. As a couple we felt that we had ‘run our gauntlet’ and we settled into a life of parenting two boys. Approximately thirteen months later our last son, who is now three, was born without assisted conception intervention. At the time of writing this thesis my husband and I have begun the arduous training process to become permanent care order parents to a fourth child. Permanent Care Order Parenting is unique to the state of Victoria. The program is designed to give permanent secure homes to children who would otherwise be destined to live in temporary foster care situations until the ages of sixteen or eighteen.
At an academic level the current study was completed and submitted in partial fulfilment of the requirements for the award of the Doctorate in Psychology (Counselling Psychology) degree at Swinburne University. However, having been a recipient of infertility treatment, and as a developing student of psychology, I have maintained an interest in the involvement of psychology and counselling in the area of assisted conception. Although my experience of treatment was, on the whole, effective and positive, I am keenly aware of the trials and tribulations of ‘waiting to get pregnant’, and the stamina and tenacity that is required in dealing with the responses of others, both at a personal and at a professional (medical intervention) level.

I have been studying as a postgraduate student for approximately six years and during that time have been working as a counsellor in several fields, including general practice and trauma therapy. My most recent work experience was as an Infertility Treatment Authority (ITA) approved counsellor at a Melbourne IVF clinic.

5.4 METHOD
Below is outlined the sample, recruitment and participation rate, the difficulties in encountered in sampling and recruitment, the participants’ demographic information and ethical issues.

5.4.1 SAMPLE, RECRUITMENT & PARTICIPATION RATE
The sample comprised of eighteen couples who had previously attended psychological assessment for the purpose of entering into gestational surrogacy arrangements as commissioning couples. All participants had English as a first language and all the women in the sample had been diagnosed with infertility or with a medical condition which would prevent a normal and safe pregnancy.

As has been mentioned, two previous studies have been conducted in the area of surrogacy by Swinburne University colleagues. *Carrying Someone Else’s Baby: A Qualitative Study of the Psychological and Social Experiences of Women who Undertake Gestational Surrogacy* (Goble, 2005) and *An Investigation of the Psychological Experiences of the Partners of Women Who Act as Gestational Surrogates* (Young, 2005). Although the participants of the current research project had not been previously studied, their potential surrogates and the partners of these potential surrogates were the participants for those previous projects listed here.
Initially I was permitted to view the names and contact details of twenty four previous, or on-going, commissioning couples who had received a positive psychological assessment and had therefore been allowed to proceed with gestational surrogacy arrangements. These couples had also agreed to be contacted about the current study. The actual psychological assessments and any other details of their approval status for surrogacy were not revealed to me. All twenty four potential participants were sent an initial introductory package (see Appendix J) which outlined the details and intended outcomes of the study, and which met with the requirements of the Human Research Ethics Committee for initial researcher-participant contact.

Fifteen couples initially gave a positive response to being part of the study. A follow up letter (see Appendix K) was then sent to the remaining nine couples to ascertain whether these couples were still at their contact addresses and whether they were still interested in taking part in the study. Five couples were presumed to be no longer at their previous addresses, but a further two couples, who were able to be contacted then agreed to take part. Two couples declined. Finally a couple was also approached who had indicated through another participant couple that they would like to be included in the study. This brought the final participant list to eighteen couples (thirty six individuals). Interviews were then conducted over a six month period. At the conclusion of the interview period thirty four individuals had been interviewed out of the eighteen couples, this was due to two of the participants (from different couples) being unavailable for interview due to the development of unexpected personal circumstances.

5.4.2. DIFFICULTIES ENCOUNTERED IN SAMPLING & RECRUITMENT

Some of the major difficulties often associated with any research, such as developing a sample and recruiting participants from that sample, were not the case here. The difficulty that I encountered was more common to the counsellor-client relationship than to the researcher-participant one. I was acutely aware throughout the process of recruiting, and then later when interviewing, that many potential participants had been through what could only be described as harrowing experiences, leading up to make the decision to enter into gestational surrogacy arrangements. It was not uncommon during initial telephone conversations with potential participants to be told that their willingness to participate was to help to others coming after them, but that the topic was associated with much pain and heartache. Where participants disclosed a psychological impact, which was currently causing them distress, it was
important to refer them back to the initial introductory packages, giving them the option to withdraw from the study or to seek counselling. At the time of each of the interviews all participants expressed the desire to continue.

5.4.3 PARTICIPANTS’ DEMOGRAPHIC INFORMATION

The following table gives the demographic information for the participants in the current study. Of major interest here is that all 18 of the women interviewed made the decision to enter into gestational surrogacy arrangements due to medical diagnoses or multiple medical conditions. All of the couples interviewed had entered, or intended to enter, into altruistic gestational surrogacy arrangements within Australia, however two couples had changed to commercial arrangements in the United States. These two couples had made their decisions after originally proceeding with local altruistic arrangements, and have therefore been considered for the current study. The demographic information was recorded at the time each interview was conducted.

Table 2  summary of demographic information at time of interviews

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Number of Couples</th>
<th>Number of Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>• married/long term partners</td>
<td>16</td>
<td>34</td>
</tr>
<tr>
<td>• separated or Divorced</td>
<td>2</td>
<td>(2 individuals declined interview)</td>
</tr>
<tr>
<td>Residential Location</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• metropolitan</td>
<td>5</td>
<td>8 (2 individuals declined)</td>
</tr>
<tr>
<td>• Melbourne suburbs</td>
<td>7</td>
<td>14</td>
</tr>
<tr>
<td>• country Victoria</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>• now residing in another state</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Medical Diagnosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• kidney Disease</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>• auto immune disease</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>• failed IVF/Treatment</td>
<td>4</td>
<td>(18 women interviewed, some with multiple conditions)</td>
</tr>
<tr>
<td>• hysterectomy</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>• bicornate uterus</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>• other uterine abnormality</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>(including bleeding disorder)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• other medical conditions</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>(including uterine or cervical cancer)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of Children at Time of Interview</td>
<td>Across All Couples</td>
<td></td>
</tr>
<tr>
<td>• children natural conception (Living)</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>• children natural conception (deceased)</td>
<td>4</td>
<td>through accidental death or death in utero after second trimester</td>
</tr>
<tr>
<td>• children IVF conception</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>• children gestational surrogacy</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>• current surrogacy pregnancies</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>• considering or attempting subsequent arrangements</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>• decision to stop (at April 2007)</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>
5.4.4 ETHICAL ISSUES

As an integral part of ethical approval being granted for the current study I considered the issue of confidentiality. Tolich (2004) argues that, ‘confidentiality is like an iceberg; only the tip is known, but what lurks unseen...is also a source of potential harm.’ (p.1). The author argues that external confidentiality is obvious and easily dealt with by the researcher by not identifying participants in a final report, whereas internal confidentiality, where participants may recognise each other is more difficult to guard. There is also the secondary problem of those known to the participants outside the study recognising them when reading a report, as they are close enough to know specific personal details.

Tolich gives the example of ‘The Fisher Folk’ where a researcher studying an underprivileged fishing community (Ellis, 1995) discovers that the individuals in the final study have ‘unravelled’ her pseudonyms for them and report their hurt and dismay at being betrayed by her writings. Tolich highlights the poignant scene where Ellis asks,

“How do you know that this is about you?”

The retort...

“Cause you’re the only one who coulda known that story about us goin’ with boys. Now everyone will know it was us…” (Ellis in Tolich, 2004; p.1).

In light of the above ethical consideration it was decided to maintain both external and internal confidentiality in the following ways:

1. Participant’s names and any other identifying material were not used in any part of the data collection, analysis or discussion in the study.
2. Couples were referred to during the process of transcribing by a number. The code to numbering was kept in a locked file.
3. The professional university transcribing service used developed their own code (see Appendix L) for protecting the names of the participants during the process of transcribing.
4. Couples were referred to as Couple 1-18 with code names, or pseudonyms, being assigned to each individual within the couples from letters of the alphabet. So, for example, Couple Number One were referred to throughout the study as Adam and Ann, Couple Number Two as Bert and Bett, Couple Number Three as Colin and Catt through to Couple Number Eighteen, Roger and Rachel (see Appendix M).
5. Any records, keys of code names or write-ups were kept in a password protected computer file only accessible to me.

6. Any correspondence (including the mailing of interview transcripts) with participants was sent to participant approved addresses or email addresses established during the course of the interviews.

A second ethical issue to be addressed was the participants’ desire to be in contact with each other. During the course of data collection many couples asked me if I would be willing to share their contact details with others in the study as they felt as if they were the only people in Victoria to be undertaking gestational surrogacy and they wanted the opportunity to talk with others going through similar experiences. I discussed this request in supervision and it was decided that I would ask couples, when I visited them, if they would be willing to share their contact details with each other. This was presented in a final report to the Ethics Committee as an unintended outcome. Hannah from Couple Number Eight responded:

“Absolutely...I’d give as much information as I could give [other participants]...and steer them straight to [the clinic] because [surrogacy is] possible. Even though it’s not possible here, it’s possible there, but you need to be super organised and determined. That’s all.” (Couple No.8, 2006; Transcript p.14).

At the conclusion of the data collection all eighteen couples were sent a card with a note of thanks and a return reply slip (see Appendix N) asking for written permission to circulate contact details. Ten couples responded and the list was prepared and circulated once it was decided that no further couples wished to be included. It was clearly written on the contact list that this was confidential and should be treated as thus.

5.5 PROCEDURE AND DESIGN OF THE STUDY

Below is outlined the formulation of the questions for interview, interview and follow up protocols and a summary of the specific procedural steps.

5.5.1 FORMULATING THE QUESTIONS FOR INTERVIEW

Initially I developed questions that I felt dealt with the three issues for inquiry investigated by the Victorian Law Reform Commission:
1. “Are the current eligibility provisions in the [Infertility Treatment] Act appropriate for application in surrogacy situations, including situations where donor gametes are used?
2. How should the legal status of the child be clarified?

However, the Commission was not my only source in developing interview questions, as the commissioning couples’ experience of the then laws formed only part of the investigation. Norbeck’s (1981) Social Support Questionnaire was considered (see Appendix O), and eventually I prepared the thirteen questions, in Table 3, that attempted to cover all of the issues for inquiry, including a detailed and in-depth account of what lay behind the surrogacy decision and how gestational surrogacy had impacted all the participants psychologically. Issues surrounding the initial decision making process, personal coping mechanisms, relationships with others and views about potential change in the law were also explored. The questions were semi-structured as this gave me a foundation with each couple from which to start each interview. This also allowed me to explore the couple’s wider narratives in detail, and by attempting to keep an open questioning approach throughout each interview I was able to gain as much information as possible. When drawing to a conclusion in each interview I always asked, “What have I missed? What have I not asked that I should have?” This was a helpful way to end each interview as it often facilitated a flow of conversation that might otherwise have not developed. The questions are also referred to in Appendix J, Introductory Packs.
Table 3  *Semi-structured questions used in interviewing commissioning gestational surrogate couples*

<table>
<thead>
<tr>
<th>Number</th>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>How did you arrive at the decision to enter into a gestational surrogacy arrangement?</td>
</tr>
<tr>
<td>2.</td>
<td>How has your relationship changed during the process of surrogacy?</td>
</tr>
<tr>
<td>3.</td>
<td>How did you protect your relationship with each other during the treatment process?</td>
</tr>
<tr>
<td>4.</td>
<td>How did you negotiate the topic of surrogacy with your gestational surrogate?</td>
</tr>
<tr>
<td>5.</td>
<td>How were your relationships impacted with others?</td>
</tr>
<tr>
<td></td>
<td>a.  Your surrogate</td>
</tr>
<tr>
<td></td>
<td>b.  Medical and professional personnel</td>
</tr>
<tr>
<td></td>
<td>c.  Family and friends</td>
</tr>
<tr>
<td>6.</td>
<td>How have you been affected as a couple by the current eligibility criteria for fertility treatment in Victoria?</td>
</tr>
<tr>
<td>7.</td>
<td>What has impacted you the most with regard to the current legal parentage laws within Victoria?</td>
</tr>
<tr>
<td>8.</td>
<td>How have you as a couple been impacted by the current Victorian laws regarding reimbursement of your surrogate?</td>
</tr>
<tr>
<td>9.</td>
<td>As a couple what do you see as the best possible scenario regarding your relationship with your surrogate, and or her partner now?</td>
</tr>
<tr>
<td>10.</td>
<td>How did/do you feel with regard to telling your family, friends and wider social circle about your decision to enter into a gestational surrogacy arrangement?</td>
</tr>
<tr>
<td>11.</td>
<td>What, if anything, could have improved your experience as a couple during the process of surrogacy fertility treatment?</td>
</tr>
<tr>
<td>12.</td>
<td>What, if anything, would you do differently if you could have your surrogacy arrangement experience over again?</td>
</tr>
<tr>
<td>13.</td>
<td>Finally what advice would you give to couples following after you in a gestational surrogacy arrangement?</td>
</tr>
</tbody>
</table>
5.5.2 INTERVIEWS AND FOLLOW UP

Once a couple had contacted me, usually by telephone, we established a time and a place for conducting an interview. Twelve interviews were conducted in the participants’ homes, two were conducted at Swinburne University and four were conducted through telephone link up. These last four were as a result of many failed attempts to meet face-to-face, but due to the variables of distance, unwell children and participants’ work commitments it was felt that this was the best way forward and allowed for the inclusion of these four couples. In almost all cases the interviews suffered from very few interruptions.

Cook (2002) reported that he had attempted to use Kirkman’s (1997) ‘Tell Me the Story’ method allowing for participants to narrate their experiences. Cook states that, ‘It was clear after two pilot interviews that the men were uncomfortable with being asked to simply talk at some length about an area of personal concern that they were not used to discussing.’ (p.108). I reasoned that as at least half of my sample were men and as I wanted to gain as much information as possible for a thorough analysis I began each interview with the prepared semi-structured questions.

The interviews lasted from forty to ninety minutes with the average being approximately one hour. All participants were extremely forthcoming and became more relaxed and appeared more trustful as their interview progressed. It became apparent that the question that would receive the most detailed answer was, ‘What advice would you give to those coming after you?’ In all eighteen cases answers centred on the theme of, ‘know your stuff before you start.’ This seemed to be especially in relation to knowing the law in Victoria. This finding is discussed in more detail in the results and discussion chapters of this thesis.

All interviews were audio taped and assurances were given at the conclusion of each interview about internal and external confidentiality. I returned transcripts to participants as soon as possible after each interview with further assurances that I would only be able to report on psychological themes and that I would be especially interested in common themes that ran across several interviews. None of the participants requested any changes be made to the transcripts, although two participants sent email information about changes in their circumstances and their decisions to terminate treatment. Both of these participants asked to still be included in the study.
5.6 DATA ANALYSIS

In the following sub-section I have outlined the specific steps taken during the process of analysis.

5.6.1 SPECIFIC ANALYSIS

1. A transcript was read as a whole several times to ensure that I completely understood the material that had been recorded. On each reading I attempted to be as open minded as possible to new concepts and themes that emerged as I became more and more familiar with the material.

2. In the next step I began to highlight any part of the text that illustrated the participant’s emotional or psychological response to the phenomenon being studied, that is the psychological experience of the participant as a commissioning parent and as being part of a commissioning couple in a gestational surrogacy arrangement. I attempted to ‘Bracket’ the phenomenon being studied and only include emotional responses about the surrogacy experience as a whole.

3. I then took each textural part (words, sentences or whole phrases) and apportioned them with an equal value. This was particularly useful in helping me to maintain The Epoche, as at this stage I was able to continue to suspend any analytical judgement.

4. I then began a process of repeatedly looking at and describing the textural parts assigning them units of psychological meaning, for example, ‘...the travel was expensive, and you'd have to drop work at the drop of a hat and take whatever flights were left to Sydney...it was frustrating that we couldn't plan’, was given the meaning unit of ‘frustration with interstate travel’.

5. I then began a process of organising the units of psychological meaning into groups or themes, for example the above meaning unit was clustered with other similarly themed units into an overall interpretative label of ‘frustration and anger’. Eventually all highlighted text was assigned an overall interpretative label and a unit of psychological meaning (see Appendix P).

6. The next step was to apply imaginative variation (Moustakas, 1994) and consider that the apparent frustration experienced might be due to variables other than the inconvenience of interstate travel. Here I considered other options such as a participant’s dislike of air travel, or the participant’s resentment at the cost of such a venture. The important part of this process to me was the searching for exemplifications that vividly illustrated the development of the structural description of the phenomenon; I was able to do this by cross referencing the
common labels and units, and discovered that any aspect of dislike of the interstate component of IVF procedures in gestational surrogacy could be confidently described as, ‘frustration at having to comply with current law and travel interstate for IVF procedures.’ In other words I was able to confidently state here that all participants were frustrated at the legal requirement to travel interstate and that variables such as a dislike of air travel was not the main reason for this frustration.

7. As a final step in the specific data analysis an initial synthesis of transformed meaning units into a consistent statement was offered. This initial statement took on the form of a list of discoveries that were discussed prior to the results and discussion sections of this study being developed and formulated. In this instance the initial statement took on the form of the Executive Summary requested by the Victorian Law Reform Commission, later forwarded to the Department of Justice, referred to in Chapter One.

5.7 CONCLUSION

In this chapter I have attempted to provide the reader with a clear rationale and a defined description of the qualitative approach used in this study. I have explained the specific process of Interpretative Phenomenological Analysis and outlined the philosophical assumptions that form the basis of the approach. I feel that IPA was the best ‘fit’ for the current study as it allowed for optimum representation of the participant’s narratives and allowed me to apply a specific step-by-step process in analysing and interpreting each couple’s experience. In the end it is hoped that the reader of this thesis is able to develop an understanding of the psychological impact that gestational surrogacy has on commissioning couples. In the remaining chapters of this thesis I look more closely at what was said during the interviews with the participants, and offer interpretations and discussion about the findings in order to fully investigate commissioning couples’ experiences of gestational surrogacy in the State of Victoria.
RESULTS AND DISCUSSION 1

CHAPTER SIX   THE PSYCHOLOGICAL IMPACT OF MAKING THE DECISION TO ENTER INTO GESTATIONAL SURROGACY: THE FEELINGS BEFORE

6.1  INTRODUCTION

The following three chapters describe and discuss the interpretations of the data gathered from the participants during the interview process. In Chapter One of this report I stated that I intended to investigate three main issues for inquiry:

- The psychological experience of entering into gestational surrogacy;
- The negotiation of relationships with all involved in the surrogacy process, including investigating the immediate relationship between the individuals in a commissioning couple; and,
- The negotiation, by commissioning couples, of the guidelines and laws which currently govern infertility treatment and surrogacy arrangements in Victoria.

This chapter deals specifically with the psychological impact of making the decision to enter into a gestational surrogacy arrangement. In presenting my findings and discussions concerning the decision making process, I will explore two areas. Firstly I review the original questions that allowed me to access the decision making process of the commissioning couples, then I examine their responses and the interpretation and psychological meaning of these responses.

This chapter reviews the responses given by the participants concerning the decision making process prior to embarking upon gestational surrogacy. Initial interpretations are offered, followed by a more detailed discussion that explores how the initial findings can be interpreted further by comparing them to established research. Final conclusions are then offered which further explore whether there are recognisable themes emerging from the responses of all of the participants of the current study, and whether this can support the argument that these themes would be apparent in any similar study designed to investigate the psychological impact of having to make the decision to enter into a gestational surrogacy arrangement.
6.2 POsing THE QUESTIONS AND RECORDING THE RESPONSES

The thirteen semi-structured interview questions posed to the participants in the current study were based on Norbeck’s (1981) Social Support Questionnaire and outlined in the methodology section of this thesis. Four questions, from the original thirteen, were designed to investigate the experiences prior to entering into gestational surrogacy arrangements and were as follows:

“Question 1: How did you arrive at the decision to enter into a gestational surrogacy arrangement?

Question 4: How did you negotiate the topic of surrogacy with your gestational surrogate?

Question 6: How have you been affected as a couple by the current eligibility criteria for fertility treatment in Victoria?

Question 10: How did/do you feel with regard to telling your family, friends and wider social circle about your decision to enter into a gestational surrogacy arrangement?”

6.2.1 QUESTION 1: MAKING THE DECISION

In answer to Question 1, the responses of the couples tended to fall into three categories. The first category appeared to deal with the knowledge that natural conception would be impossible due to reproductive system congenital abnormalities, such as uterine malformation. This category also represents those couples in the study where natural conception was highly unlikely, but not impossible, again due to reproductive congenital conditions, such as a woman having a bicornate, or split, uterus. The second category dealt with histories of women with medical conditions that would be deleteriously affected by becoming pregnant, such as in the case of lupus or kidney disease. The final category represents those couples with often long, and distressing, histories of infertility and sub-fertility, only being diagnosed once a couple had tried to conceive naturally for some time.

Couples 5 and 6 are both examples of participants who knew that natural conception was impossible due to reproductive system congenital conditions;

“Really it [gestational surrogacy] was our only option of having a biological child of our own. I don’t have a uterus; I knew that when I was a teenager.” (Elise, Couple No.5, 2006; Transcript p.1).

“I was born without a uterus, so basically Filip has always known since we’ve been together…So I guess I always knew that that [gestational surrogacy] was a way that we could still have our own family.” (Feroze, Couple No.6, 2006; Transcript p.1).
Couple 7 outlined their experience of accepting gestational surrogacy as an option after attempting to conceive naturally despite the high odds against this occurring:

“...I had a different sort of uterus. It’s sort of biconical [bicorne], which is basically split through the middle, so each side is attached to one tube...and [the consultant] planted the seed on a number of occasions...firstly [after] one miscarriage and then one ectopic pregnancy...that surrogacy might be our best option, so eventually we took it seriously and started to look into it.” (Gia, Couple No.7, 2006; Transcript p.1).

Couples 1 and 14 are examples of couples where the woman in the couple would be at a severe health risk in attempting to carry a baby to full-term:

“I guess that the reason that we took this avenue [of gestational surrogacy]...is when I was a pre-teen I was diagnosed with lupus in my kidneys and the doctor said, ‘You’ll never have children. You’ll never be able to carry children on your own because of your kidneys...you’ll lose your kidneys.’ ” (Ann, Couple No.1, 2006; Transcript p.1).

“I fell pregnant thirteen years ago and everything went fine up until about twenty weeks...I was told at the time that I had the flu...about three weeks later I was rushed into hospital with severe pre-eclampsia and lost my little girl...she lived for three days and it was then found that I had kidney failure...and I got told, ‘Don’t even try having another child. Forget about it. You’re not going to be able to carry.’ ” (Nell, Couple No.14, 2006; Transcript p.1).

The final category, couples where infertility, or sub-fertility, is finally diagnosed is best represented by couples 10 and 15 in the study:

“Jack and I had been diagnosed infertile for about ten years. We’d had a few IVF unsuccessful attempts. I’d had an ectopic pregnancy and a ruptured tube and my sister...my husband used to say to me, ‘If we put your egg in a good oven, it'll fire.'...and my sister [suggested] ‘Would you like a surrogacy situation?’...and we thought, ‘Well yeah, I guess it's the only way if we're going to have a baby.’ ” (Jack & Jo, Couple No.10, 2006; Transcript p.1).

“We’ve done multiple IVF treatments here in Victoria and we had a second opinion on why. We knew why, but whether it would actually work with the IVF, and that particular doctor told us to stop wasting our money and to put all our money into surrogacy. At the time we didn’t want to do it because obviously it’s such a big thing to do, so we sat on it for about a year; two years...the surrogate had come to us two years prior and said, ‘If you ever want to do it, I’ll do it for you.’ ” (Oscar & Olivia, Couple No.15, 2006; Transcript p.1).

The above responses were in answer to Question 1. The discussion concerning these responses will be explored later in this chapter, where the responses to all four of the
questions about making the decision for gestational surrogacy are examined together; this allows for a thorough exploration and interpretation of the whole picture of the decision making process. In the next section I present the responses of the participants to Question 4.

6.2.2 QUESTION 4: FINDING A SURROGATE

In response to question 4 of the semi-structured interview questions, “How did you negotiate the topic of surrogacy with your gestational surrogate?” Participants’ responses appeared to flow naturally from their responses to Question 1.

The first category of responses was that of couples who eventually looked to commercial arrangements within the United States. Often these arrangements were considered as either an apparent last resort, or considered to be the only option once couples had investigated the laws governing surrogacy in the State of Victoria. A second response category was where couples had been approached by either relatives or friends who had already had discussions within their own families or social networks about acting as gestational surrogates.

Couples 1 and 18 are the best examples of couples who chose to enter into commercial gestational surrogacy arrangements in the US, after beginning the process of altruistic surrogacy within Australia and deciding to move to regulated commercial arrangements overseas. A consistent message from both of these couples was that they felt that there was no other option left open to them once they had attempted or explored gestational surrogacy within Victoria:

“Well, it took another five cycles; failed cycles where they [the IVF team] didn’t get anything, and in the end I gave up. In the meantime we decided to go with our four [frozen] embryos that we had from when we’d tried to find a surrogate in America, cos we knew the process [of gestational surrogacy] in Australia is just so difficult and you can’t advertise for a surrogate and there’s no protection here for couples.” (Adam & Ann, Couple No.1, 2006; Transcript p.3).

“We looked at it [gestational surrogacy within Victoria] and it’s just a minefield. I think surrogacy is emotionally probably the most challenging thing that I could ever do in my life. Then coupling that with trying to get through the Victorian legal system, it was just so prohibitive...for our level of comfort, there were too many risks as well and we weren’t prepared to take those risks, given that there was [a US commercial arrangement] alternative...we wanted to ensure that when our children were born, we were acknowledged on the birth certificate and that it wasn’t a question of us ever having to adopt them or even apply for parental rights.” (Rachel, Couple No. 18, 2006; Transcript p.2-3).
Couples 4, 8 and 11 are examples of couples who were approached by friends or relatives who had already thought through their offers of being gestational surrogates:

“I had to have a hysterectomy when I was sixteen, so we had no other way around it and we thought we would remain childless and then Doug’s sister offered to do it, but then she had a marriage breakdown. Our new surrogate actually asked me, ‘How’s your surrogate? How’s that all panning out?’...and I said, ‘Not good, we’ve got all the embryos in the freezer and she’s pulled out.’ Then she [the eventual surrogate] went home and discussed it with her husband and three elder kids all over the weekend...yeah rang us on the Monday and offered to do it.” (Delia, Couple No. 4, 2006; Transcript p.2-3).

“After my emergency caesarean and hysterectomy I said to Hals’s sister at the time, ‘I still would love to have more children.’ And she was fully aware of the situation and in passing she said to us, ‘Well you know, if you ever wanted to have anymore children that I’d help you out with that.’ And then a couple of times in the last six years she sort of said it again...and then when I rang her to ask if her offer was still open to have a baby for us...and it just lead on from there.” (Hannah, Couple No. 8, 2006; Transcript p.1-2).

“...because after I lost the second baby and we’d had the funeral and all the rest of it, mum said to me, ‘You can’t do that any more to yourself; I’ll do it.’ Then my sister laughed at her and said, ‘You can’t do it; I’ll do it.’ So then someone else said, ‘Well I’m not doing it.’ I’ve got three sisters too, so that’s how it came up, but we never asked my sister, she came to us on numerous occasions.” (Kara, Couple No. 11, 2006; Transcript p.2).

As was the case for Question 1, the responses to Question 4 are explored further in the results and discussion sections of this chapter. Below are outlined the responses given for Question 6.

6.2.3 QUESTION 6: ELIGIBILITY CRITERIA

I have included Question 6 in this section as it became apparent during the early phases of each of the interviews that couples had been deeply affected by the current eligibility laws in Victoria. As it currently stands only couples who have been assessed as clinically infertile, or who are at risk of passing on a congenital condition, are allowed access to infertility treatment. In the case of gestational surrogacy it is the gestational surrogate who is clinically assessed and not the commissioning couple. Therefore, in almost all cases, commissioning couples can not access treatment as their surrogate cannot be assessed as clinically infertile. This issue has been addressed by the Victorian Parliament and included in the law reforms coming into effect from July 2009.
Couples 6 and 7 best represent the impact of seeking treatment within the State of Victoria, and then being forced to seek treatment from interstate clinics:

“Yeah…we were lucky at the time that there were a couple in Melbourne who were doing surrogacy at an interstate clinic at the same time, so we went halves [on flying a nurse down to give the injections to prepare for ovum pick up]. We did it at the same time, but it was an expensive venture. That’s just one of the expensive ventures that we had to do. Every little bit of treatment we’ve had to fly interstate for. Nobody would touch us in Melbourne. They were all too frightened. They’d start saying, ‘Maybe we could…oh no.’ [A clinic] in Melbourne were going to help us and were waiting and waiting and waiting and were getting advice from lawyers…and then really actually I’m pleased because the doctor down there said to me, ‘Look I don’t want you waiting around for ever, go interstate.” (Filip & Feroze, Couple No. 6, 2006; Transcript p.9).

“You start looking at the financial side and think, ‘Wow, it would be so easy if we could just go down the road and do this…Why do we have to go to another state? Isn’t this just one country?’ All these frustrations…I guess I had a sense of frustration. Why can’t we just do it normally like you can do it in other parts of the country.” (Grant & Gia, Couple No. 7, 2006; Transcript p.7).

Feroze from Couple Number 6 also spoke about her feelings of guilt that she experienced in attempting to research the possibility of gestational surrogacy within the State of Victoria:

“It almost makes you feel like a criminal in your own State, and we’re sneaking around to have something that...where I should be able to just go up to the clinic which is five minutes away...up here where there’s been 800 babies born from IVF...” (Feroze, Couple No. 6, 2006; Transcript p.7).

Queenie from Couple Number 17 also echoes this:

“I was scared that we were going to be found out. It was very dicey sort of stuff because it was so illegal in Victoria. And people just shut doors in our faces. When I went to see and IVF specialist in Melbourne, he just couldn’t wait to get me out of the room, he was frightened.” (Queenie, Couple No. 17, 2006; Transcript p.10).

Below are the responses to the final question to be explored in this chapter. All of the above responses to Questions 1, 4, 6 and then 10 will be explored in more detail in the results and discussion sections of this chapter.

6.2.4 QUESTION 10: REVEALING YOUR DECISION

In the initial phase of each interview I tended to ask, “How did you feel about telling people?” as opposed to asking, “how do you feel?” This was because I wanted retrospective answers to help me to understand what was happening for the
individuals and the couples in the lead up to actually starting the treatment phase of gestational surrogacy. In response to Question 10, “How did you feel with regard to telling your family, friends and wider social circle about your decision to enter into a gestational surrogacy arrangement?” couples tended to respond that they were initially anxious and worried about the reactions of others, but that once they had embarked on telling people, reactions were on the whole positive which gave them the confidence to be open with a wider social circle. Interestingly in just about every case, once I posed Question 10, individuals and couples moved very quickly from telling me how they felt at the prospect of informing others to the actual experience of the positive reactions that they encountered. Couples 2 and 9 talked about their experiences:

“Everyone has been positive. I can honestly say that we have not had one negative”… (Bett)... “Yeah, even from my point of view, like I obviously had friends, male friends who were married with children, and male friends who were single, and every single one of them, because they know of Bett’s condition and that, have all been, ‘That’s fantastic!’ Now I’m sure they not just saying that to our face...I think they’ve genuinely all been happy that we’ve had a child. So, there’s probably some person out there who thinks it’s not right, and bad luck. But as far as we’re concerned, everyone that we’ve been involved with has been very positive.” (Bett & Bob, Couple No. 2, 2006; Transcript p.21).

“Our family and friends were just fantastic, calling every day with support and our surrogate’s parents were behind her 100 percent and really proud of her, as they should be”... (Ivy)... “The whole maternity staff were informed of the situation, knew our scenario, knew what was going on... (Isaac)... “They were just, they were absolutely, they bent over, I know they kept saying that they didn’t do anymore than they would for anyone else, but they just bent over backwards.” (Ivy & Isaac, Couple No. 9, 2006; Transcript p.10 and 12).

6.3 RESULTS AND ASSIGNING INTERPRETATIVE LABELS AND UNITS OF PSYCHOLOGICAL MEANING

Using the principles of Interpretative Phenomenological Analysis, Giorgi (1985) and Moustakas (1994), as outlined in Chapter Five of this report, I was able to identify several recurrent themes across the interview responses to Questions 1, 4, 6 and 10 that highlighted the experiences of the couples in their lead up to embarking on the process of gestational surrogacy.

One of the first things that I noted when reading through each of the responses in Sections 6.2.1 and 6.2.2 was the resignation of each couple to the fact that gestational surrogacy was most likely their last, or only hope of having their own biological child. I
referred to this as a ‘philosophical acceptance’. Of the 18 couples interviewed 27 individuals spoke about their belief and acceptance that gestational surrogacy was the only route for them to have a child.

A second psychological theme that became apparent was that of anxiety. Several couples, as was evidenced from the responses recorded here, spoke about their feelings of anxiety about the process of gestational surrogacy in Australia and about whether the treatment process would work for them. Overall 23 participants confessed that they had been, prior to the process, or were still, where they were about to embark on the process, anxious that it would not work; I assigned ‘anxiety’ as the interpretative label here, and broke it down into the unit of psychological meaning of ‘anxiety-that the process won’t work’. This interpretation is discussed in more detail in the next section.

Several individuals in the study also expressed an ‘initial anxiety-about the reactions of others’ (6 participants, all men) and ‘vulnerability-about what others might think’ and a ‘vulnerability-at having to divulge personal information to medical, legal and professional ethics personnel’ (12 participants, all men). This finding, although less significant than some of the other results, where more participants seemed to be affected, is consistent with the findings of Cook (2002) who found that most men in his study were initially reticent, and expressed feelings of vulnerability, in sharing their stories of their infertility. The response of Larry from Couple Number 12 provides the best example of this:

“...it’s something that’s pretty personal too...I’ve got two kids, but if I was, and I probably should speak for the majority of males here, if you don’t have kids and you were doing this straight off the bat, you’d feel inept. You’d feel as if people would think that there is something wrong with you and you’re not as manly or whatever...all the people that have got to be involved in it, it’s a pretty personal thing. I mean right down to the psych test. The psych test wasn’t too bad, but you know the doctors, the solicitors...” (Larry, Couple No. 12, 2006; Transcript p.9).

The next interpretative label that I assigned was that of ‘confusion’, breaking it down into the two units of psychological meaning of, ‘confusion-about the lack of information’ and ‘confusion-about conflicting information’. My rationale for including this theme in a chapter investigating the early experiences of commissioning couples is based on the number of comments that were made about how difficult it was to explore the option of gestational surrogacy within the State of Victoria. This was particularly evident from the responses listed above which highlighted the confusion, even amongst
professionals. Of all of the couples interviewed 21 participants stated that they had been confused about the process because of lack of information and similarly 21 participants stated that they had been confused because of conflicting information. Rachel from Couple 18 stated that:

“The risks really were that there didn’t seem to be any great cohesions in the laws and even within Victoria, even to different doctors, the advice that we got ranged from, ‘It’s entirely illegal, you’ll end up in jail’ through to, ‘You could possibly do it, but don’t ever tell me that you’re doing it, I’d lose my license.’” (Rachel, Couple No. 18, 2006; Transcript p.2).

Frustration and anger appeared to have been the natural progression following on from the identified theme of confusion. 31 participants out of 34 expressed feelings of frustration with an unknown system. Similarly 31 participants expressed frustration at the lack of information and 29 participants expressed frustration at the variance in information. The overall interpretative label that I assigned here was, ‘frustration and anger’, being broken down into ‘frustration and anger-with the system’, ‘frustration and anger-at the lack of information’ and ‘frustration and anger-at varying information’. The frustration experienced by the participants in the study appeared, in part, to also underpin feelings of ‘disempowerment and lack of control’, being divided into the units of psychological meaning of, ‘disempowerment and lack of control-at the apparent lack of information’ (19 participants) and, ‘disempowerment and lack of control-at being at the ‘mercy’ of professionals in the process’ (19 participants). The comments made by Couple 12 support the development of this latter interpretative label and the associated units of psychological meaning.

“...I mean a lot of people in the professions don’t actually understand, like we don’t, why the government actually intervenes...For me it’s very frustrating when I know I’ve actually got two embryos waiting and a person who’s willing to do it...and it’s so frustrating because our surrogate could walk in, the procedure could be over and done with in half an hour, and yet we have to do all this stuff and all this traveling”.... (Lara & Larry, Couple No. 12, 2006; Transcript, p.5-6).

As was shown by the responses of Couples Number 6 and 7 financial stress was a major concern in embarking on gestational surrogacy. Financial stress and stress with the system, and the process underpinning gestational surrogacy in Victoria were strong themes that could be identified in all of the interviews. 32 out of 34 participants expressed negative feelings about the mounting costs of gestational surrogacy, and 31 out of 34 participants discussed their feelings of stress at not being able to place a fiscal ceiling on the process. All 34 participants expressed feeling stressed about
inconsistencies in the system and in the process, and at the logistics during the process, including practicalities such as the need for interstate travel. I assigned an overall label of ‘financial stress’ being broken down into ‘financial stress-at the mounting costs’ and ‘financial stress-at not being able to predict future costs’ for the theme of feelings of stress about the money required to complete gestational surrogacy. I assigned an overall interpretative label of ‘stress’ and broke it down into the following units of psychological meaning for stress not associated with finance; ‘stress-at the system’, ‘stress-at the process’, and ‘stress-at the logistics during the process.’

Couple number 8 is the best example of the labels and units assigned above:

“…I think it’s disgraceful to be quite honest. We had no Medicare rebate, and then I’m clinically infertile, and yet I’m not able to access that. And I just think it’s terrible. It’s not something that we’ve chosen to do and it really needs to be addressed. I mean I’ve got private health insurance and even for my, I opted to be completely under general anesthetic to have my harvest, I wasn’t covered at all… I think I was given eleven dollars back out of three hundred and fifty…it’s just a reflection of the legislature. It’s really out of touch and I think Victoria’s got very old values and old standards…I don’t think that they’re up to speed and it’s not effective. Whatever they’re trying to have operating in State law doesn’t work, because we’re sitting here today having to go to another state.” (Hal & Hannah, Couple No. 8, 2006; Transcript, p.6-7).

The three positive themes that I identified from couples early experiences of making the decision to enter into gestational surrogacy were ‘determination and commitment-being completely focused on having a child’, ‘excitement-about any possible transfer success’, ‘excitement-about the birth of a child’. The excitement expressed could also be seen in the help being offered by others, as was evident in the comments in Section 6.2.4, where it was reported that others supported the couples during their initial decision making processes. This is explored more fully in Chapter Seven.

Overall all 34 participants expressed feelings of determination and commitment to having a child and 12 (six couples) of the participants still waiting for the outcome of their gestational surrogacy process expressed excitement at the prospect of finally having a child. Bett from Couple Number 2 best describes her feelings of determination,

“It was just the hardest journey just to get there and to finally feel, ‘OK, it’s worked, and then for it not to work, it was just, so I think part of me was like, ‘I’ve just got to have some hope that that two years wasn’t worth nothing’…and I tried again.” (Bett, Couple No.2, 2006; Transcript p.10).
19 participants discussed their feelings of excitement about possible successes and 12 participants talked about the feelings of excitement at the birth of their children in gestational surrogacy arrangements. Keith and Kara provide us with an example of the excitement felt at the beginning of the process where a surrogate comes forward,

“First my mum offered to be a surrogate and everyone laughed at her...then Kara’s sister came forward and we were just so thrilled.” (Keith & Kara, Couple No. 11, 2006; Transcript p.1).

The positive feelings indicated by the participants are discussed in more detail in the next section.

Table 4 outlines all of the interpretative labels and units of psychological meaning identified in response to questions designed to explore the initial experiences and psychological impact of having to make a decision to enter into gestational surrogacy. Number of participants affected is also given. Several of these psychological themes have not been previously reported on, as to date there have been no published systematic studies of the impact of gestational surrogacy on commissioning couples in Australia.
Table 4  Interpretative labels and units of psychological meaning assigned for the decision making process

<table>
<thead>
<tr>
<th>Interpretative Label</th>
<th>Unit of Psychological Meaning</th>
<th>Number of Participants Stating</th>
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| Anxiety                       | • That the process won’t work  
• About the reactions of others                                               | 23                             |
| Confusion                     | • About the lack of information  
• About conflicting information                                                            | 21                             |
| Determination & Commitment    | • Being completely focused on having a child                                                   | 34                             |
| Disempowerment & Lack of Control | • At the apparent lack of information before and during the process  
• At being ‘at the mercy’ of professionals in the process | 19                             |
| Excitement                    | • About any possible transfer success  
• About the birth of a child                                                                | 19                             |
| Financial Stress              | • At the mounting costs  
• At not being able to predict future costs                                                    | 32                             |
| Frustration & Anger           | • With the system  
• At the lack of information  
• At varying information  
• At being ‘at the mercy’ of professionals in the process | 31                             |
| Guilt                         | • Regarding the process seemingly being ‘pushed underground’                                   | 29                             |
| Philosophical Acceptance      | • Of the decision for surrogacy                                                                 | 27                             |
| Stress                        | • At the system  
• At the process  
• At the logistics during the process                                                           | 34                             |
| Vulnerability                 | • About what others might think  
• At having to divulge personal information to med/legal/ethics profs.                         | 6                              |

6.4  INTERPRETATION, COMPARISONS AND DISCUSSION

Several psychological themes were presented in the previous section. These psychological themes represented the feelings that the commissioning couples in this study had about their gestational surrogate experiences, and in particular about their experiences leading up to making their surrogate decisions. Many of the feelings reported by the couples could be perceived as negative, such as, anxiety, stress and confusion, but some were reported as being positive, such as, determination and
excitement. The intention in this section is analyse these psychological themes within the context of the established literature discussed which explores how individuals overcome grief in order to continue with, and improve, their lives. I am particularly interested in how the commissioning couples in this study dealt with their inevitable losses and whether the impact of their experiences allowed them to make sense of their negative feelings about both their own losses of fertility and about the negative aspects of their surrogacy arrangements.

In Chapter Two of this thesis several models and theories were presented which discussed the individual’s ability to attenuate to feelings of loss and grief whilst attending to daily life functioning. Stroebe and Schut’s (1999) cognitive stress theory was presented which argues that individuals develop either problem-focused coping or emotion-focused coping mechanisms in dealing with grief and stress. Three loss and grief models were also presented and two models of stress and coping were discussed. Gillies and Neimeyer (2006) argued in their model of meaning reconstruction pathways that decreased distress results from dealing with negative emotions and assigning new meaning to any pre-loss structures, these new meanings are then used in the emotional processing of new experiences. Rubin’s (1999) two track model of bereavement and Covington and Burn’s (2006) keening syndrome of infertility-specific grieving model both discussed the significance of the individual needing to make sense of their loss as a way of healing, and then being able to attend to old and new daily life tasks and experiences. Aldwin and Stokol’s (1988) deviation amplification model of coping, and Neimeyer’s (2001) dual process model of coping both argued that individuals learn to cope with loss by effectively attending to their feelings of grief and loss, whilst also attending to daily life functioning and life events. I suggested that the dual process model of stress and coping might be the most appropriate model for the current study. Commissioning couples need to be able to deal with the initial loss of their fertility, and with any losses associated with failed surrogacy attempts, as well as attending to daily functioning and the major life events of the gestational surrogacy arrangements themselves.

In analysing why couples would be anxious that the process of gestational surrogacy would not work for them, it is my belief that the couples in the current study were so well versed in the intricacies of the treatment phase of gestational surrogacy, that they were able to fully appreciate that it might fail. Many of the commissioning couples had already attempted several IVF procedures before, or as part of their surrogacy
arrangements, at the time that they were interviewed. An aspect of financial stress may also have been at work here, as couples were already aware of the mounting costs of infertility treatment. In the majority of cases the couples in this study had used, or were planning to use, their own gametes in the IVF process of their gestational surrogacy arrangements and they were acutely aware, that in several cases, it may have been the quality of gametes that contributed to failed attempts in treatment regimes.

In returning to Speroff et al.’s identification of infertility problems in couples, we see that there is approximately a 40 percent contribution to infertility by women, 40 percent by men, 10 percent is undiagnosed or idiopathic and 10 percent is considered to be a joint male and female contribution. No matter what the origins of the couple’s infertility problems (in the current study), there was still the chance that the process of IVF would not work based on the plethora of complicating factors that cause IVF cycles to fail. Interestingly of the 23 participants who stated that they had felt anxious about any possible success using IVF procedures with the commissioning mother and the gestational surrogate mother, 11 were individuals who had already had several experiences of failed IVF attempts.

Within the context of the loss and grief and stress and coping frameworks it would appear that although many of the couples discussed their feelings of anxiety, and of stress, in making their decisions, they did not allow these feelings to shape those decisions. Many of the couples appeared to have adopted a dual process approach in dealing with their feelings of anxiety. They attended to these feelings and discussed them openly, but they also were able to put any negative feelings aside when entering into the process of their surrogacy arrangements. Hal, from Couple Number 8, talks about the anxieties that he has about the process of gestational surrogacy, and about his being able to eventually come to terms with these issues and give his full attention to the process.

“We had some, probably the most difficult times that we encountered were all around the [process] issues, and I struggled to be honest, but after a while of looking at, and being exposed to surrogacy, it’s not that big a deal.” (Hal, Couple Number 8, 2006; Transcript, p.3).

Within the context of the models presented, I would like to propose that in dealing with the loss of fertility and the need to enter into surrogacy arrangements the commissioning couples in this study acknowledged their anxieties about their losses and about the surrogacy process, but that through repeated exposure to both they were
able to make sense of their experiences and perceive them to be less impactful than they had first feared. The couples were also able to use the new understandings of their experiences to help them in their daily functioning and in their gestational surrogacy arrangements. This finding supports the argument by Aldwin and Stokol (1988), in their deviation amplification model, that individuals, who learn to cope with anxiety, whilst attending to daily life, develop even stronger coping mechanisms for dealing with new experiences.

In analysing the responses of confusion, financial stress, stress, frustration and anger, and disempowerment, Couples 16, 3, 13, and 17 spoke about their experiences and the deleterious psychological impact of feeling as though they were unable to find consistent information and support when making the decision to enter into gestational surrogacy:

“We just wanted information that was actually based on the Act [Infertility Treatment Act, 1995], and people could actually read with their own eyes, what the legal requirements are. We found out really by default through our obstetrician...if you try to read the Act they are so confusing in every state...people don’t care what Section 24 and Paragraph 27 are. They want to know what the hard core fact is and the simple answer; can we do it? Yes or no?” (Pete, Couple No. 16, 2006; Transcript p. 15).

“...it was like close the door, keep it hush hush. When I spoke to the nurse about what the blastocyst method was [post fertilisation technique of growing embryos on to five days before transfer to enable the strongest to survive and the weakest to perish], when I went to her and said, ‘What's blastocyst in gestational surrogacy?’ It wasn’t an open conversation...you only pick things up afterwards. You see it happening, but you don’t question it, because you think that they [the medical team] are so open about everything...The nurse came from the back of the desk and said, ‘Who told you about that?’ in a secretive voice...I got very, very angry and I couldn’t think straight, so I forgot I’d already asked about the blastocyst method.” (Catt, Couple No. 3, 2006; Transcript p.27 and 30).

“...We got such a bad referral that we couldn’t use it. He [the referring doctor to the IVF clinic] was saying that I was grief stricken and that I was talking about our deceased daughter in the present sense...The fact is that I think that my grammar was completely correct [in the context]. So then it turns out that he had lost a sibling when he was seven, like our son had, so I think that he was getting a bit...and he’s a catholic, I think he was philosophically opposed.” (Mo, Couple No. 13, 2006: Transcript p.6).
“...Because you suddenly find that you’ve got to go interstate with the surrogacy and we made one trip to Sydney, that was a bit strange...it seemed to be a high powered doctor who was in it for the money rather than for helping the couple.” (Quan, Couple No. 17, 2006; Transcript p.1).

What was evident from the responses of the participants in this current study was that all of the couples had had to process the psychological experiences associated with their feelings of confusion, disempowerment, stress, financial stress, anger and frustration in order to continue with their gestational surrogacy arrangements. Many of the participants stated that they had agreed to take part in the current study in order to potentially improve the experiences of gestational surrogacy for others. As was previously mentioned Jo, from Couple Number 10 in particular wanted gestational surrogacy to be embraced by those who had experienced it and to celebrate its positive outcomes. The focus for this individual was not the grief associated with infertility and the stress associated with surrogacy, but the new meanings associated with the experience of having a child through the process. This is similar to Gillies and Neimeyer’s model where individuals have a positive psychological response to their grief and then use this to apply new meaning to old experiences.

Almost all of the participants commented on the nature of stress in gestational surrogacy and all of them discussed the impact of the financial stress. This kind of stress needs to be analysed here as the compounding impact needs to be considered. Couples continued on with the decision to enter into gestational surrogacy despite issues of potential financial loss and stress. It may be that the couple’s capacities to live functional lives whilst dealing with grief and stress, as per the models outlined, allowed them to be able to be completely focused on having a child through gestational surrogacy despite the emotional and financial difficulties. As was mentioned earlier in this chapter, all 34 of the participants interviewed stated in no uncertain terms that they were determined and committed to having children through gestational surrogacy. Filip from Couple Number 6 epitomised this determination:

“Yeah, we’re both very passionate about becoming parents and I think we realise that this is something that we really want and we will go to any lengths to make it happen I guess”. (Filip, Couple No. 6, 2006; Transcript p.1).

Aldwin and Stokol (1988) discuss the concepts of adaptive and maladaptive traits in stress and coping and Stroebe and Schut (1999) explore problem-focused and emotion-focused coping. It is my analysis that the couples in the current study had
become so practised at focusing on the adaptive traits needed to cope with the process of gestational surrogacy, such as the development of determination, that the potential maladaptive traits, such as ruminating about costs, were managed and dealt with in a problem-focused fashion leading to an emotion-focused result. In other words the commissioning couples in this study overcame procedural obstacles such as finance in order to attempt to have their children.

Both Covington and Burns (2006) and Cook (2002) discussed the concept of disenfranchised grief in infertility. Whilst exploring with the commissioning couples in the current study about their decisions to enter into gestational surrogacy arrangements, it did not become immediately apparent that any of these couples had experienced an emotional disenfranchisement from those around them. Although several of the couples did share that they had felt guilty because they felt as if they were involved in criminal acts that others did not have to involve themselves in, in order to conceive and have children. Feroze, from Couple Number 15, talks about having to ‘sneak around’ quietly trying to access information about a possible illegal process within her home State. Other couples spoke about their negative feelings concerning such areas as the need for interstate travel and the logistics of gestational surrogacy, but the majority of all of the responses from the couples concentrated on their feelings about the need to be resilient in the face of such obstacles. Olivia, from Couple Number 15, is an example of this:

“The impact is hard. It’s a difficult process. It is very difficult for me and it’s time consuming and heart breaking. It’s difficult...you’ll get very disappointed and you might have a couple of down days and then you’ll get back up again, because you know you have to be. But it takes it toll.” (Olivia, Couple No. 15, 2006, Transcript P.16).

As mentioned previously, Rubin (1999) discusses the concept of functional lives whilst dealing with the stress and grief of loss and Covington and Burns (2006) recognise the legitimacy of the disenfranchised grief characterised by such emotions as anger, disbelief, guilt, loss of control and anxiety in loss of fertility. In making the decision to enter into gestational surrogacy arrangements the majority of the couples in the study had to acknowledge that the circumstances leading to their decision were often painful and sometimes traumatic. It may be that the couples in this study were so prepared by their previous experiences in infertility, and in attempting to understand surrogacy within their home States, that they became even more resilient, and less vulnerable, each time they experienced the next difficulty that often characterises the process of
gestational surrogacy, and more resolved in their decisions to try to have children through this process.

Tedeschi et al. (1988) postulates the theory that grief itself makes those strong enough to cope with it, as individuals become, ‘sadder but wiser’. It may be that as Tedeschi et al. proposed, the couples in the current study became wiser by their experiences and that they assimilated and accommodated this new wisdom and used it as a resource to survive the process of grieving their lost fertility. They then developed the psychological strength to consider gestational surrogacy and made their decisions even after the difficulties of researching the process.

The philosophical acceptance that I identified in the majority of the participants (27 out of 34), that gestational surrogacy was their only option to have a child might also be compared to Tedeschi et al.’s (1988) philosophy. The couples in the current study, who had accepted their infertility, often recognising the sadness of such an acceptance, were determined to find other solutions to their involuntary childlessness. It may well be that because these couples were strong enough to survive their grief they were also strong enough to be determined and committed to the process of gestational surrogacy.

Positive feelings of excitement, especially for those couples still attempting surrogacy, were also highlighted in the responses of the participants concerning their experiences of telling others about their decisions. These positive responses by others are dealt with in the next chapter which explores the psychological impact of social support in more detail. However 12 participants discussed their excitement about the births of their children using gestational surrogacy, and 19 participants shared their feelings of excitement about any possible transfer successes. This was supported by several comments, the most poignant being that of Ann in Couple Number 1:

“...Then it was all excitement, then you’ve got to pull yourself back in...and from there is was sort of just taking each step as it goes because she’s got to reach milestones. And we couldn’t believe it and we got to twenty weeks, and we couldn’t believe it and we got to twenty eight weeks, and I thought, ‘Gosh, we’ve got a good chance now.’” (Ann, Couple No. 1, 2006; Transcript p.5).
Neimeyer (2002) argued in support of Stroebe and Schut’s (1999) dual process model, that,

“Persistent negative affect intensifies grief, yet working through grief, which includes rumination, is the essence of coming to terms with a bereavement. Positive reappraisals, on the other hand, sustain the coping effort, yet if positive psychological states are maintained relentlessly, grieving is neglected. Alternation between these psychological states emerges as essential.” (Neimeyer, 2002; p.67).

The above model is essentially stating that grief should not be ignored, but that positive reappraisal should also be embraced in dealing with loss and grief. My experience of the couples that I interviewed was that in almost all cases the participants had dealt with their grief and had developed the capacity to positively reappraise. My analysis is that it was this capacity that allowed the participants to feel some excitement at the prospects of the process working. This identified interpretative label can be linked to that of determination and commitment. Those who had succeeded were now parents and those waiting were still hopeful, excited and determined.

6.5 CHAPTER SUMMARY

In the decision making process analysed here, I have predominantly compared my findings with the models and theories presented in Chapter Two of this report, as these dealt specifically with the initial loss and grief associated with loss of fertility and the possibility of living with involuntary childlessness. In returning to Freud’s definition of injury in grief, presented earlier in this report, that it is, “the loss of a loved person, or something else that has taken the place of a loved person”, we can see that the loss of fertility for couples in the current study meets this definition. For many of the couples in the study, they were not just experiencing the loss of what a child might be to them, but for some couples they had also experienced the death of a premature infant or young child. In every case in this study the pain of the diagnosis of infertility had, ‘taken the place of a loved person’. It is my belief that the couples were only able to embark on a mission as potentially harrowing as gestational surrogacy because they had been made stronger by their experiences of surviving their losses.

This analysis appears to fit well with the models presented in this report. The original grief work hypothesis proposed by McCabe (2003), the meaning reconstruction model
offered by Gillies and Neimeyer (2006), the two track model suggested by Rubin (1999) and Covington and Burn’s Keening Syndrome Model (2006) all point to the *surviving griever* being able to continue to function whilst having the internal capacity to process loss. All of the couples in this study exhibited the same capacity; they all continued to function even to the point of continuing to look for solutions, despite their previous experiences of loss.

In relation to the deviation amplification model of stress and coping (Aldwin and Stokol, 1988) and the dual process model presented by Neimeyer (2002) and Stroebe and Schut (1999) all of the couples in the current study appeared to be able to move between grief and a commitment to daily functioning, whilst continuing on with working through to the possible solution; the prospect of gestational surrogacy.

As there is so little written about the psychological impact of gestational surrogacy on commissioning couples, it is difficult to say whether the findings in this chapter might be in contrast or similar to other studies exploring the same themes. Although the material presented in this chapter concerning loss and grief, and stress and coping, can be supported by the established literature reviewed, until more is written about the specific experiences of surrogacy we are, to a great extent, reliant on this research alone.

It became apparent during the interview phase of this study that the commissioning couples were focused and resilient in deciding that gestational surrogacy was their only option for having children. In the next chapter I explore whether this resilience was enhanced by the couples’ experiences of positive social support.
RESULTS AND DISCUSSION 2

CHAPTER SEVEN  RELATIONSHIPS AND GESTATIONAL SURROGACY: FEELINGS DURING THE PROCESS

7.1  INTRODUCTION

In chapter Six I stated that I intended to investigate the three issues of inquiry presented in the thesis outline of this report. The particular issue for inquiry pertinent to this current chapter is the investigation of the negotiation of relationships with all involved in the surrogacy process, including exploring the immediate relationship between the individuals in a commissioning couple. In exploring the intricacies of the relationships between the individuals in the couples, and in exploring their relationships with others around them, I was able to analyse the psychological impact of social support on the commissioning couples during the process of their gestational surrogacy experiences.

In this chapter I will be presenting my findings concerning the effects on relationships during the course of gestational surrogacy arrangements, and in particular during the treatment phase of the process. As mentioned previously the relationships examined in this study were, the primary relationship between the individuals in a commissioning couple; the relationship between that couple and their gestational surrogate; the relationship between the couple and the professional community; and lastly the relationship between the commissioning couple and their wider familial and social network.

As for Chapter Six, I review the original questions posed to the commissioning couples in this study and then offer an interpretation and discussion about their responses. I will continue to follow the pattern of presenting my findings, offering early interpretative labels in relation to these findings, and then comparing them to the established literature previously reviewed. As this results and discussion chapter looks specifically at the impact on relationships during the treatment phase of gestational surrogacy I will be drawing heavily on supporting evidence from Chapter Three, The Impact of Social Support during Gestational Surrogacy.
The following sections will present the questions posed by the investigator and the responses given by the participants concerning the effect on relationships and the impact of social support during gestational surrogacy, and in particular during the treatment phase of the process. After analysing the data a chapter summary is then offered that explores whether there are recognisable themes emerging from the responses of the participants.

7.2 POSING THE QUESTIONS AND RECORDING THE RESPONSES

As for Chapter Six, semi-structured interview questions, based on Norbeck’s (1981) Social Support Questionnaire, were designed and asked of the commissioning couples who participated in the study. Five questions were designed to investigate the effect on relationships and the impact of social support; they were as follows:

*Question 2: How has your relationship changed during the process of surrogacy?

Question 3: How did you protect your relationship with each other during the treatment process?

Question 5: How were your relationships impacted with others?
   a. Your surrogate
   b. Medical and professional personnel
   c. Family and friends

Question 8: *How have you as a couple been impacted by the current Victorian laws regarding reimbursement of your surrogate?

Question 9: As a couple what do you see as the best possible scenario regarding your relationship with your surrogate, and her partner now?*

*Relevant to all participants at the time of interview as the laws governing gestational surrogacy in the State of Victoria at that time virtually prohibited the process.

7.2.1 QUESTIONS 2 AND 3: THE IMMEDIATE RELATIONSHIP BETWEEN THE COMMISSIONING COUPLE

In answer to Questions 2 and 3, the couple’s responses typically answered both of these questions concurrently and their responses fell into three separate categories. The first category was centered on the couple’s joint determination to see gestational surrogacy through to a successful outcome. The second category seemed to centre on how the experience of entering into gestational surrogacy had placed the couple’s intimate relationship under stress, but that the necessity to ‘pull together’, whilst working through the complexities of the experience, had strengthened the relationship in the longer term. The final category here represents those couples who
responded that the experience only served to strengthen what was already a solid relationship, often made stronger by traumatic life events which had lead to the need for gestational surrogacy in the first place.

Couples 6, 7 and 9 gave the best example responses of determination being the key to changing and protecting the relationship between the individuals in a commissioning couple:

“...When we were doing an adoption workshop Filip was saying something like, ‘Well I’m a determined person. I just fight till I get, I’ll just keep going, and I’ve just adopted that as well. I think we both just work together. We laugh together; you have to or you’d go insane...we’d laugh about the situation we’d been through with visiting doctors and stuff like that. I understand that in some relationships it [gestational surrogacy] can really cause problems or it can really bring you together and I’m sure it’s brought us together—definitely.” (Feroze, Couple No.6, 2006; Transcript p.3).

“Umm...we are both on a mission, and we're both in it together and our relationship through this whole process has grown from strength to strength; surprisingly, and I know that these sort of things make or break; for us it’s certainly been a positive in that respect at least.” (Grant, Couple No.7, 2006; Transcript p.1).

“There was always times where one of us was feeling low when the other one was feeling confident. Yeah, it was basically sticking to our plan and our goal. We knew what the end result was that we wanted to achieve at the end of it all. And regardless of what we were going through, the end result was always going to be better than what we were going through now. And in the end it was just really supporting each other...” (Isaac, Couple No.9, 2006; Transcript p.1).

The responses to the above questions, and to all of those presented in this section, are further examined in the results and discussion sections of this chapter. Similarly to Chapter Six this allows for an exploration of the topic as a whole, in this case of the impact of social support during treatment.

The responses given below support the category which proposes the idea that some couples experienced the necessity to pull together during the process of gestational surrogacy and that this served to strengthen their relationships.
Couples 5 and 11 offer the best response examples of how the experience of entering into gestational surrogacy placed the intimate relationship between individuals in the couples under stress, but that the processing and management of this stress contributed to relationships becoming stronger:

“It’s [the experience of gestational surrogacy] probably made us appreciate each other. Probably made us a bit closer just for what we’ve had to go through, because as you know it’s not an actual normal pregnancy or anything. All the stress of is it going to work and isn’t it going to work? It’s probably brought us a lot closer I think. We’ve had to nut it out together and we didn’t know anyone who’d ever done it. It was sort of hard to go through from start to finish by ourselves, pretty much. We made that a big project and then a joint project wasn’t it? We were together making calls and writing letters.” (Edward & Elise, Couple No.5, 2006; Transcript p.1-2).

“I would have expected and thought, and I’m sure a lot of people would have thought, after everything that we’d been through, that they can’t keep going through these sort of negative things; it won’t last. Something’s got to give. But it was really different. We, I suppose in a way we were pleasantly surprised how much it sort of bonded us a little closer than we ever could have.” (Keith, Couple No.11, 2006; p.3).

The responses of Couples 3, 8 and 13 best represent the final category of there being no significant changes in the relationships between individuals in the commissioning couples as solid relationships had already been formed in response to previous difficulties or trauma. These responses are also examined more closely in the following sections of this report.

“Colin watched me suffer with my health a lot and having seen all that and him wanting a child and me wanting a child, but it wasn't the priority of the relationship. Having him come close to losing me once, I think a child would have been a bonus, if the child had come a long, the thought of having a child would have just been a bonus if it had worked out. But it wasn’t, what’s that saying, ‘end all, be all’. As long as we had each other.” (Catt, Couple No.3, 2006; p.4).

“I think we had a solid foundation to start with and I think when we first met we always had the idea that three children in the family was something that we'd like to have and that was our concept of a family...Hannah had her hysterectomy nearly five years ago...and her feelings never waned. In five years you can just see the intensity of that feeling...convinced me effectively that that's something that Hannah can't move on from until we go through this...so at the back of all of this is the understanding that we had always at the start when we first met and the rest was just me catching up emotionally.” (Hal, Couple No.8, 2006; p.2).
Interviewer: How, or, has your relationship at all changed between the two of you during that process of going through surrogacy?

“Not at all. I think you wonder sometimes how strong your marriage is and we’ve been married twenty years and I think we’ll have another twenty years, but when our child died, it’s the sort of thing that can tear people apart and it didn’t. It really drew us together. And there was no blame, we were just so united...It (gestational surrogacy) brought quite a bit of humour...in a very sad time it was actually quite humourous.” (Mel, Couple No.13, 2006; p.3).

7.2.2 QUESTION 5: THE RELATIONSHIPS WITH OTHERS

In posing Question 5 I was attempting to identify the impact on the relationship between a commissioning couple and others involved in the gestational surrogacy arrangement. It was also this question that initially allowed me access to the impact on the couples of social support during the treatment phase of the process.

In response to Question 5a, the majority of the couples responded that they have had positive relationships with their surrogate birth mothers that continued to be, or became even more positive as the process of gestational surrogacy arrangements unfolded. Any notable exceptions seemed to be where couple’s arrangements had halted because of either the commissioning couple’s or the surrogate’s circumstances.

Couples 1 and 4 offer good examples of responses to the question of how relationships were positively impacted with the surrogate birth mothers. Couple Number 14 talked more specifically about the potential for the relationship to be negatively affected:

“We have a fantastic relationship...we took them [several frozen embryos] over [to the surrogate] and we went and spent two weeks. We lived with them. I thought that might be a bit intense, but we just had a great time...that’s been the most relaxing holiday I’ve had, because the [surrogate’s] kids loved our child, and you know full-time entertainment. Our surrogate’s just the most relaxed person and so yeah, we’ve just got a great relationship.” (Ann & Adam, Couple No.1, 2006; Transcript p.9).

“It’s absolutely fantastic. Our surrogate’s not maternal at all towards them [the commissioning couple’s children] and if she sees them in the supermarket cos they live near us, it’s, ‘Hi kids, how you doing?’ And the kids know that they grew in her belly, but absolutely the way that you would want a true surrogacy to go, I feel...Birthday parties and things like that we go to their kids, they come to ours and things...Brilliant, we get on really well...we get on great, get on really good with them...just mates, you run in to them in the street and say, ‘G’day’ to them...It’s absolutely perfect...And the surrogate went into it with the idea in her head that all she was doing was helping out a couple who couldn’t have Kids.” (Delia, Couple No.4, 2006; Transcript p.3-4).
“You wouldn’t believe the stress and pressure. It was amazing. I don’t have any ill feeling towards our surrogate’s partner because of what happened, because of the counselling he was going to with our surrogate. It brought out immeasurable issues for him and his childhood and things and all of it became too much...It just became way, way too much for me. If it had all kept on going smoothly, if you can use that term, then it would all probably have worked out ok...but things just happened that were adversely impacting my surrogate...it just wasn’t worth anymore heartbreak, any more pressure, and I just decided it’s just too difficult and it was going to cause more trouble between our surrogate and her partner, and between us, then forget it. I’d rather just not do it.” (Neil & Nell, Couple No.14, 2006; Transcript p.4-6).

In response to Question 5b, ‘How were your relationships impacted with medical and professional personnel?’ couple’s responses fell into two very distinct categories; those who stated that they felt that they were treated with respect by the professionals involved in the gestational surrogacy process and those who felt they were not.

Couples 9 and 1 gave the following respective responses:

“They [the obstetric and midwifery team at the Hospital] were like; I can’t recommend them highly enough. We had the best experience...but the staff were fantastic. They never once made us feel that we weren’t the parents...it was just really special. They were just really excited, but it was a really special case and...They were just, they were absolutely, they bent over, I know they say that they didn’t do any more than they would do for anyone else, but they just bent over backwards.” (Isaac & Ivy, Couple No.9, 2006; Transcript p.11-12).

“Oh well the law’s an ass in this country because every state is different. You go to Queensland, it’s got different regulations. You go to Sydney or New South Wales as opposed to the Australian Capital Territory, as opposed to Victoria...and to be honest, the Ethics Committee when we were looking at it and we wanted to get some things changed and they just said, ‘We’ve got lawyers on here. We’ve got Catholic priests on the committee...They’ve got one woman on the Ethics Committee...It was like an old school committee, and to be honest we knew that we were just pushing shit up hill. We weren’t going to get anything done.” (Adam & Ann, Couple No.1, 2006; Transcript p.11).

Question 5c, ‘How were your relationships impacted with family and friends?’ provided me with the most data about the impact of social support during gestational surrogacy, and in particular during the treatment phase of the process. All couples, whether they had completed a full cycle of gestational surrogacy treatment or not, and whether a live birth had resulted from treatment or not, responded that they had been impacted by a positive response from their wider social circle.
Couples 2, 8 and 18 are the best examples of this unanimous response:

“Even from my point of view, like I obviously had male friends, male friends who were married with kids and male friends who were single; and every single one of them, because they’d known about Bett’s condition and that, have all been, ‘That’s just fantastic!’ Now I’m sure they’re not just saying that to our face...I think they’ve genuinely all been happy that we’ve had a child. There’s probably some person out there who thinks it’s not right, and bad luck...As far as we’re concerned everyone that we’ve been involved with have been very positive.” (Bob & Bett, Couple No.2, 2006; Transcript p.21).

“Fantastic, we haven’t had any issues at all, we’ve had nothing but encouragement, but then a lot of my friends knew about what had happened to me initially and I think had seen me go through the journey of the last five years of putting on a brave face, but at the same time always wanting children.” (Hannah, Couple No.8, 2006; Transcript p.4).

“The babies were only ten days old and I went into the store and he [the shopkeeper] made a comment. He said, ‘You know I didn’t realise you were pregnant.’ Then he said, ‘But in hindsight you probably have got a bit fat haven’t you?...That kind of thing is very funny when it happens...Yes, and my little god daughter was eight at the time, and she was at a family dinner, and obviously her extended family didn’t know anything about it, and she announced...that her godparents were having twins, and one of the old ladies said, ‘I didn’t realise that she was pregnant’, and she [the god daughter] said, ‘Oh, no, no, no, she’s having the baby with another lady’. The dinner party came to a screaming halt...[There was no problem].” (Rachel, Couple No.18, 2006; Transcript p.7-8).

A lesser theme that emerged in response to Question 5c was the theme of isolation. Several individuals made the comment that they did not know anyone else going through the process of gestational surrogacy at the time that they were. Two men also commented on feeling isolated from the process as their female partners seemed to them to be more involved and more considered by the professionals involved. Couples 10 and 15 are examples of this:

Interviewer: What could have improved your experiences as a couple going forward for gestational surrogacy?

“I guess if there’s more structure in place for it. It felt like we were the only people who had ever done it. You amaze me to say that there are seventeen other couples that you’re going to be interviewing.” (Jo, Couple No. 10, 2006; Transcript p.8).
“...The male pretty much gets excluded and that’s difficult...They're [the doctors] really not that forthcoming at all to be honest. Even if you go and speak to the specialist, they don't say much to you. They're pretty bad to the guys really...I don't go to every consult that she goes to because she works in the city and I generally work out this way, so it would be improper really for me to go in there to be honest.” (Oscar & Olivia, Couple No. 15, 2006; Transcript p.16-17).

As for Questions 2 and 3, all of the responses to Question 5 are explored in more detail later in this chapter.

7.2.3 QUESTIONS 8 AND 9: THE RELATIONSHIP WITH THE SURROGATE

In presenting the responses of the participants regarding their relationships with their surrogates, the responses can be categorized into two parts; reimbursement, and future relationship. Question 8 dealt specifically with the issues surrounding the current Victorian laws and reimbursement, and Question 9 asked the commissioning couples to think about how they would like their relationship to look with their surrogate from this point on. None of the couples directly answered the question about reimbursement, but instead gave answers that illustrated how they had ‘helped’ their surrogates to, ‘not go under’ financially whilst taking ‘time off’ to give birth and then recover physically.

The responses from Couples 5, 6 and 10 are the best representations of this response.

“Yeah, pretty much because it was family [we didn't have a legal contract]. It was just like an offer that we took up...We made sure that our surrogate and her husband wouldn't go under, sort of thing; everyone was aware and all that. She had a caesar and she said that she’d never recovered so quick...she didn't have to do any nappy changing and her husband took holidays from work and his mum cooked for her, and we all just made sure she got well. It’s all about support isn’t it?” (Edward & Elise, Couple No.5, 2006; Transcript p.9).

“...We’ll be the emotional support. When you’re saying financial, we’re not actually giving her the money, but what is it if we pay for a cleaner to come in, or paying for her to go down and have a massage...Our surrogate is pretty unique in that respect. She won’t accept payment...We have said from the word go that we want to cover all of her payments, all her cost...I can guarantee that if you looked at the truth of what are our surrogate's costs, she’s had to put in financially, but has not told us.” (Filip & Feroze, Couple No.6, 2006; Transcript p.13).
“We’d paid for all her medical expenses and for her tests that she’d had done interstate, but we fully understood she was giving us this baby. There was no money changing hands. We were happy to compensate her because she was working a little bit part time...She said, ‘No, no, no, I’m looking after my children and having your baby.’ So I think, I do understand that it is altruistic 100 percent, but it’s a big dent in somebody else’s life.” (Jo, Couple No.10, 2006; Transcript p.7).

In answering the question posed about the type of relationship that the commissioning couples hoped to have with their surrogates now and in the future, all the couples who were attempting to, or who had had children through the process, indicated a desire to remain in contact. Couples 8 and 10 give the best response examples of how they would like their relationships with their surrogates to be. I have also chosen the response from Jo, from Couple Number 10, as she appeared to have an even bigger vision of what the relationships between all commissioning couples and their surrogates might look like if the process were legalized and regulated in Victoria, rather then just confining her answer to herself and her own situation.

“...She will always be this biological surrogate, this child’s genetic aunty, and as they want to put it in Victoria, ‘the birth mother’. However, genetically, this child is ours and this child will be raised as ours and our surrogate has already told her daughter that she wants to carry a child for us. So, from day one this child will be known as our child, not the surrogate’s. I don’t see our relationship changing, in fact it could just enhance it...I mean, what a special aunty.” (Hannah, Couple No.8, 2006; Transcript p.9).

“...I’d like to have a picnic in the park, once a year, or something...They’re [the surrogates and their partners] entitled as much to support and everything as well, they’ve done a magnanimous gesture. There’s nothing for them, they have the baby and then they’re out of the picture. I just think ongoing commendation, not commendation, that’s the wrong expression, but just, there’s other families out there...It’s both thanks and celebration. It’s, ‘Hey! Look at all these wonderful little kids. If it wasn’t for you gestational chappies, these little ones wouldn’t be here.’ And so there is, there should be that connection or something. I’m not saying that you have to get together every week, nothing like that...but just some sort of sense of network and support.” (Jo, Couple No.10, 2006; Transcript p.9-10).

In the following sections I explore all of the responses presented in this chapter and offer interpretations and explanations in the context of the impact of social support on commissioning couples in gestational surrogacy arrangements.
7.3 RESULTS AND ASSIGNING INTERPRETATIVE LABELS AND UNITS OF PSYCHOLOGICAL MEANING

As for Chapter Six I again used the principles of Interpretative Phenomenological Analysis as outlined in the methodology section of this report. I was able to continue to identify several recurrent themes across the interview responses to Questions 2, 3, 5, 8 and 9 that illustrated the experiences of the couples in the study and how their relationships with others were impacted, and how they themselves were impacted by their own networks of social support during the process of gestational surrogacy.

As mentioned in the previous chapter, all 34 of the participants, talked about their determination to have a child through gestational surrogacy arrangements. In response to Questions 2 and 3, “How has your relationship changed during the process of surrogacy?” and, “How did you protect your relationship with each other during the treatment process?” the first theme I was able to identify was again the one of the couple’s joint determination to see gestational surrogacy through to a successful outcome. Section 7.2.1 of this report outlined the couple’s responses and Isaac’s response in particular, from Couple Number 9, epitomised the feelings of determination expressed by the commissioning couples in this study, “Yeah, it was basically sticking to our plan and our goal.” The interpretative label that I offered here was the one previously identified in Chapter Six when identifying couple’s early experiences of making the decisions to enter into gestational surrogacy arrangements, that of ‘determination and commitment’, with its adjacent unit of psychological meaning, ‘being completely focused on having a child’.

In further response to Questions 2 and 3 some couples answered that their relationships with their partners became stronger as a result of having to work through the process of gestational surrogacy and some answered that their already solid relationships were even further strengthened. I have given this theme the interpretative label of, ‘strong relationship with partner’ with its unit of psychological meaning being, ‘between the individuals in each couple.’ In all, 32 out of 34 individuals interviewed identified their strong relationships with their partners as being a protective factor in their ability to deal with the complexities of gestational surrogacy.

Another theme identified here, as couples responded to Questions 2 and 3, was the theme of ‘exhaustion’. In commenting on how they had ‘made it through’ the experience many individuals, 13 in all, described how arduous and tiring the process of gestational surrogacy can sometimes be. Neil and Nell, Couple Number 14,
highlighted this when talking about their feelings of being under unrelenting pressure, “You wouldn’t believe the stress and pressure.” The interpretative label I assigned here was ‘exhaustion’ with two units of psychological meaning also being applied, ‘exhaustion-emotional exhaustion’, and ‘exhaustion-physical exhaustion’. A further negative emotion identified by a small number of the participants, in Section 7.2.2, was that of isolation. This has been labelled as, ‘isolation-as a couple’, and ‘isolation-as a male in the process.’

In response to the Question 5a, b, and c; “How were your relationships impacted with others; your surrogate; medical and professional personnel and family and friends?” I was able to identify four interpretative labels, gratitude, guilt, positive experience of support, and disempowerment.

22 of the 34 participants interviewed described their feelings of gratitude for what their surrogate had done for them. I have given this theme an interpretative label of ‘gratitude’ with an associated unit of psychological meaning of ‘toward the surrogate’. Of the 20 individuals who now have children, 5 described feelings of guilt about what their surrogate went through in order to help them to achieve parenthood. I have labelled this theme, ‘guilt’ and broken it down into a unit of psychological meaning of, ‘about what the surrogate goes through’. Overall 33 out of the 34 individuals interviewed stated that they had had positive experiences in their relationships with their surrogates and that they had received positive support from them. In Section 7.2.2 of this report, Delia talks about her positive feelings about her surrogate, “Brilliant, we get on really well...we get on great, get on really good with them...just mates, you run in to them in the street and say, G’day’ to them...It’s absolutely perfect.” This psychological theme has been labelled and united as ‘positive experience and support-from the surrogate’.

In relation to relationships with the professional community, doctors, nurses, psychologists, lawyers, and ethicists, 19 participants stated that they felt a ‘disempowerment and lack of control-at the apparent lack of information before and during the process’. Likewise 19 participants further stated that they felt a ‘disempowerment and lack of control-at being ‘at the mercy’ of professionals in the process.’ However it must be remembered that the interviews conducted for the current study asked participants to reflect on the whole time line of their gestational surrogacy experiences, keeping this in mind, 31 participants stated that they had had positive experiences and support from the medical professionals, and 29 participants commented that they had had positive support from legal professionals during the
whole process. I have labelled and united these as, ‘positive experience and support-from medical profession’ and ‘positive experience and support-from legal profession’ respectively.

In response to Question 5c, concerning the impact of positive social support from family and friends in the wider community, 31 out of 34 participants commented on the affect and impact of support from this group. This theme was given the interpretative label of, ‘positive experience and support’ and the unit of psychological meaning of, ‘from family and friends and the wider community’.

In response to Questions 8 and 9 concerning participants being able to reimburse their surrogates and concerning their hopes for commissioning couple-surrogate relations, the two main themes identified, labelled and united, were again ‘guilt-about what the surrogate goes through’ and ‘positive experience and support-from the surrogate’. Under the latter interpretative label, 19 participants described their desire for their relationships with their surrogates to continue on in the same positive vane. Although it was not mentioned that the reimbursement issue caused specific financial stress to commissioning couples, during the interviews conducted, 32 individuals commented on the stress of the mounting costs of gestational surrogacy, and 31 people described feelings of stress at there being no finite monetary figure. The theme of financial stress is worth mentioning here, as although I am more concerned with relationship impact in this chapter, it is important to note that both individuals and couples in the study commented on the enormous financial stress associated with the gestational surrogacy process.

As for Chapter Six, I have provided a table which clearly identifies the interpretative labels and units of psychological meanings for the current chapter. Table 5 gives the labels and units assigned for impact on relationships and impact on Social Support.
Table 5  Interpretative labels and units of psychological meaning assigned for impact on relationships 
And impact of social support

<table>
<thead>
<tr>
<th>Interpretative Label</th>
<th>Unit of Psychological Meaning</th>
<th>Number of Participants Stating Affect</th>
<th>Previously Identified in Chapter Six</th>
</tr>
</thead>
<tbody>
<tr>
<td>Determination &amp; Commitment</td>
<td>• Being completely focused on having a child</td>
<td>34</td>
<td>Yes in relation to positive personal attributes needed to embark on the decision making process</td>
</tr>
<tr>
<td>Disempowerment &amp; Lack of Control</td>
<td>• At the apparent lack of information before and during the process</td>
<td>19</td>
<td>Yes in relation to difficulties encountered in embarking on the decision making process</td>
</tr>
<tr>
<td></td>
<td>• At being ‘at the mercy’ of professionals in the process</td>
<td>19</td>
<td></td>
</tr>
<tr>
<td>Exhaustion</td>
<td>• Emotional exhaustion</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Physical exhaustion</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>Financial Stress</td>
<td>• At the mounting costs</td>
<td>32</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• At not being able to predict future costs</td>
<td>31</td>
<td></td>
</tr>
<tr>
<td>Gratitude</td>
<td>• Toward the surrogate</td>
<td>22</td>
<td></td>
</tr>
<tr>
<td>Guilt</td>
<td>• about what the surrogate goes through</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Isolation</td>
<td>• As a couple in the process</td>
<td>4</td>
<td>Yes in relation to difficulties encountered in embarking on the decision making process</td>
</tr>
<tr>
<td></td>
<td>• As a male in the process</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Positive Experience &amp; Support</td>
<td>• From the surrogate</td>
<td>33</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• From medical profession</td>
<td>31</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• From legal profession</td>
<td>29</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• From family and friends and wider comm.</td>
<td>31</td>
<td></td>
</tr>
<tr>
<td>Strong Relationship with Partner</td>
<td>• Between the individuals in each couple</td>
<td>32</td>
<td>Yes in relation to positive personal attributes needed to embark on the decision making process</td>
</tr>
</tbody>
</table>

7.4 INTERPRETATION, COMPARISONS AND DISCUSSION
A number of psychological themes have been presented in this chapter. These themes, like the themes in Chapter Six of this report, represent the feelings that the commissioning couples in this study discussed in relation to their experiences of
gestational surrogacy, and in particularly here, their experiences of how their relationships were affected during the treatment process. I am particularly interested, in the current chapter, to explore the notion that there occurs in gestational surrogacy an impact on relationships between the individuals in a commissioning couple and between that couple and all others involved in the process. I am also interested to explore whether the impact of these relationships by others is perceived as positive social support, and whether this is an important factor in a couple’s ability to cope with the oftentimes complex nature of gestational surrogacy, and in particular the treatment phase of the process. The purpose of this section then, is to compare the findings from the current chapter with the established literature previously presented which discussed the importance and the impact of social support during major life events.

In Chapter Three of this thesis I gave several definitions of social support and I outlined several models and theories which discussed its relevance and importance in life crises and major life events. Cobb (1976) and Hurdle (2001) both described social support as being the information that an individual perceives that he or she is loved, esteemed and cared for, and that that these feelings, of being positively regarded by others, have the potential to influence the individual’s behaviour and actions. Elizur and Mintzer (2003) suggested a conceptual path model and argued that the perception by the individual of being able to elicit unconditional positive regard and support from others is inextricably linked to the development of self-acceptance and self-esteem.

Three models of social support were also presented; Coping Facilitation Theory (Pearson, 1986); the Path Model of Emotions and Adaptation (Swanson, 2000) and the Social-Contextual Model of Coping (Berg et al., 1998). Coping facilitation theory argues that social support facilitates coping through promoting emotionally sustaining and problem solving behaviours which have the potential to act as agents for change. The path model is based on the principles of cognitive stress theory and asserts that individuals, within the context of being part of a larger network, go through a continuous process of meaning assessment, or meaning appraisal, in responding to the impact of their circumstances. The social-contextual model explores how individuals anticipate everyday life problems and cope with them in relation to other people around them.
Cobb (1976) and Nosek et al. (2004) both discussed the significance of social support during life crises; such as illness recovery or as in long term support in disability. Lechner et al. (2007), Verhaak et al. (2005) and Fouad and Fahje (1989) were also presented in Chapter Three of this report as these researchers have all conducted studies into the effect of social support on women, and or couples, during IVF treatment cycles.

I suggested that social support, particularly within the context of gestational surrogacy, can be a double edged sword as it can be experienced as a positive element, but that to be able to access it, and enter into a supportive and sometimes reciprocal network, individuals need to possess the personal capabilities and characteristics that enable them to avail themselves of all that a social network can offer. My purpose here is to explore the responses of the commissioning couples about their experiences of social support and compare them against the models and theories discussed.

In returning to the original three issues for inquiry presented by the Victorian Law Reform Commission in 2003, it could be said that commissioning couples in gestational surrogacy were disempowered by the existing Victorian laws concerning access to infertility treatment. In almost all cases the couples interviewed for this study had accepted a clinically fertile surrogate in order to achieve a pregnancy. There were very few cases of couples being approached by potential surrogates where the surrogate herself would be unable to conceive without IVF involvement. As was made evident in Section 7.2 of this report, 19 participants felt that they had been disempowered by the current system. Cobb (1976) and Nosek et al. (2004) both discuss the importance of support during health crises, and Lechner (2007), Verhaak et al. (2005), and Fouad and Fahje (1989) all discuss its importance specifically during the process of the treatment phase of IVF. I would like to suggest that the lack of support within the system for commissioning couples in obtaining access to treatment for their surrogates has had a potentially deleterious psychological impact on them. I would further like to suggest that the positive support offered by those in their social networks helped the commissioning couples to continue to be resilient in the face of any procedural obstacles.

This latter notion is supported by Elizur and Mintzer’s (2003) conceptual path model, which argues that potentially disenfranchised individuals are able to maintain positive levels of self-esteem because of their experiences of positive social support.
The model suggests that there is a strong link between self esteem and the ability to access positive social support. For the couples in the current study it would appear that the validation of their experiences by others led to them feeling more confident and self assured about their decisions. My suggestion here is that it was this self assurance, or positive self esteem, that enabled the commissioning couples to access support from their networks and perceive these relational interactions as positive experiences.

Prohibiting commissioning couples from accessing treatment for their surrogates may also have lead to the other negative feelings expressed by the participants discussed in this chapter. Although very few individuals talked about feeling isolated, several discussed about their feelings of exhaustion, financial stress and guilt. The feeling of criminal guilt, in particular, was discussed in Chapter Six of this report. Both the path model and the social-contextual model explore how individuals try to understand their feelings in their circumstances and constantly attempt to appraise and apply meaning about what to do next. These models also assert that this is only possible within the context of relationships with others. As was seen in the responses to Question 5b, nearly all of the participants in this study expressed feelings about their experiences of positive social support. I suggest here, that once again, it was these experiences that impacted the commissioning couples and helped them to maintain their focus in trying to have children through the, sometimes arduous, process of gestational surrogacy. Quan, from couple Number 17, epitomised this when talking about his experience of an IVF specialist who helped Quan and his partner navigate the logistics of the process,

“They were there to help you...and he, yeah, just as I say he was a professional. He said, ’Right I can do this for you. This is what you’ve got to do.’ And it wasn’t as if he was making dollars out of it...He’d communicate with your GP and he’d liaise everything. It was just great. It was a bit of a relief to find someone decent.” (Quan, Couple No. 17, 2006; Transcript, p.11).

As was seen from the models presented in Chapter Two of this thesis, individuals who are able to cope with the grief of loss during the course of their daily functioning further develop skills for coping with major life events. The commissioning couples in the current study were undoubtedly coping with loss, whilst coping with everyday life, and dealing with the process of their gestational surrogacy arrangements. Within the context of the evidence presented in Chapter Three of this report, I would like to suggest that the dual processing approach, adopted by the commissioning
couples, was further supported by their experiences of positive support within their social networks. This was highlighted by the response of Bett, who talked about her feelings about being supported by those around her,

“...And even professionally, at work they were just so supportive. They organized for me to get maternity leave, ...They didn't have to do that under the legal side of things, and they treated me as if I was the one having, they gave me a big party for the baby coming, and yeah, it was just so awesome. I must say, I've not had one negative, if anything it has been the opposite end of the scale where I just can’t believe people are so positive.” (Bett, Couple No.2, 2006; Transcript p.22).

As was previously stated, all 34 of the participants interviewed in this study expressed feelings of being determined and committed to the process of gestational surrogacy in their attempts to have their children. Verhaak et al. (2005) found that women who had a good understanding of the process of IVF, and who perceived that they had good networks of social support, coped well with failed treatments and were more resilient in attempting further procedures. 33, out of the 34 participants interviewed in the current study, said that they felt that they were being positively supported by their surrogates, 31 expressed feelings about support from medical professionals, 29 talked about positive support from legal professionals, and 31 discussed the positive impact of support by friends and family. 22 participants stated that they had feelings of gratitude towards their surrogates. In the light of the established literature presented thus far, my suggestion is that the commissioning couples in the current study continued to be determined and committed because of the positive impact that their networks of social support had on them during their experiences of treatment in gestational surrogacy.

As is evident from the participant responses in Section 7.2.1 of this report, nearly all of the commissioning couples interviewed talked about their feelings about the support offered to them by their partners during gestational surrogacy. 32 individuals stated that a strong relationship with their partner was the key to coping during the process. Many couples commented on the need to act collaboratively in order to deal with any difficulties or procedural obstacles.

Hurdle (2001) argued that social ties help individuals to cope with, ‘crises, life transitions and deleterious environments.’ The author further argued that, ‘the need for connection and relationships with others is a primary motivation that determines cognition, affect and behaviour.’ As previously mentioned one of my
earliest motivations for undertaking this current project was my interest in studying the link between social support and the positive impact that this might have on couples undergoing infertility treatment. I would like to suggest at this point, that in light of the material offered by Hurdle, it is likely that the positive social impact of the intimate relationship between the individuals in the commissioning couples allowed these couples to develop the skills to be able to cope with the life changing experience of entering into gestational surrogacy arrangements. In other words the impact of their relationships helped them to cope with, ‘crises, life transitions and deleterious environments’.

Based on the responses from the commissioning couples in this study, and based on the evidence presented from established literature, it does seem that strong relationships and positive social support contributed to the participant’s feelings of coping during their gestational surrogacy experiences. The positive themes identified through the use of interpretative labels and units of psychological meaning, such as determination and commitment, and positive experience of support, have all been linked to relational themes, such as, strong relationship with partner and positive support from others. Likewise any negative themes identified, such as, disempowerment and lack of control, and emotional and physical exhaustion, have been linked positively to relational themes, in that couples expressed that they were able to cope with any negatives because of the positive impact of their relationships during the process of their gestational surrogacy arrangements.

7.5 CHAPTER SUMMARY
The primary purpose of this chapter was to interpret and analyse the data offered by the participants concerning their relationships with others during the course of their gestational surrogacy experiences. A two way analysis process appears to have occurred here. Firstly the individual participants’ relationships to others, including the immediate relationship between the individuals in each commissioning couple, were interpreted and analysed. Next, but just as importantly, a secondary analysis occurred concerning the impact of social support on the commissioning couples through their social network whilst involved in the process of gestational surrogacy. Identified themes such as, determination and commitment, disempowerment, positive experience of support and strong relationship with partner provided enough evidence to presume that there was a strong link between the positive impact of social
support and the participants’ ability to cope with the overall impact of their
gestational surrogacy arrangements. In comparing this with the findings presented
in established research I was able to see that commissioning couple’s relations with
others and other’s relationships with the commissioning couples played a very
important role, and for some continues to play a pivotal role in their ability to cope
with, and on occasion positively embrace, the unpredictable nature of the experiences
of gestational surrogacy.

As for the previous chapter, it is difficult to make an assessment as to whether the
findings presented here might be collaborated by the findings of similar studies
designed to investigate the psychological impact of social support on commissioning
couples. This is primarily because, as previously asserted, there has been so little
research into this area. In the methodology section of this thesis I discussed the work
of Yardley (2003) who argued that any research needs to leave a ‘paper trail’ which
other researchers can follow when investigating similar phenomenon. It is hoped
that by presenting the responses of the participants in this study, and by presenting a
synthesis of the established literature concerning the importance of social support
during life events, in a methodical way, would allow for the findings to be compared
to further research in this area.

In the next chapter I look at attachment and other concerns in gestational surrogacy.
There are some established studies which specifically address these areas, and it is
my intention to explore whether the findings from the current study compare with
this literature.
RESULTS AND DISCUSSION 3

CHAPTER EIGHT  RETROSPECTIVE IMPACT: FEELINGS AFTER GESTATIONAL SURROGACY

8.1 INTRODUCTION

In Chapter Four of this thesis I examined several public perceptions concerning the process of altruistic gestational surrogacy. I suggested that three common stereotypical beliefs are, that attachment between infants and commissioning parents is compromised; that exploitation of surrogates is commonplace; and that commissioning parents are interfering with nature and ‘playing God’ in using the process of gestational surrogacy in order to have their children. The questions posed to the participants, and the responses explored, in this chapter helped me to access information about the commissioning couples’ psychological experiences in the period after the initial treatment phase, or phases, of their gestational surrogacy arrangements. The couples’ retrospective responses allowed me to explore their feelings about how they may have approached the process of gestational surrogacy differently and about their desire for change to the current system. The issues discussed explore aspects of attachment and bonding, surrogate well-being, and the intricacies of treatment and how these might be improved for others, as well as indirectly exploring whether couples were affected or influenced by public opinion about these areas.

The main issue for inquiry in considering the responses of the participants in this chapter was to explore the feelings of the commissioning couples about their experiences, after being involved in the process of gestational surrogacy for some time. One of the difficulties encountered in analysing the responses was that the participants became separated into two distinct groups, those who had become parents through the process of gestational surrogacy, and those who had not. For those couples where the process had not been successful, there emerged two further sub-groups, those determined to continue and committed to more cycles of treatment, often with new surrogates, and those facing involuntary childlessness in terminating the process of gestational surrogacy altogether. For this reason I did not ask specific questions about attachment and bonding, but asked couples to discuss their particular feelings in looking back over their experiences to date. Further
studies are currently being carried out within Swinburne University concerning the attachment styles of the commissioning parents who participated in this current study. It is predicted that this will yield invaluable data about the experiences of surrogacy and attachment within Australian culture.

As was the case for the two previous chapters I have briefly presented the original questions posed to the participants, in this instance those questions designed to investigate the psychological impact post their gestational surrogacy arrangements. I then continue to follow the pattern of presenting the couples’ responses, offering early interpretative labels in relation to these responses, and then comparing these findings to the established research previously presented. A chapter summary is then offered. As Chapter Four of this report looked specifically at attachment and other concerns I drew heavily from the studies presented there in the comparisons and discussion section of this chapter.

8.2 POsing THE QUESTIONS AND RECORDING THE RESPONSES
The four questions delivered here were designed to explore the feelings of the participants and the psychological impact of the consequences of their gestational surrogacy experiences. The questions looked in particular at the participants’ retrospective thoughts, and about how the process of surrogacy might have been improved for them. The questions were as follows:

“Question 7: What has impacted you the most with regard to the current legal parentage laws within Victoria?
Question 11: What, if anything, could have improved your experience as a couple during the process of surrogacy fertility treatment?
Question 12: What, if anything, would you do differently if you could have your surrogacy arrangement experience over again?
Question 13: Finally what advice would you give to couples following after you in a gestational surrogacy arrangement?”

8.2.1 QUESTION 7: LEGAL PARENTAGE
In answer to Question 7, the responses fell into three distinct categories, but all under a broad theme of ‘major impact’. It would appear that all of the commissioning couples who had a child through gestational surrogacy in Victoria were affected by the legal parentage laws governing the process and were concerned that a birth certificate could not be issued for their child, or children, with both of the commissioning (biological) parents’ names appearing. However as was outlined in Chapter One of this report there seemed to be many variations concerning whose names appeared on birth certificates issued for children born as a result of
gestational surrogacy to Victorian parents. Three distinct categories of responses appeared. The first was from those parents who had neither of their names on the birth certificate. The second was from those parents who had the commissioning father’s name on the birth certificate, but not the commissioning mother’s. The third group of responses were from those parents who were openly worried about the difficulties of being issued a birth certificate for their child. These were the couples in the current study that had made the decisions to enter into commercial arrangements in the United States. The implications of these decisions meant that these couples were able to avoid Victorian legislation and be issued with full birth certificates, before returning to Australia, with both of the commissioning parents’ names appearing and no mention of the surrogate mother or of the surrogacy process.

Couples 1 and 18 are both examples of commercial arrangements where only the commissioning parents’ names appeared on the birth certificate:

“...That you’ve got to adopt the child! Well that’s one of the other reasons why we wouldn’t do surrogacy here; because it’s not [classed as] your child. One of the great things about [a commercial arrangement] is that the child was legally ours before it was born...Six weeks before it was born you sort of go to court and that’s where the...so on our birth certificate we are the biological parents...You don’t adopt...The contract that’s drafted up between you and the surrogate, and she forgoes any parental rights and basically you’re on the birth certificate when the child’s born, and when you’re over there you have to apply to the Australian Government to get a passport...there’s no risk to us keeping the child because it’s ours as soon as it’s born.” (Adam & Ann, Couple No.1, 2006; Transcript p.13).

“I know literally just so many couples who’ve done it, where they have a surrogate that’s in Victoria that goes into hospital and gives birth to their [the commissioning couple’s] child...and then they end up becoming guardians of the children. And that just wasn’t sitting well with us. We wanted to ensure that when our children were born we were acknowledged on the birth certificate, and it was never a question of us ever having to adopt them or to even apply for parental rights, or guardianship or anything. We just wanted it to be very straightforward.” (Rachel, Couple No.18 2006; Transcript p.3).

Couple Number 9 responded that the commissioning father’s name appeared on the birth certificate along side the name of the surrogate mother:

“In the end we spoke to a few different legal firms and just said, ‘this is what we’re looking at doing’, and they just said...You can put that you’re the father, there’s no reason why anyone can contest that...We’ve got all the DNA stuff done already, and we’ve got the records there to state, so that if anyone wants to contest it, it’s there...We know who’s child it is. We don’t need to adopt. How often do you get out the certificate...if we
ever need to get passports or something, everything is in my name, we’ve got all the legal rights anyway...we sat down with CentreLink and explained the whole story to them. Told them basically what had happened and when they went through to sign all the paperwork they put my [the commissioning father’s name] down and they said when they went to the mother’s name, instead of putting the surrogate’s name down they put my wife’s [the commissioning mother] as my partner and wrote, ‘biological mother’ on the form.” (Isaac, Couple No.9 2006; Transcript p.9).

Couples Number 2, 4 and 5 gave examples of situations where neither the commissioning father’s nor the commissioning mother’s name appeared on the birth certificates issued for their children. Instead both the surrogate mother’s name and that of her current partner or husband appeared:

“I mean realistically I don’t have parental rights to my child at all. I’m not recognised at all. What I need to do, the first process that I need to go to the family court to get, I think it’s guardianship. So that’s the initial petition we put through to the family court, with I think they said something like you put forward an application to adopt somewhere down the track. But then you’re talking about things like, you have to go through an adoption agency. You then have to bring a social worker or someone into your home to assess your home life. So we’re bringing external parties in again to go through the whole process that we’ve been through.” (Bob & Bett, Couple No.2, 2006; Transcript p.25).

“The only problem is that neither Doug nor myself are on the birth certificate. It’s the surrogate parents...and their child that they had between them at the time is on the birth certificate, and our names aren’t on there. We were under the understanding that Doug’s name could be on it when they changed the laws...the birth certificate issue is the annoying part. Even when our children had to go to school, we’re in a small community here so everybody knew, but we as the parents weren’t allowed to enroll our children, the surrogate parents had to. I don’t understand why we can’t just have a DNA test to get the birth certificate changed; we have actually had a DNA test.” (Doug & Delia, Couple No.4, 2006; Transcript p.11 & 13).

“Well we’ve still got a birth certificate. Obviously the surrogate and her husband are on it as our child’s parents and we’re trying to get that changed at the moment. We’re going through solicitors in Melbourne. We’ve been to court and we’ve had that adjourned off because of the commission into surrogacy...Our surrogate and her husband don’t want their name on the birth certificate, so it sort of offends them a little bit too, but we thought we could get around it without adopting our child, if we can’t we’ll have to.” (Elise, Couple No.5 2006; Transcript p.7).

The responses to the above questions are explored in more detail in the latter sections of the current chapter. The following section outlines the responses to both Questions 11 and 12.
8.2.2 QUESTIONS 11 AND 12: IMPROVING YOUR EXPERIENCE AND THE CHANCE TO DO THINGS DIFFERENTLY

In answering Question 11, concerning what might have improved the gestational surrogacy experience for the commissioning couples in the study, participants appeared to automatically also respond to Question 12, ‘What, if anything, would you do differently if you could have your surrogacy arrangement experience over again?’ Without a doubt nearly all of the participants, and in particular those who had become parents, focused their responses on the changes that they would like to personally see happen in order to improve the gestational surrogacy experience within the State of Victoria.

Couples number 2, 6, 10 and 16 are examples of commissioning couples who responded to both Questions 11 and 12 simultaneously and who focused their responses on the need for change to insure a more efficient and less expensive process:

“That we could have gone straight to Sydney and even just talked to someone about surrogacy…the whole process would have been quicker, would have been less physically and mentally demanding and cheaper…There is a structure in Sydney, there is absolutely (hits table with hand) no structure in Melbourne. Basically the structure in Melbourne is a circle, and they will just keep you going round in a circle because I think they’re hoping that they’ll get surrogacy legalized in Victoria, but it’s only a hope. In Sydney it’s actually a structured process that you can go through to get to your end goal.” (Bob, Couple No.2 2006; Transcript p.32).

“This isn’t my choice. I’m not putting myself through this because I want to. If only people and governments could just walk in our shoes. See what we’ve been through, how much we want this and just give us a bit of support. We’re hard working people, we pay our taxes, we do everything right…The simplicity is that it should be more accessible [in the State]. It shouldn’t be so hard that you have to go behind closed doors, type of thing.” (Filip & Feroze, Couple No.6 2006; Transcript p.20).

“I fell apart at the end because I thought, ‘It’s not going to happen.’ The doctor in Sydney was brilliant in making it all happen and we went to Sydney IVF Ethics…and we got the tick in the box at the very last, but the pressure was enormous…I guess now I know the procedure and what’s involved, I would probably have simplified things and gone to Sydney to start with.” (Jo, Couple No.10 2006; Transcript p.12).
“...Well it’s all the IVF procedure, and you’re not just paying for IVF yourself, you’re also paying for the surrogate. All the procedures, virtually, cost money...and if I could’ve knocked off work and gone and done a two hour interview, I could have just gone back to the office [instead of having to drive 19 hours to an interview in another State]. It certainly would have been a lot easier...I think that somewhere, with probably obstetricians, or even just your local GPs, [you were] supplied with some form of information that is actually based on the Act [the Infertility Treatment Act 1995], and people could actually read with their own eyes what the legal requirements are, we found out through default through our obstetrician...If you try to read the Acts, they are so confusing throughout every State...When reading the Act people don’t care what Section 24 and paragraph 27 are. They want to know what the hard core fact is, and the simple answer, can we do it or no?” (Pete & Pearl Couple No.16 2006; Transcript p.13 &15).

The best examples of participant disappointment and the need for change to the system came after the interviews in two separate email letters concerning additions to transcripts, firstly from Pearl, Couple Number 16, and then from Olivia, Couple Number 15.

“...It is just so sad that we have to stop, but the system isn’t working for us...at this stage we have no more embryos left and I am not sure that we could put our surrogate through another round...we have run out of resources...the whole thing is so difficult to do and it’s disappointing and sad...very sad, but I guess we’re lucky to already have one child.” (Pearl, Couple No. 16, 2007, email correspondence).

“...At this stage we will be stopping as we have run out of money and eggs. Our surrogate has kids and I don’t think she wants to keep going [interstate]. We might look for another one, but it will take years to start again with someone else. We are hoping that changes might be coming and then maybe we can start again...” (Olivia, Couple No. 15, 2007, email correspondence).

**QUESTION 13: ADVICE TO THOSE COMING AFTER**

Question 13, ‘Finally what advice would you give to couples following after you in a gestational surrogacy arrangement?’ provoked responses that appeared to centre around the couples’ desires to prevent anyone, about to embark on the gestational surrogacy journey, from being procedurally and emotionally unprepared. Several couples also commented about their continued experiences of support after the process of gestational surrogacy and stated that good relationships within their social networks, especially with their surrogates, were essential to this process.
The response from Couple Number 1 is the best example of positive social support being required after the initial treatment phase of surrogacy had ended:

“...then we had our child with our surrogate, who was just, who is just lovely...even though we had bad luck we hit the jackpot with her. We’ve actually just travelled to see her in April, and we just had a lovely time...we have a fantastic relationship...it was the most relaxing holiday...she’s just the most relaxed person and her kids love our baby...you know full on entertainment” (Adam & Ann, Couple No. 1, 2006; Transcript p.9).

Couples 8 and 14 gave the best examples of their feelings about the need to be procedurally and emotionally prepared in order to cope with the process of gestational surrogacy, Couple Number 14 also highlights the importance of a good relationship with the surrogate throughout the process:

“...At the moment I’d say, ‘Absolutely [you can do gestational surrogacy and live in Victoria]. I’d give them as much information as I could give them and steer them straight away to New South Wales, because it’s possible. Even though it’s not possible here, it’s possible there, but you need to be super organised and determined that’s all.” (Hannah, Couple No.8 2006; Transcript p.14).

“I wouldn’t hesitate in recommending it if that was their only option. Give it a go because you’ll end up hating yourself if you don’t give it a go...You’ve got nothing to lose. I’m sure there are marriages that would break up and I accept that, but if having a family is your aim, then you have to have a go at it...I think I’d tell people definitely go and do it with open eyes and check out everything before you start, as in the legal part of it, be sure of what the situation is and to be confident with the person who is being your surrogate, because if someone says, ‘Yeah I’ll do it for you.’ They have to know definitely what they are doing...it is clearly not a process for the faint hearted. Even going through the counselling, it opens your eyes to a lot of things. You can’t make a half go of it, it’s got to be 100 percent commitment and you have to understand what’s going on.” (Neil & Nell, Couple No.14 2006; Transcript p.12 & 13).

As for Chapters Six and Seven all of the responses to the above questions are now explored in more detail in the following sections of this chapter.
8.3 RESULTS AND ASSIGNING INTERPRETATIVE LABELS AND UNITS OF PSYCHOLOGICAL MEANING

As for Chapters Six and Seven I used the principles of Interpretative Phenomenological Analysis in assigning labels and meanings to participant responses. In analysing the participant responses to Questions 7, 11, 12 and 13, I was able to identify several recurrent themes that illustrated how commissioning couples continued to be impacted after their initial gestational surrogacy experiences. Five themes describing negative psychological impact were identified; disappointment, financial stress, frustration and anger, philosophical acceptance at terminating the process, and the perception of the process as being a traumatic experience. Two positive themes were also identified. The first described the participants’ feelings about changing the process of gestational surrogacy within Victoria, and the second looked at the positive experience of support after the commissioning couples had been involved in the process of surrogacy for some time.

As previously mentioned, there emerged two distinct groups of responses to this last set of questions. Firstly there appeared to be the responses from the group that had become parents, some of whom did not have their names on the birth certificates for their children, and were grappling with the issue of legal parentage. This was seen in the comments from Bob and Bett in Section 8.2.1 who talked about feeling as if they had no legal rights to their child born through gestational surrogacy and that they may be subjected to yet more professional formal assessments in establishing whether they were good enough to legally adopt this child. The second group of responses arose from those couples still attempting gestational surrogacy, and who expressed feelings of frustration and anger with the current system. As was seen in Section 8.2.2, Filip and Feroze were a poignant example of this,

“This isn’t my choice...If only people and governments could just walk in our shoes. See what we’ve been through, how much we want this and just give us a bit of support. We’re hard working people, we pay our taxes, we do everything right.” (Filip & Feroze, Couple No.6 2006; Transcript p.20).

As can also be seen in Section 8.2.2, Pete and Pearl talked initially about the financial burden of the process of gestational surrogacy and then about their feelings of frustration regarding current legislation,
“If you try to read the Acts, they are so confusing throughout every State...When reading the Act people don’t care what Section 24 and paragraph 27 are. They want to know what the hard core fact is, and the simple answer, can we do it or no?” (Pete & Pearl Couple No.16 2006; Transcript p.13).

Couple Number 13 in particular spoke about their feelings and the negative emotional impact of having to go through the process of gestational surrogacy in Victoria and then through the adoption process in their home State in order to receive a re-issue of their biological child’s birth certificate:

“Well it just meant that we couldn’t do it in Victoria. We had to get all our information from a State that wasn’t easily accessible. It cost us an absolute fortune in airfares. We had to re-mortgage the house. We stopped counting when we had spent 40 grand...When the eggs had been collected I had to pay top price for the flight because you only had a couple of days notice. It was expensive, it was awkward...I've got to say we were pleased to do adoption. First of all we had long term guardianship, but we thought we could lose our child at any moment. And then when we adopted, that was awful because the adoption agency didn’t want us to...we hadn't been on a waiting list, and we went, ‘Oh my God, so does that mean that if we put our biological child on the list, our child could go to the next family?’ Even the judge said, ‘Look this is ridiculous!’ ” (Mol & Mel, Couple No.13, 2006; Transcript p.7 & 9).

I have assigned the interpretative label of ‘frustration and anger’ in describing the feelings of those couples who expressed a deep dissatisfaction with the current system governing the process of gestational surrogacy within Victoria. I then assigned three units of psychological meaning to further explain these feelings of frustration with the logistics of surrogacy and with the current laws concerning legal parentage. These units were, ‘frustration-with the system’, ‘frustration-with interstate travel’, and ‘frustration-at difficulties surrounding issue of birth certificate’. Overall 31 participants expressed difficulties with the current system of gestational surrogacy. 26 expressed frustration at the requirement to travel interstate for procedures, and 11 (all parents) stated that they had been negatively impacted by the legal parentage laws.

In response to the comments from couples about the mounting financial costs of gestational surrogacy, I assigned the same two units of psychological meaning as in the previous results and discussion chapters. To the overall interpretative label of ‘financial stress’ I added the units of ‘financial stress-at the mounting costs’ and, ‘financial stress-at not being able to predict future costs’. Nearly all of the participants in the study expressed anxiety about this aspect of their surrogacy arrangements; 32 expressed negative feelings about the mounting costs, and 31
expressed negative feelings about not being able to predict the overall sum eventually required for the process.

In all eight participants spoke about their feelings of disappointment about failed treatment attempts. An example of this was seen in Jo’s response about the psychological impact of a failed cycle, “...I fell apart at the end because I thought, ‘it’s not going to happen.” Six participants talked about their feelings of disappointment about having to terminate the process of gestational surrogacy, and interestingly the same six participants expressed a philosophical acceptance about their decision to stop. Four participants recalled feelings of trauma following the process of gestational surrogacy. Catt from Couple Number 3 recalled her experience of egg collection as being, ‘extremely traumatic’ due to procedural complications. Quan and Queenie, Couple Number 17, talked about their feelings of devastation at the ‘pulling out’ of their surrogate and at the impact of the whole process of infertility, gestational surrogacy and failed pregnancies,

“I think there’s an element of trauma there...certainly there’s a pressure and there’s an expectation that you’ll have kids and be a family and that sort of thing, and for us it hasn’t been that way and it’s been very traumatic...we’ve buried three [pre-term] kids.” (Quan, Couple No. 17, 2006; Transcript p.16).

In identifying the psychological themes of disappointment, acceptance at ending the process, and perceived trauma I assigned three interpretative labels and adjacent units of psychological meaning; ‘disappointment-about failed transfers’ and ‘about having to stop the process’; ‘philosophical acceptance-about the decision to terminate surrogacy’; and ‘traumatic experience-failed process’.

One of the major, positive, psychological themes that became apparent when discussing retrospective thoughts and feelings with the couples in the study about their gestational surrogacy experience was their unequivocal desire for change. Examples of this can be seen in the couples’ responses to Questions 11 and 12. 27 Participants expressed a desire for future couples not to have to travel interstate. 29 discussed their feelings about the positive impact that reducing the cost of gestational surrogacy would make, likewise 27 participants desired medical rebates for treatment procedures. 27 participants expressed a desire for accessible information about the process, whether the process was available in Victoria or only interstate, and 26 stated that they would prefer that the whole process of gestational surrogacy be available to them and to future commissioning couples wholly within
the State of Victoria. Finally 22 participants discussed their feelings about their desire for change concerning the current laws governing the issuing of birth certificates in gestational surrogacy situations.

An overall interpretative label of ‘a desire for change’ was assigned for all of the above. The units of psychological meaning that were assigned were, ‘a desire for change-no travel’, ‘a desire for change-less cost’, ‘a desire for change-medical rebates’, ‘a desire for change-more available information’, ‘a desire for change-process available in Victoria’ and finally, ‘a desire for change-birth certificate’.

A second major, positive, psychological theme that became apparent when interviewing the couples in the current study was the theme of positive experiences in continued social support, especially the support offered after the initial treatment phase of the gestational surrogacy process. In particular the positive impact of the relationships with families and friends seemed to play an important role for both of the distinct groups identified, the commissioning parents group, and the non-parents group either waiting for the results of more treatment, or those who had stopped treatment altogether. 31 out of 34 participants described their relationships with their familial and social network as positive and 22 participants described their relationship with their surrogates as the same. The interpretative labels and units of psychological meaning applied here were as for Chapter Seven, ‘positive experience and support-from family and friends’ and ‘positive experience and support-from the surrogate’. These themes are discussed further, in the next section, in relation to the social network paradigm outlined in Chapter Four of this report.

As for Chapters Six and Seven, a table has been provided which clearly identifies the interpretative labels and units of psychological meaning assigned to the responses for Questions 7, and 11, 12 and 13. Cross reference has been made to those themes previously identified.
Table 6  Interpretative labels and units of psychological meaning assigned for continuing impact

<table>
<thead>
<tr>
<th>Interpretative Label</th>
<th>Unit of Psychological Meaning</th>
<th>Number of Participants Stating Affect</th>
<th>Previously Identified in either Chapters Six or Seven</th>
</tr>
</thead>
<tbody>
<tr>
<td>Desire for Change</td>
<td>• No travel</td>
<td>27</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Less cost</td>
<td>29</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Medical rebates</td>
<td>27</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• More available information</td>
<td>27</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Process available in Victoria</td>
<td>26</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Birth certificate</td>
<td>22</td>
<td></td>
</tr>
<tr>
<td>Disappointment</td>
<td>• About failed transfers</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• About having to stop the process</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Financial Stress</td>
<td>• At the mounting costs</td>
<td>32</td>
<td>Identified in chapters Six and Seven</td>
</tr>
<tr>
<td></td>
<td>• At not being able to predict future costs</td>
<td>31</td>
<td></td>
</tr>
<tr>
<td>Frustration and Anger</td>
<td>• With the system</td>
<td>31</td>
<td>Identified in Chapter Six</td>
</tr>
<tr>
<td></td>
<td>• With interstate travel</td>
<td>26</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• At difficulties surrounding issue of birth certificate</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>Philosophical Acceptance</td>
<td>• At the decision to terminate surrogacy</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Positive Experience of Support</td>
<td>• From the surrogate</td>
<td>22</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• From family and friends</td>
<td>31</td>
<td></td>
</tr>
<tr>
<td>A Traumatic Experience</td>
<td>• Failed process</td>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>

8.4 INTERPRETATION, COMPARISONS AND DISCUSSION

In the previous section of this report several psychological themes were identified which represented the feelings of the commissioning couples in this study. These feelings were specifically about the couples’ experiences after they had been involved in the process of gestational surrogacy for some time. As for the feelings identified in the previous results and discussion chapters, the feelings presented in this chapter could be loosely categorised into either negative or positive psychological themes. The intention in this section is to offer an interpretation, or analysis, of these themes within the context of the established literature previously presented. I am particularly interested in exploring whether the commissioning couples in this study were impacted by their own feelings about attachment and about the relationships with their surrogates as the process of gestational surrogacy continued. I am also
interested to explore whether the couples expressed any concerns about the intricacies of the treatment process.

In Chapter Four of this thesis several theories and models were presented that discussed the criticisms of attachment and bonding, human exploitation, and the role of the commissioning parents in choosing IVF treatments in gestational surrogacy. A number of unpublished public opinion pieces were also presented. Szikla (1996), Ozolins (1998), and Wilkinson (2003) all argued that gestational surrogacy, especially commercial arrangements, fundamentally changed the relationships between human beings and would always result in a women acting as surrogates being exploited. Wilkinson also raised the question about whether surrogates have the potential to exploit desperate commissioning couples. Other opinion pieces did not deny the risk of exploitation, but questioned whether others have the right to impose sanctions on women concerning their choices for their own bodies. The criticisms of commissioning parents orchestrating nature and ‘playing God’ appeared to be based almost solely on the public perception that even altruistic gestational surrogacy is ‘immoral’ and ‘ungodly’, and that in choosing treatment outcomes, chiefly the fate of embryos, couples were defiling the natural order of things.

MacCallum and Lycett et al. (2003), Golombok and MacCallum et al. (2006), Golombok and Murray et al. (2006) and van de Akker et al. (2000) all presented established research findings which suggested that attachment and bonding are not compromised in gestational surrogacy. These findings support the work of Bowlby and Ainsworth (1965) who argued in attachment theory that it is early relational experiences which form the bases for patterns of attachment, and that secure attachment comes from positive social experiences with primary care-givers in infancy. Kirkman (2002) was also suggestive of attachment not being compromised in gestational surrogacy as a child born of this arrangement develops in childhood and adolescence. A section was also presented in Chapter Four which discussed the issues of attachment and bonding in adoption and in blended families. The work of Ruschena and Prior (2004), in particular, pointed to the possibility that attachment can occur in these situations. Ultimately I concluded that secure attachment patterns can develop in atypical circumstances, including the circumstance of gestational surrogacy. I suggested that, quite apart from the need to move away from traditional dyadic models of attachment theory, it is possible that a model that includes the influences of others is more appropriate in gestational surrogacy. Lewis’ (2005)
social network model was proposed and is discussed in more detail in this next section.

In analysing why any of the commissioning couples in this study expressed feelings of disappointment about aspects of their gestational surrogacy experiences, I found that all expressions of disappointment was linked to failed treatment process, or to feelings that the system of surrogacy in Victoria had failed. These feelings can probably be best explained by the models of loss and grief already described in the previous chapters of this report. I did not find that any of the participants expressed their disappointment within the context of public criticism or public concern. In contrast to this the couples who expressed disappointment with the system, or disappointment with their treatment outcomes, also expressed that they still felt supported by their social networks. One response from Feroze, in Couple Number 6, may have alluded to an unspoken opinion about the natural order of who is able to conceive and who cannot:

“I remember that I had one comment from a lady where I said something to her once, she asked me if I was going to have children and I said, ‘Funnily enough we’re going through IVF’, and she sort of said, ‘Oh well if it doesn’t work for you, you should just look at it that it was never meant to be for you.’...And I thought, ‘well that’s very fine for you, and I’ve got to appreciate your opinion, but take a walk in my shoes.’” (Feroze, Couple No. 6, 2006; Transcript p.17).

This comment was the only one of its kind across all of the interviews and so cannot be relied upon as indicative of general public opinion. In all 31 participants stated that they continued to receive positive support throughout their experiences, and 22 commented on the continuing support from surrogates.

Likewise in discussing their feelings of philosophical acceptance in terminating the process of gestational surrogacy or, of their feelings of trauma in thinking back over their experiences, none of the participants appeared to be aware of negative public opinion. In making the decision to stop treatment, the six participants who expressed feelings about this did not appear to make their decisions because of public influence. Only four participants expressed feelings of having been traumatised, but as was seen from the responses of Quan and Queenie this was in relation to the oftentimes arduous nature of the process of surrogacy, and not due to negative social support or negative public opinion. As for the psychological theme of disappointment, it may be that any sadness associated with terminating the
gestational surrogacy process, or feelings of the process having been traumatic, are better explained by the models of grief and stress previously outlined.

In examining the participant’s responses concerning their feelings of financial stress, again no responses were recorded which pointed to negative public opinion about the process of gestational surrogacy. As can be seen from the previous section of this report, the commissioning couples stresses related to finance were based on the mounting costs of treatment and the inability to place a finite figure on the eventual sums required. None of the participants appeared to have been accused by others of exploiting their surrogates or of ‘playing God’ in paying for, and continuing, treatment. I did not find that the couples in this study were even aware of these criticisms or that their decisions were influenced by them.

As was indicated in the previous section of this report the commissioning couples’ frustrations and anger were with the system, with the requirement to travel interstate, and with the difficulties surrounding the issuing of birth certificates. Several of the responses recorded in Section 8.2 of this report showed the depth of feelings by the participants about these areas. It may be that in this case public perception does have an indirect role to play. Although none of the participants seemed to be aware of any negative public opinion it is interesting to note that many of the couples were affected by the laws governing gestational surrogacy arrangements. These laws are formed, to a certain extent, by public opinion, and the laws are certainly imposed by others who are part of the public community. It may well be that public fear of exploitation of surrogates and fears that commissioning couples ‘play God’ in gestational surrogacy contributed to the difficulties of completing the process within Victoria. This could be said then to have influenced the couples in the current study and may have contributed to negative psychological impact.

The finding that the commissioning couples who had become parents were frustrated with the laws governing birth certificates is probably the first major indicator of the desire for strong attachment that may exist for these couples with their children. As was previously stated, MacCallum and Lycett et al. (2003), Golombok and MacCallum et al. (2006), Golombok and Murray et al. (2006) and van de Akker (2000) have all suggested that attachment and bonding are not compromised in gestational surrogacy. The Golombok and MacCallum studies listed above are three studies of the same families over the first three years of children’s lives born through
gestational surrogacy. The studies all concluded that the surrogacy families had strong measures of positive psychological well-being indicative of secure attachment patterns. Although it might be suggested that the couples in this study wanted to be issued birth certificates with both parent’s names appearing because of feelings of ownership, I would like to suggest that the couples wanting their children to belong to them officially is an indication of them wanting them emotionally. It could be argued that the fear that children could be removed from commissioning parents, because of anomalous birth certificating, is a strong measure of how attached commissioning parents are to their children, and how desirous they are of positive relationships leading to potentially secure attachment patterns. This finding is also supported by van de Akker who stated that, “in the formation of families [through gestational surrogacy], individuals and couples are willing to overcome infertility and raise their children no matter what the origins of these children’s births.” (p.81). Although at this stage, due to a dearth in established literature, these findings are only speculative, early indications are that the commissioning parents in the current study, are concerned with emotional attachment with their children over and above issues of legal rights and ownership.

The Golombok and MacCallum studies (2003 & 2006) also explored the connection between the parents expressing positive feelings about their surrogacy arrangements and the formation of positive relationships with their children, thus laying down the foundations for secure attachment patterns to develop. As can be seen from the responses recorded by the participants in this study many of the couples perceived their experiences as positive, and further stated that these positive experiences were enhanced through the continued support of others. Ann from Couple Number 1 offers the best example of this:

“One thing I haven’t said is that all the heartaches and all the stress and all the finances, it doesn’t matter when you’ve got the child. When the child was born and I was just looking at our child in that theatre, and I was just looking at our child, I just couldn’t, it was life I’d been given, I don’t know. I just couldn’t believe it all. And I think Adam broke down. For the first time, he hadn’t, he’d been stoic the whole way along, and then he broke down when he was talking to his mum, ‘Our child’s safe now!’ And he was bawling. And it’s, I know, it’s, and we are just fortunate that we could have afforded to do it. But it is a positive experience, it’s not a negative experience, and if you’re lucky enough to have, like we’ve been through heartache because it didn’t work this time, because at least we’ve got the child, and a lot of people don’t have that.” (Ann, Couple No.1, 2006; Transcript p.22 & 23).
As was outlined in Chapter Four, Kirkman (2002) recalls her experiences of early motherhood. Kirkman’s child, Alice, now in her twenties, was the first child to be born in a gestational surrogacy arrangement in Australia. Kirkman’s sister acted as a surrogate after Kirkman and her husband were unable to conceive due to medical reasons. Kirkman talks about responding to Alice during a tantrum:

“As Alice was a demanding baby, but responded to what I did for her... 
...She was upset about something, and threw an impressive archetypal tantrum...I said that I would stay nearby until she felt better... When I picked her up she immediately quietened and relaxed. Alice has always been an impressive human being.” (Kirkman, 2002; p.141),

As was also outlined in Chapter Four, when recalling her experiences of having to tell her husband that the media had learned of their arrangement with Kirkman’s sister, Sev Kirkman merely responded, “We’re going to have a baby and that’s all that matters.” (p.142). This comment by Sev further supports van de Akker’s argument that when raising their infants commissioning parents are willing to do this no matter what the gestational origins of these children. It is also interesting to note here that Sev, the commissioning father, was aware of public opinion but was not negatively influenced by it:

“He seemed truly unconcerned. If public knowledge was the price to pay for fatherhood, he was happy to pay it.” (p.142).

In analysing the commissioning couples’ responses, thus far, I would like to suggest that none of the couples expressed negative feelings about the opinions of those in their social networks, and none of the couples appeared to have been influenced by wider negative public opinion during their continued experiences of gestational surrogacy. With regard to the issue of attachment and bonding I did not ask the couples direct questions about this, chiefly because not all of the couples had become parents through the process. However early indications that the commissioning parents’ group were negatively psychologically impacted by the laws governing birth certificates in surrogacy may be indicative of these parents’ desires to positively bond with their children. As has been previously discussed, attachment theory (Bowlby & Ainsworth, 1965) argues that positive early relational experience is connected with the development of secure attachment patterns.

One of the positive themes that I identified from the participants’ responses was that of a desire for change. On average over two thirds of the participants stated that they would actively seek change in the areas of the requirement for interstate travel, in the
expense associated with the process, in the lack of any medical rebates, and in the lack of consistent accessible information. None of the participants seemed to be lacking in confidence about expressing their feelings concerning these issues, as might be expected if they were aware of negative public opinion. As can be seen by the responses from Pearl and Olivia, in Section 8.2.2, feelings of concern were expressed about how the current system was affecting the lives of surrogates in particular. It would appear that the commissioning couples in this study wanted positive changes to be made to the current system for the benefit of all and that these desired changes were not being influenced by any negative public opinions.

A second positive theme that I identified, and which has been highlighted throughout this section, was the theme of continuing positive social support. As was previously mentioned, 31 out of 34 participants stated that they had continued to receive positive support from their families and friends during gestational surrogacy and, 22 stated that their relationships with their surrogates also continued to be positive. I would like to suggest, that in terms of attachment and bonding, this continuing social support offered to the couples may potentially lead to their children’s development of secure attachment patterns. As was mentioned earlier, Lewis (2005) proposed a social network model in raising children. This model does not negate Bowlby and Ainsworth’s (1965) theory of attachment but rather expands on it to include the polytrophic influences beyond the mother-child dyad, or parent-child triad. If commissioning parents model how to have strong supportive relationships with their wider social networks, then it is probable that the children born to these parents will be positively influenced by this modelling and will in turn know how to form secure relationships throughout life. This supports the concept proposed by the African proverb highlighted in Chapter Four, that, ‘It takes a village to raise a child.’

In exploring the commissioning couples’ desire for change to the current system of gestational surrogacy within Victoria, and in exploring their feelings and perceptions about the continuing support being offered to them during the process, none of the couples expressed any negative feelings about any perceived negative public perceptions. Likewise none of the couples seemed to be aware of negative opinions or influenced by them in making their decisions during the course of their arrangements. The networks outside of the immediate couples appeared to be perceived as positive and as having a positive psychological impact.
8.5 CHAPTER SUMMARY

The purpose of this chapter was to present the responses of the commissioning couples in this study concerning their continuing experiences of the process of gestational surrogacy. Through an analysis of these responses I was able to explore several issues for inquiry surrounding the couples’ retrospective experiences, predominantly their feelings about what they might have done differently, and how their relationships with others continued to be affected throughout the process. The psychological impact of the relationships explored included the experiences of social support, but indirectly also explored their feelings about having children and their feelings about those who impose the laws governing gestational surrogacy within Victoria. The psychological impact of wider public opinion, and potential negative social influence, was not able to be fully investigated as the responses of the commissioning couples in this study focused almost entirely on their experiences of continuing positive social support.

The feelings analysed of the commissioning couples in this chapter did not support any negative public perceptions about altruistic gestational surrogacy arrangements, chiefly that the process defies God and nature, and that human exploitation is rife. The comments recorded seemed only to support the idea that individuals are open minded about gestational surrogacy and are willing to support those who embark on the process.

Early indications were that the commissioning couples who had become parents in this study were concerned about attachment and bonding with their children, and were worried about the legalities and permanency of their relationships in the light of anomalous birth certificates being issued. The couples were not at ease with the issuing of certificates where one or both of the commissioning parent’s names did not appear. I suggested that this might be a marker of the couples’ desires to form secure attachment patterns with their children. I further suggested that because of the psychological impact of the positive social support being offered to the commissioning couples, it may be that this social network offers the children born within it a strong foundation for forming secure attachment patterns.

In the next chapter I present the major psychological themes identified within this thesis, the limitations of the study, suggestions for future research and practice, implications for clinical practice and final comments.
CHAPTER 9 CONCLUSIONS

9.1 MAJOR THEMES
The aim of this study was to address a significant shortcoming in the research about the psychological impact of altruistic gestational surrogacy on commissioning couples. My investigation of the feelings and experiences of these couples was comprised of a detailed analysis, interpretation, and evaluation of interview-based qualitative information within the context of established research. In this concluding chapter it is my intention to offer an integration of the findings of this study and illustrate that there are significant psychological themes and patterns which have emerged from the rich data provided by the participants. I also discuss the limitations of the study and point to areas for future research and practice. I then consider the implications for counselling practice, before offering final closing comments.

The major psychological themes identified in this study were determination and commitment, stress, strong relationship with partner and positive experience and support from others. Further psychological themes identified which were almost as significant, in terms of number of responses, were anxiety, confusion, a desire for change, disempowerment and lack of control, excitement, exhaustion, frustration and anger, gratitude and philosophical acceptance. Lesser themes, again in terms of number of responses, were disappointment, guilt, isolation, trauma and vulnerability.

As was highlighted in Chapter One of this report, the problem of infertility is a worldwide epidemic with as many as one in six Australian couples being affected by either primary or secondary infertility. While many causes of infertility can be investigated and diagnosed with some hope of treatment, there remain many idiopathic causes that cannot. Of the eighteen couples interviewed in the current study nearly all had attempted to try to conceive naturally before embarking on gestational surrogacy arrangements. Others had long accepted the need for such arrangements due to medical conditions preventing normal conception. What was evident from the findings in this study was that all of the couples considered gestational surrogacy as their last chance to have children. What was also evident was that the couples had reached their decisions after long processes of consideration or investigation and diagnosis. It is of little surprise then to find that one of the most significant
psychological themes that emerged from the commissioning couples was that of frustration and anger with the then current system for gestational surrogacy arrangements within the State of Victoria. Individuals, and couples, discussed at length about their feelings of anxiety and confusion and about their feelings of disempowerment, exhaustion and stress, including financial stress in response to attempting their surrogacy arrangements within their home State.

These important psychological themes can be interpreted using the models outlined earlier in this thesis. The models of grief and stress are relevant in explaining the losses experienced by commissioning couples in this study. These losses were twofold, the loss of fertility, and the losses experienced as a result of failed treatment cycles. The feelings of grief and loss were further compounded by the difficulties that the couples experienced with the then current system of gestational surrogacy within Victoria. The commissioning couples in the current study appeared to have adopted a philosophical acceptance about their fertility status and the need for gestational surrogacy, but in nearly all cases any expressions of feelings of sadness associated with this were further exacerbated by the couples’ feelings about the complex nature of the surrogacy process.

The themes of frustration and anger emerged again as couples who had been successful in having children battled with fears surrounding the issuing of anomalous birth certificates. Studies designed to investigate early attachment and bonding between commissioning couples and their children suggested that commissioning parents had positive representations of their children and that surrogacy families showed positive levels of psychological well-being. The investigators in all of the studies presented argued that these were clear markers that attachment and bonding is not compromised in surrogacy families. The conclusion was then drawn in the current study that if parents in Victoria are nervous about not being issued with birth certificates for their children, and therefore by implication feel that they have little legal parenting rights; then this is strong evidence to suggest that these parents wish to raise their children and provide them with the necessary social armoury to become well adjusted and securely attached.
The results presented from the established studies in attachment and surrogacy also indicated that the commissioning parents’ perceptions of their surrogacy arrangements as being positive may be related to secure attachment patterns being formed with their children. Based on this finding the conclusion was drawn in the current study that as the commissioning couples reported positive feelings about their surrogacy experiences then it was likely that they too would form positive attachments with their children. It was suggested in this report that further studies are needed in the area of attachment in gestational surrogacy, but that the early indications from both established literature, and the findings from this study, indicated positive parenting styles in successful gestational surrogacy arrangements. It was proposed that commissioning couples are just as capable of providing their children with the basis for secure attachment patterns as in the non-surrogacy population. In presenting the evidence from established literature that attachment can occur in the situations of adoption and blended families, I further argued that the development of secure attachment patterns is possible in atypical circumstances.

A further significant finding of this study was that the commissioning couples interviewed were motivated to enter into gestational surrogacy arrangements because of their complete determination and commitment to having children. It is not surprising then that the couples who had had to make the decision to stop the process expressed negative feelings such as disappointment, and talked about their feelings of being traumatised by the process. Again the models of grief highlighted in this thesis are useful in explaining this type of loss and grief, and of stress. I suggested, that as for other negative feelings experienced by the commissioning couples, the complexities of the process of gestational surrogacy further added to any feelings of sadness and trauma.

Upon further analysis of the participants’ responses concerning the stress experienced in gestational surrogacy arrangements, a significant finding was that all of the participants interviewed described their frustrations about their difficulties in finding consistent and available information. These frustrations also appeared to be directed at the logistics of the process within the State of Victoria, including the then requirement to travel interstate to access treatment. The illogicality of the eligibility laws governing access to treatment compounded the negative psychological impact in this area. Responses here appeared to centre on these stressors being further stimuli for feelings of confusion and anxiety, again about the lack of consistent information and also about the fear that treatment would be expensive, logistically difficult, and in the end prove unsuccessful.
What became apparent in studying traditional models of loss and grief was that, although they could be used in part to explain the losses experienced in infertility, there were few appropriate models available, and none which looked specifically at the continuous losses that are experienced in gestational surrogacy arrangements. Dual processing models of stress and coping best explained the loss responses given by the participants in the current study. These models, based on the theories of psychosocial transitions in loss, allowed for the deviation, or oscillation, between grieving a loss and focusing and attending to daily life functioning.

In the case of this study, the commissioning couples needed to attend to daily life functioning and to the major life event of having a child through the process of gestational surrogacy. It was suggested that Neimeyer's (2002) dual processing model of coping could be adapted to the area of continuous loss in infertility and in failed treatment attempts as couples could involve themselves in a process of dosage, loss-orientation and restoration-orientation, cognitive appraisal and reappraisal. This allowed the commissioning couples to attend to the grief and stresses in their gestational surrogacy arrangements in a non-linear way whilst attending to the continuing process of their surrogacy arrangements.

For the commissioning couples in this study the meaning of their experiences were made sense of, and built upon, by their desires to change the then current system of gestational surrogacy within the State of Victoria. The couples expressed strong feelings about all of the aspects of surrogacy that they would like to see changed in order to improve the process for themselves and for others. This meaning reconstruction was also explained by the models of loss and grief and stress and coping presented in this thesis.

A further major theme that emerged from the findings of the current study was that in coping with the difficulties and oftentimes complex nature of gestational surrogacy, many of the commissioning couples relied upon their strong relationships with their partner, that is the individuals within each of the couples relied heavily upon each other. The models of social support presented in this thesis stated that socially supportive relationships can often have therapeutic value in times of stress or life change. The couples in this study also discussed their feelings about the support and encouragement being readily available from their surrogates, from their family and friends and from their wider social networks, including both the medical and legal communities. Even those couples, who expressed feelings of disempowerment
at some medical, legal or professional meetings, still discussed how their ability to access social support, to some degree, lessened the impact of any negative affects.

The evidence presented in the established literature suggests that individuals who are able to access social support during times of crisis, and in fact during everyday life functioning, are more likely to maintain healthy levels of mental and physical health. This has major implications for counselling practice in gestational surrogacy arrangements, these implications are discussed later in this chapter.

I suggested in this thesis that the commissioning couples interviewed did not appear to be aware of any negative public opinion in making their decisions to enter into their gestational surrogacy arrangements. The possible public perceptions that surrogacy leads to human exploitation, and to the commissioning couples taking on god-like roles, were not mentioned by the couples in their responses. The criticism that attachment and bonding in gestational surrogacy are compromised was also not mentioned by the participants. The focus of the responses concerning the views of others was always on the impact of social support, and that this was experienced as positive and welcomed by the commissioning couples.

Coping facilitation models, adaption models and social contextual models were explored during the earlier parts of this thesis and are helpful in explaining the findings in the current study, that positive social support leads to positive psychological impact, and that this promotes positive self-esteem, positive self-acceptance, and positive coping. Social contextual models, such as Elizur and Mintzer’s (2003) conceptual path model suggested that there is a significant correlation between depression, self-esteem, locus of control and accessing social support. The findings of this study appear to align with this as it would seem that the couples were determined, focused, and sure of themselves in pursuing their goals, with strong internal loci of control. The suggestion in this study was that those who were strong in themselves were those that could manage their gestational surrogacy arrangements and were in turn able to access social support systems to help them to cope. This again has important implications for counsellors working in the area.
The psychological themes of positive experience and support from surrogates, family and friends, and from the wider community can also be best explained by social network models which discuss the importance of polytrophic influences. Lewis’ (2005) social network model, described in Chapter Four of this thesis, can be applied to the finding in this study that the commissioning couples were part of socially supportive networks which may contribute to the development of secure attachment patterns. The argument here was that the social network paradigm does not negate other earlier models of dyadic attachment, but suggests that there might be more. The commissioning couples in the current study discussed in detail the specific support that they received from others and I presented the argument that a positive social network, and the commissioning parent’s ability to access it and present it as a positive concept, would only serve to help any children born to develop patterns of secure attachment.

The commissioning couples interviewed in this study did express negative feelings about aspects of the surrogacy process which impacted them negatively, such as financial stress, disappointment and the lack of consistent and available information. However, the overall impression that I received from interviewing the commissioning couples was that they felt that their experiences of gestational surrogacy were positive, even in the face of procedural and logistical difficulties. One of the major contributors to these feelings, that surrogacy could be perceived as having had a positive psychological impact, was the couples’ experiences of positive social support.

It has been my intention throughout this report to accurately present the findings related to all of the psychological themes presented, however there did exist some limitations to this study. These limitations are discussed in the next section of this thesis.

9.2 LIMITATIONS

As is always the case with any social study, either qualitative or quantitative, it is possible that including more participants would help the investigators and the readers to discover more about particular social phenomenon. The sample here was the fullest sample that could be investigated at the time, although a possible way of improving the size of the sample may have been to include more couples who had sought out commercial arrangements in the US. However I chose only to use the
information from those couples who had seriously considered gestational surrogacy within Victoria before moving to overseas plans, as those couples who had chosen commercial arrangements from the very outset would not be able to fully comment on their experiences of gestational surrogacy within their home State.

I have already articulated the reasons for choosing to study the psychological responses of commissioning couples, as opposed to the responses of individuals. I am aware that qualitative studies of individuals would also be helpful, but it was decided that this would constitute two projects rather than one, with gender responses being studied separately. Previous studies have been conducted into the psychological themes apparent for female gestational surrogates, and then for the male partners of these surrogates. By studying the responses of both of the individuals within each commissioning couple, the impact could be explored on the couples as a whole within their intimate relational units.

As is also the case with any investigatory study time limits persist. As this study was never intended to be a longitudinal one the responses of those commissioning couples yet to come have not been assessed. It is however likely that those couples who have begun to embark on the pathway of gestational surrogacy, since the announcement of the intended changes to the law in Victoria, will already experience their arrangements very differently from the participants in the current study. The commissioning couples studied here had to respond within a system of prohibition and illogical legislation. One particular inquiry for further research will be the effect on commissioning parents being able to make a direct application to the Supreme Court of Victoria for full legal parentage of their children. As part of this application the Registrar of Births, Deaths and Marriages will be instructed to make an amendment to any birth certificate on the register where the process of gestational surrogacy has taken place after July 1, 2009. The Status of Children Act 1974 states that the notation, ‘closed-surrogacy’ will appear on such birth certificates. It is unclear though, at this stage, whose names will appear on any certificates issued, or re-issued to the commissioning couples in this study, whose children were born prior to July 2009.
9.3 FUTURE RESEARCH AND PRACTICE

As I have previously asserted, very little established research has been published in Australia concerning the psychological impact of gestational surrogacy on commissioning couples. There is an ongoing need for further research into this area. Studies designed to compare experiences between couples who have embarked on gestational surrogacy journeys prior to 2009, and those who are only beginning their journeys as law reform takes place would build a better understanding of whether these reforms are improving the experiences of commissioning couples. It would also be helpful to explore the experiences of those couples who had chosen commercial arrangements over purely altruistic ones to assess the psychological impact of each system.

As was previously mentioned, changes to the Status of Children Act 1974 propose that commissioning parents of children born in gestational surrogacy arrangements may now make an application to the Supreme Court in order to secure their position as legal parents to their children. It would therefore be useful to conduct further research into any impact that this has on attachment and bonding for the commissioning parents in the current study. It is hoped that the next study in the series exploring the psychological impact of surrogacy, to be conducted by my colleagues, ‘An investigation into the psychological impact of altruistic gestational surrogacy on children and families’, would explore this in more depth as the commissioning parents from the current study are approached and asked to further participate. It would also be useful to conduct studies into attachment where donor gametes have been used in gestational surrogacy situations. Research of this nature would again provide information for counsellors and clinicians working in the area.

Further to the above, studies designed to investigate what motivates commissioning couples to terminate fertility treatment in gestational surrogacy, presumably accepting the position of childlessness, would also help professionals working in the area to know how to best support these couples.

Finally, probably the most significant implication for future research is for studies to be designed that investigate and explore the psychological impact of gestational surrogacy on the children born of such arrangements. Until recently there has been little access in this area as children have been too young to be involved in such studies, and commissioning parents may well still be in the process of explaining gestational surrogacy to their children. However much has been learned from older children and adults about the psychological impact of their open verses closed
adoptions, and the openness about their biological origins in the use of donor gametes. It is hoped that further studies into the impact of being the children born in gestational surrogacy arrangements would provide further rich data to continue to inform law reform, regulation, and clinical practice.

9.4 IMPLICATIONS FOR COUNSELLING PRACTICE

“As many as 5 to 12 million individuals of child bearing age in the United States [as many as 1 in 6 couples in Australia] may now be infertile. For couples who wish to conceive, but cannot do so, discovery of physical infertility coupled with strong expectations about conceiving and raising children, sets the stage for a complex series of reactions, labelled here as the crisis of infertility. Infertile couples frequently struggle with strong feelings, ranging from disbelief and denial to isolation, guilt and grief. Problems of coping with infertility are worsened by physical and psychological stresses accompanying medical procedures. The marital relationship may be severely tested as well. For many individuals, the infertility crisis is resolved with virtually no support from anyone. With empathy and understanding, counsellors can help infertile individuals to work through the crisis productively”. (Cook, 1987; p.465).

The most significant implication for counselling practice is that workers in the area need to have a thorough understanding of the emotional impact of being unable to conceive naturally. Counsellors who begin gestational surrogacy counselling sessions with a knowledge of the grief and loss that has been experienced by their clients will be better able to guide them through the process, and support them during, the almost inevitable times, of failed treatment cycles and disappointments.

A second significant implication for practice would be that counsellors working in the area would be better able to offer guidance and support if they themselves understand the correlation between self-esteem, emotional resilience, locus of control, social networks and the ability to access support from these networks. I began with questions about treatment tenacity in the context of socially supportive networks and whether couples were less likely to ‘give up’ if they experienced strong support from each other and from family and friends, and the wider social community. From the evidence presented in this thesis it would seem that commissioning couples perceived that supportive social networks had a beneficial psychological effect. One role of the counsellor in gestational surrogacy arrangements may well be to teach couples how to best access social support. A good theoretical knowledge is essential here as the individuals in the couples presenting
for counselling might still be attempting to deal with grief and loss as well attending to the any continuous losses and disappointments along the way.

Cook (1987) suggests that when meeting with couples facing infertility and the need for treatment, an initial place to start in counselling would be with the possible *iatrogenic stressors*, such as the stress of the diagnosis of infertility itself, and the psychological and physiological reactions to the medical procedures endured by the couple (mostly the woman) to achieve the diagnosis. Cook argues that the cost, inconvenience, uncomfortableness of procedures needs also to be explored. At times ambivalent results from tests, only add to the couple’s rising anxiety about their inability to conceive and can often lead to a feeling of ‘*lost time*’ when ‘rest’ periods are advised between either diagnostic tests or cycles of infertility treatment.

Menning (1980) argued that the following possible emotional responses need to be considered by the counsellor when helping infertile couples; disbelief and surprise, denial, anxiety, anger and loss, isolation and alienation from others, guilt, inadequacy and low self-esteem, depression and grief, and resolution, that is, an acceptance of infertility and the ability to begin to process the different options open to them, including involuntary childlessness. For mental health professionals and counsellors working in the area of infertility, Cook (1987) suggests that couples are encouraged to see their problem as a shared one requiring dual efforts to reach resolutions. Couples should also be encouraged to take control over their situations through asking questions and through gaining a clear understanding of medical explanations and treatments. Cook further suggests that couples should be encouraged by counsellors to explore the potential benefits of support groups and be willing to consider the possibility of raising non-biological children through donor conceived programs. The implications of these counselling guidelines for gestational surrogacy would be similar. As the outcome of the 2008 Parliamentary Bill concerning gestational surrogacy in Victoria comes into effect the Infertility Treatment Authority (ITA) is currently developing protocols for counsellors in the state of Victoria who will be working in the area of gestational surrogacy.
9.5 FINAL COMMENTS

The experience of commissioning couples in gestational surrogacy arrangements is complex and profound. The common psychological themes reported here indicate that whilst commissioning couples are made up of individual people, and each couple is different from the next, the themes and patterns that have emerged are similar. Whilst the whole area of Assisted Reproductive Technology rapidly advances, bringing with it the need for law reform, legislation and change, it is important not to lose sight of those who are directly impacted by the process. In gestational surrogacy it is the individuals who make up the families who have their own stories to tell. It seems prudent then to finish this report with the comments from Alice Kirkman, the first child to be born from a gestational surrogacy arrangement within Australia. I think that this quotation only serves to remind us that a person is more than the sum of their gestational origins.

“Here is my story. It is about the child of six parents, but one mum and dad. First there was the sperm donor and his wife. The sperm donor was required because dad had a low sperm count. It was quite easy to count the sperm: zero. Mum had eggs, but one important ingredient was missing: a uterus...So my Aunt, Linda, lent her uterus for about eight months and had to put up with my fantastic 3 a.m. techno dancing. She has a husband, Jim, and mum, surprisingly enough is married to dad. That makes six parents, the full parenting fiasco, seeing as this will be read by a bunch of psychiatrists and psychologists, I should mention that I know who my mum and dad are. They’re the ones who tell me that there really is carpet [underneath the mess] in my room and I should dig for it.” (Alice Kirkman in Kirkman, 2002; p.144).
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PART 4—SURROGACY

39: Certain surrogacy arrangements to require approval of Patient Review Panel
A registered ART provider may carry out a treatment procedure on a woman under a surrogacy arrangement only if the surrogacy arrangement has been approved by the Patient Review Panel.

40: Matters to be considered by Patient Review Panel in deciding application for approval of surrogacy arrangement
(1) The Patient Review Panel may approve a surrogacy arrangement if the Panel is satisfied of the following—
(a) that a doctor has formed an opinion that—
   (i) in the circumstances, the commissioning parent is unlikely to become pregnant, be able to carry a pregnancy or give birth; or
   (ii) if the commissioning parent is a woman, the woman is likely to place her life or health, or that of the baby, at risk if she becomes pregnant, carries a pregnancy or gives birth;
(ab) that the surrogate mother's oocyte will not be used in the conception of the child;
(ac) that the surrogate mother has previously carried a pregnancy and given birth to a live child;
(b) that the surrogate mother is at least 25 years of age;
(c) that the commissioning parent, the surrogate mother and the surrogate mother's partner, if any, have received counselling and legal advice as required under section 43;
(d) that the parties to the surrogacy arrangement are aware of and understand the personal and legal consequences of the arrangement;
(e) that the parties to the surrogacy arrangement are prepared for the consequences if the arrangement does not proceed in accordance with the parties' intentions, including—
   (i) the consequences if the commissioning parent decides not to accept the child once born; and
   (ii) the consequences if the surrogate mother refuses to relinquish the child to the commissioning parent.
(f) that the parties to the surrogacy arrangement are able to make informed decisions about proceeding with the arrangement.
(2) In making its decision under subsection (1), the Patient Review Panel must have regard to the following—
(a) a report from a counsellor who provided counselling under section 43 to the parties;
(b) an acknowledgment by the parties that the parties have undergone counselling and obtained legal advice as required by section 43.
(3) This section is subject to section 41.
41: Patient Review Panel may approve non-complying surrogacy arrangement in exceptional circumstances

The Patient Review Panel may approve a surrogacy arrangement, despite failing to be satisfied of the matters referred to in section 40(1) in relation to the arrangement, if the Panel believes—
(a) the circumstances of the proposed surrogacy arrangement are exceptional; and
(b) it is reasonable to approve the arrangement in the circumstances.

42: Application of general requirements for treatment to surrogacy arrangement

For the purposes of applying Division 2 of Part 2 to a treatment procedure carried out under a surrogacy arrangement—
(a) the requirement that a criminal records check be sighted by the counsellor applies to a criminal records check for each party to the surrogacy arrangement; and
(b) the requirement to give permission for a child protection order check to be conducted applies to all parties to the surrogacy arrangement; and
(c) the requirement to comply with the criteria in section 10(2)(a) does not apply to the surrogate mother.

43: Counselling and legal information

Before a surrogacy arrangement is entered into the commissioning parent, the surrogate mother and the surrogate mother's partner, if any, must—
(a) undergo counselling, by a counsellor providing services on behalf of a registered ART provider, about the social and psychological implications of entering into the arrangement, including counselling about the prescribed matters; and
(b) undergo counselling about the implications of the relinquishment of the child and the relationship between the surrogate mother and the child once it is born; and
(c) obtain information about the legal consequences of entering into the arrangement.

44: Surrogacy costs

(1) A surrogate mother must not receive any material benefit or advantage as a result of a surrogacy arrangement. Penalty: 240 penalty units or 2 years imprisonment or both.

(2) Subsection (1) does not prevent a surrogate mother being reimbursed for the prescribed costs actually incurred by the surrogate mother as a direct consequence of entering into the surrogacy arrangement.

(3) To the extent that a surrogacy arrangement provides for a matter other than the reimbursement for costs actually incurred by the surrogate mother the arrangement is void and unenforceable.

45: Prohibition on certain publications

(1) A person must not publish, or cause to be published, a statement, advertisement, notice or document—
(a) to the effect that a person is or may be willing to enter into a surrogacy arrangement; or
(b) to the effect that a person is seeking another person who is or may be willing to enter into a surrogacy arrangement or to act as a surrogate mother or to arrange a surrogacy arrangement; or
(c) to the effect that the person is or may be willing to arrange a surrogacy arrangement; or
(d) to the effect that a person is or may be willing to accept any benefit under a surrogacy arrangement, whether for himself or herself or for another person; or
(e) that is intended or likely to counsel or procure a person to agree to act as a surrogate mother; or
(f) to the effect that a person is or may be willing to act as a surrogate mother. Penalty: 240 penalty units or 2 years imprisonment or both.

(2) In this section—

**publish** means—
(a) publish in any newspaper; or
(b) publish by means of television, radio or the Internet; or
(c) otherwise disseminate to the public.

(Victorian Legislation and Parliamentary Documents, March 2010)
APPENDIX B

EXECUTIVE SUMMARY

AN EXPLORATION OF THE PSYCHOLOGICAL EXPERIENCES OF COMMISSIONING GESTATIONAL SURROGATE COUPLES

PREPARED FOR MARY POLIS, VICTORIAN LAW REFORM COMMISSION
BY JAC TRACEY DOCTORAL STUDENT SWINBURNE UNIVERSITY

BACKGROUND TO THE STUDY
In summary this study was undertaken to present the psychological experiences of commissioning gestational surrogate couples. It was intended that two main areas would be investigated:

1. The experience and psychological impact of deciding to enter into a gestational surrogacy arrangement.
2. The experience and psychological impact of the process of surrogacy in relation to;
   a. The negotiation of relationships with all involved in the surrogacy process, including the immediate relationship between a commissioning couple.
   b. The negotiation of current guidelines and laws which govern fertility treatment and surrogacy arrangements in Victoria.

THESIS PROPOSAL
A thesis proposal was put forward to the Human Research Ethics Committee at Swinburne University in July 2006 outlining in detail the proposed design for the current study including a semi-structured interview protocol based around questions dealing with the main areas of investigation listed above. It was intended, and subsequently transpired, that the following three questions were posed to participants by the researcher as part of the interview process:

1. How have you been affected as a couple by the current eligibility criteria for fertility treatment in Victoria?
2. What has impacted you the most with regard to the current legal parentage laws within Victoria?
3. How have you as a couple been impacted by the current Victorian laws regarding reimbursement of your surrogate?

PREVIOUS RESEARCH AT SWINBURNE UNIVERSITY OF TECHNOLOGY
It was intended that this study would complete the picture of the psychological experiences of all adult heterosexual clients involved in the process of surrogacy in Victoria. Two previous studies had been completed by Postgraduate Students at Swinburne University; An Exploration of the Psychological Experiences of Surrogate Mothers, Goble (2004), and An Exploration of the Psychological Experiences of the Heterosexual Partners of Surrogate Mothers, Young (2004); both have been successfully submitted to the examining board.
THE AIMS OF THE STUDY
The educational and scientific aims of this project were as follows:

- To provide a systematic investigation of the psychological experiences of commissioning gestational surrogate couples. To date there are no published investigations into this area in Australia.
- To provide legislators with invaluable data during the process of law review and reform.
- To provide data for the legal fraternity to improve understanding and reduce negative experiences for commissioning couples.
- To provide invaluable data for health and medical and allied professionals in improving the services offered to commissioning couples.
- To provide information for commissioning couples in Australia in order to improve the process and experiences for these couples.

SUMMARISING THE SPECIFIC PROCEDURE
1. Interviews were recorded using a digital transcriber. Each interview was then professionally transcribed.
2. Transcriptions were then returned to participants with an assurance that only non-identifiable psychological themes would be considered for the write up of the study, especially those themes that were common across several interviews. Participants were also encouraged to edit any parts of the transcript that they did not want to be considered by me during the analysis phase of the study.
3. Contact was maintained with the participants and from time to time new information was added, in written form, by the participants if they wished to have this included in the study, for example, more than one participant wished to include that they had now ceased surrogacy arrangements as they had come to the end of their supply of ovum from the commissioning mother. It was stated that a consideration in not beginning a new round of egg collection was the need for interstate trips to conduct IVF transfers into the surrogates.
4. Based on the principles of Interpretative Phenomenological Analysis (Giorgi, 1985; Moustakas, 1994; Smith, 2003) specific data analysis was conducted on each of the transcripts provided by the participants.
RESULTS AND DISCUSSION

Table 2  summary of demographic information at time of interviews

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Number of Couples</th>
<th>Number of Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>married/long term partners</td>
<td>16</td>
<td>34</td>
</tr>
<tr>
<td>separated or Divorced</td>
<td>2</td>
<td>(2 individuals declined interview)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Residential Location</th>
<th>Number of Couples</th>
<th>Number of Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>metropolitan</td>
<td>5</td>
<td>8 (2 individuals declined)</td>
</tr>
<tr>
<td>Melbourne suburbs</td>
<td>7</td>
<td>14</td>
</tr>
<tr>
<td>country Victoria</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>now residing in another state</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medical Diagnosis</th>
<th>Number of Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>kidney Disease</td>
<td>4</td>
</tr>
<tr>
<td>auto immune disease</td>
<td>2</td>
</tr>
<tr>
<td>failed IVF/Treatment</td>
<td>4</td>
</tr>
<tr>
<td>hysterectomy</td>
<td>6</td>
</tr>
<tr>
<td>bicornate uterus</td>
<td>6</td>
</tr>
<tr>
<td>other uterine abnormality (including bleeding disorder)</td>
<td>8</td>
</tr>
<tr>
<td>other medical conditions (including uterine or cervical cancer)</td>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of Children at Time of Interview</th>
<th>Across All Couples</th>
</tr>
</thead>
<tbody>
<tr>
<td>children natural conception (Living)</td>
<td>8</td>
</tr>
<tr>
<td>children natural conception (deceased)</td>
<td>4</td>
</tr>
<tr>
<td>children IVF conception</td>
<td>1</td>
</tr>
<tr>
<td>children gestational surrogacy</td>
<td>10</td>
</tr>
<tr>
<td>current surrogacy pregnancies</td>
<td>2</td>
</tr>
<tr>
<td>considering or attempting</td>
<td>4</td>
</tr>
<tr>
<td>subsequent arrangements</td>
<td>2</td>
</tr>
<tr>
<td>decision to stop (at April 2007)</td>
<td></td>
</tr>
</tbody>
</table>

*Note: Some individuals interviewed had multiple conditions.*
Table 2  Specific table of results: Interpretative labels & units of psychological meaning

<table>
<thead>
<tr>
<th>No.</th>
<th>Interpretative label (Having Feelings of...)</th>
<th>Units of psychological meaning (As feelings Relate to...)</th>
<th>Number of Participants affected</th>
</tr>
</thead>
</table>
| 1.  | Confusion                                   | • About the lack of information  
     |                               | • About conflicting information  | 21                               |
| 2.  | A Desire for Change                        | • No travel  
     |                               | • Less cost  
     |                               | • Medical rebates  
     |                               | • More available information  
     |                               | • Process available in Victoria  
     |                               | • Birth certificate  | 27  
     |                               | 29  
     |                               | 27  
     |                               | 26  
     |                               | 22  |
| 3.  | Disempowerment & Lack of Control           | • At the apparent lack of information before and during the process  
     |                               | • At being ‘at the mercy’ of professionals in the process  | 19  
     |                               | 19  |
| 4.  | Financial Stress                           | • At the mounting costs  
     |                               | • At not being able to predict future costs  | 32  
     |                               | 31  |
| 5.  | Frustration & Anger                        | • With the system  
     |                               | • With interstate travel  
     |                               | • At the lack of information  
     |                               | • At varying information  
     |                               | • At difficulties surrounding issue of birth certificate  | 31  
     |                               | 26  
     |                               | 31  
     |                               | 29  
     |                               | 11  |
| 6.  | Gratitude                                  | • Toward the surrogate  | 22  |
| 7.  | Guilt                                      | • For what the surrogate goes through  
     |                               | • Regarding the process seemingly being pushed ‘underground’  | 5  
     |                               | 10  |
| 8.  | Positive Experience & Support              | • From the surrogate  
     |                               | • From family & friends  
     |                               | • From legal profession  
     |                               | • From medical profession  
     |                               | • From wider community  | 33  
     |                               | 31  
     |                               | 29  
     |                               | 31  
     |                               | 31  |
| 9.  | Stress                                    | • At the system  
     |                               | • At the process  
     |                               | • At the logistics during the process  | 34  
     |                               | 34  
     |                               | 34  |
| 10. | Vulnerability                              | • About what others might think  
     |                               | • At having to divulge personal information to medical/legal/ethics professionals  | 6  
     |                               | 12  |
SUMMARY OF RESULTS

The couples or individuals who took part in this study were all led to the decision to enter into a gestational surrogacy arrangement based on the medical condition of the females in the study. These conditions ranged from uterine abnormalities such as, no uterus, either due to a congenital condition or due to emergency hysterectomy; through to conditions such as Kidney or Auto Immune Disease that would severely compromise either mother or baby should the commissioning mother attempt a pregnancy herself.

In a number of cases some females had also attempted years of fertility treatment themselves, but were unsuccessful due to gynaecological problems such as Multiple Fibroids or Ovarian Cysts.

I have attempted in this Executive Summary to only include Units of Psychological Meaning that are relative to the issues for inquiry by The Commission, however it should be noted that ten other Units of Meaning were also identified concerning participants’ emotional and psychological responses to the personal phenomenon of being commissioning parents in surrogacy arrangements.

As can be seen from Table 2, the three areas that received the least amount of comment from participants during the interview process were, ‘Guilt–For What the Surrogate Goes Through’ (5 affected), ‘Vulnerability–About What Others Might Think’ (6 affected), and ‘Guilt–Regarding the Process Seemingly Being Pushed “Underground” ’ (10 affected). I am at the early stages of analysis in terms of the Discussion Section of my thesis, but am considering that these areas are of smaller concern to participants because they are so completely focused on having a child. Under the Unit of Psychological Meaning headed ‘Determination and Commitment’, all 34 participants stated that they had been or are currently, ‘completely focused on having a child’. For example:

I suppose back then the way you feel about it is, you’re going ahead with it no matter what it takes anyway...Most surrogate situations, I suppose the parents are just so committed no matter what it takes...because I think that the attitude is, “Well we’re going to do it anyway, so anyone that may want to change it or help us, [we] don’t give a stuff about it anyway...’

Jae So, you’re saying you’re almost belligerent?

Yes, absolutely, absolutely.  

Couple No, 11, 2006.

The three areas that received the most attention in Table 2 were, ‘Stress–At the System, At the Process and At the Logistics During the Process’ (all 34 affected) ‘Positive Experience and Support–From the Surrogate’ (32 affected), and Financial Stress– At the Mounting Costs’ (31 affected). It is also of interest to note that 9 out of the 11 comments regarding ‘Frustration and Anger–At Difficulties Surrounding the Issue of Birth Certificate’ were from successful commissioning parents in gestational surrogacy arrangements. The Units Of Meaning here are specific and descriptive, therefore it is obvious that the psychological impact expressed by the participants is in most cases due to the descriptors listed with them; for example a second descriptor for ‘Financial Stress’ was ‘At Not Being Able to Predict Future Costs’ (31 affected) this means that out of 34 participants 31 stated that they had been affected by the financial pressure of gestational surrogacy. The cost of the procedure appears to range from approximately $30-40,000
where successful first transfers took place, through to approximately $250,000 plus for couples who gave up in Australia and eventually sought surrogacy arrangements overseas.

The recommendation section of this summary outlines some of the possible changes that could reduce the cost for infertile couples who seek to have a child through gestational surrogacy.

RECOMMENDATIONS
The Infertility Treatment Act 1995 states the following as part of its principles:

- The welfare and interests of any person born, or to be born, as a result of a treatment procedure are paramount
- Human life should be preserved and protected
- The interests of the family should be considered
- Infertile couples should be assisted in fulfilling their desire to have children


Based on the guidelines listed above and on the results presented here, the recommendations of this Executive Summary are as follows:

1. Federalise and regulate gestational surrogacy in Australia so that it is a recognised process in infertility treatment with a determined protocol that all involved in the process, including the medical and legal fraternities, understand what can and cannot be done.
2. Abolish the need for Victorian couples to have to travel interstate for treatment, thereby reducing cost to the couple and family inconvenience to the couple and potential surrogate.
3. Recognise that clinical infertility is a reason that commissioning couples seek gestational surrogacy; therefore base the current eligibility for treatment in Victoria on the fertility status of the commissioning mother, not the surrogate.
4. Allow private Health Insurers to offer rebates for treatment in surrogacy arrangements.
5. Make provision for the biological parents (the commissioning couple) to be recognised on the birth certificate of their biological child, thereby cancelling the need for adoption by the commissioning parents of this child, and therefore reducing the confusion regarding legal parentage of any child born in a gestational surrogacy arrangement.
6. Through establishing a determined protocol allow for a legal contract to be binding regarding the reimbursement of reasonable expenses by the commissioning parents toward the surrogate mother.

REFERENCES
Media release

From the Deputy Premier and Attorney-General, and the Minister for Health

Tuesday, 9 September, 2008

REFORMS TO PROTECT CHILDREN AND PROVIDE CERTAINTY

The Brumby Government today introduced new laws on assisted reproductive treatment and surrogacy which will ensure our state meets requirements under Federal discrimination laws, bring Victoria into line with other states and better reflect the reality of modern families.

Deputy Premier and Attorney-General Rob Hulls said the overarching objective of the reforms was to protect the best interests of children born using such treatment.

“Assisted reproductive treatment is an area of rapid technological change dealing with issues that are very important to Victorian families,” Mr Hulls said. “These reforms will better protect children and provide certainty for families.

“Families come in all shapes and sizes and always have. We want to ensure that regardless of family structure, a child born through a surrogacy arrangement, to a single mother or to a same-sex couple receives the same legal protections as others.”

The proposed new laws are based on the recommendations of the Victorian Law Reform Commission, which consulted extensively over a four-year period in preparing its report to Government.

“Victoria’s laws in this area are out of date and unclear, and have been found to breach Federal discrimination laws. These reforms provide a legal framework for what is already occurring in the community,” Mr Hulls said.

The Commission found that parental capacity was based on good parenting skills rather than relationship status or sexual orientation.

Among other measures, the new laws will:
- Provide better protection for children by requiring checks for criminal records and child-protection orders for potential parents and establishing a state-wide review panel to consider cases where a presumption against treatment applies;
- Ensure Victoria’s laws are compatible with Federal discrimination laws by providing that women regardless of marital status or sexual orientation can gain access to assisted reproductive treatment;
- Facilitate surrogacy arrangements by removing the anomaly that surrogate mothers must be infertile to receive treatment in a clinic; and
- Ensure stronger legal protection for children by giving legal recognition to the commissioning parents in a surrogacy arrangement, or the female partner of a child’s mother.

The legislation will be the subject of a conscience vote in Parliament.

The Commission’s recommendations on adoption are being considered by a national working group set up by the Community and Disability Services Ministerial Council in light of broader issues facing adoption services across the country.

Health Minister Daniel Andrews also introduced two bills which reproduce the current laws that maintain a prohibition of human cloning and allow for the continuation of research involving human embryos, as two separate pieces of legislation.

Mr Andrews said that this would fulfil the commitment made by the Government last year to separate the medical research provisions and clinical treatment aspects of the laws regulating assisted reproductive technology, whilst ensuring that Victoria’s laws remained nationally consistent.
# Appendix D

## Medical Causes of Infertility

<table>
<thead>
<tr>
<th>Male</th>
<th>Female</th>
<th>Combined</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Defective spermatogenesis</strong>:</td>
<td><strong>Ovarian Factors</strong>:</td>
<td><strong>Advanced age of female beyond 35 yrs, ageing reduces the fertility of male but spermatogenesis continues through out life</strong></td>
</tr>
<tr>
<td>- Undescended Testis</td>
<td>- Anovulation or Oligo-ovulation</td>
<td>- Infrequent intercourse</td>
</tr>
<tr>
<td>- Orchitis (e.g. Mumps)</td>
<td>- Luteal Phase Defect (LPD)</td>
<td>- lack of knowledge of coital technique</td>
</tr>
<tr>
<td>- Genetic Factors</td>
<td>- Lateinised Unruptured Follicle (LUF)</td>
<td>- Timing of coitus to utilize the fertile period</td>
</tr>
<tr>
<td>- Testicular Toxins (drugs, radiation)</td>
<td>- Polycystic Ovarian Disease</td>
<td>- Apareunia</td>
</tr>
<tr>
<td>- Endocrinal (Thyroid)</td>
<td></td>
<td>- Dyspareunia</td>
</tr>
<tr>
<td>- Varicocele</td>
<td></td>
<td>- Anxiety and apprehension</td>
</tr>
<tr>
<td>- Primary Testicular Failure</td>
<td></td>
<td>- Use of lubricants during intercourse</td>
</tr>
</tbody>
</table>

| **Obstruction of Efferent Duct**: | **Peritoneal factors**: | **Immunological factors** |
| **Congenital...** | - Peritoneal Adhesions | - Exposure to DES |
| - No Vas Deferens | - Endometriosis | |
| - Young’s Syndrome | | |

| **Acquired...** | | |
| - Ineffective (e.g. STDs, TB) | - Uterine Hypoplasia | |
| - Surgical Trauma | - Inadequate Secretory Endometrium | |

| **Failure to Deposit Sperm High in vagina**: | **Uterine factors**: | |
| - Impotency | - Uterine Hypoplasia | |
| - Ejaculatory Failure | - Inadequate Secretory Endometrium | |
| - Retrograde Ejaculation | - Fibroid Uterus | |
| - Hypospadius | - Endometritis (tubercular in particular) | |
| - Bladder Surgery | - Uterine Synechiae | |
| - Psychosexual | - Congenital Malformation | |
| - Drug Related | | |

| **Defect in Sperm & Seminal Fluid**: | **Cervical factors**: | |
| - Immotile Sperm | - Congenital Elongation of Cervix | |
| - Sperm Antibodies | - Uterine Prolapse | |
| - Low Fructose | - Acute Retroverted Uterus | |
| - Oligo-asthenospermia | - Fault in the Cervical Mucus | |

| **Vaginal factors**: | | |
| - Atresia vagina (partial or complete) | | |
| - Transverse Vaginal Septum | - Narrow Introitus (causing pain) | |
| - Septate Vagina | | |

| **Cervical Mucus Abnormalities** | | |
| | | |

Adapted from Fertility-Treatment.Org (2005)
### Appendix E

#### Table 2  Medical Terminology Explanations

<table>
<thead>
<tr>
<th>Male Medical Conditions</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypospadius</td>
<td>Abnormal opening of the penis</td>
</tr>
<tr>
<td>Oligo-astheno-azoospermia</td>
<td>Abnormal sperm shape</td>
</tr>
<tr>
<td>Varicocele</td>
<td>Swelling of veins above testis</td>
</tr>
<tr>
<td>Young's Syndrome</td>
<td>Respiratory Disease causing abnormal sperm transportation</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Female Medical Conditions</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anovulation</td>
<td>Absence of Ovulation</td>
</tr>
<tr>
<td>Cervical Mucus Abnormalities</td>
<td>Viscous mucus, antisperm antibodies, low acidity, infection.</td>
</tr>
<tr>
<td>Endometriosis</td>
<td>Development of endometrial cells, forming lesions and or growths, affecting the uterus &amp; affecting other organs such as the intestines</td>
</tr>
<tr>
<td>Hypoplasia</td>
<td>Under development of sexual organs</td>
</tr>
<tr>
<td>Luteal Phase Defect</td>
<td>Disruption of menstrual cycle</td>
</tr>
<tr>
<td>Luteinised Unruptured Follicle</td>
<td>Follicle failure in releasing egg</td>
</tr>
<tr>
<td>Narrow Introitus</td>
<td>Constricted mid vaginal opening</td>
</tr>
<tr>
<td>Polycystic Ovarian Disease</td>
<td>Many follicles (sometimes referred to as cysts) that have not matured for egg release</td>
</tr>
<tr>
<td>Uterine Synechiae</td>
<td>Band like structures within gestational tract</td>
</tr>
<tr>
<td>Vaginal Atresia</td>
<td>Congenital or acquired malformation of the vagina</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Combined</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apareunia</td>
<td>Inability to accomplish sexual intercourse</td>
</tr>
<tr>
<td>Dyspareunia</td>
<td>Painful sexual intercourse</td>
</tr>
<tr>
<td>Exposure to DES</td>
<td>DES (Diethylstilboestrol or Stilboestrol) hormone drug prescribed to pregnant women between 1938-1980. Research indicates decreased fertility in those exposed.</td>
</tr>
</tbody>
</table>
Appendix F


Procedural Steps

Prior to Fertility Treatment

- Medical diagnosis of infertility & that gestational surrogacy may be a viable option.
- Referral to an IVF clinic within Victoria by a General Practitioner or Medical Specialist.
- Referral by the Victorian clinic to an interstate IVF clinic, either in ACT or NSW.
- Information packs provided by the interstate clinic to the commissioning couple and their surrogate, the couple & their surrogate then provide responses to specific questions & are given the opportunity to ask questions in return.
- Consultation with the following (to be arranged by the commissioning couple).
  - Gynaecologist
  - Lawyer
  - Psychologist and or Psychiatrist
- The above provide information on the issues that they covered to the interstate clinic and that clinic’s appropriate Ethics Committee.
- Consultation with Victorian Human Services Department regarding adoption.
- All parties meet with the clinician & counsellor of the interstate clinic to provide further information.
- The interstate IVF clinic Ethics Committee then meets to consider all reports & makes a decision as to the suitability of the commissioning parents & the surrogate and her partner for gestational surrogacy. If yes then IVF proceeds, if no then the commissioning couple & their surrogate are counselled as to what needs to be addressed before re-submission to the Ethics Committee.
- A three month ‘cooling off’ period is then issued to allow all parties time to consider the process.
- Commissioning parents undergo further blood tests; commissioning father provides another sperm sample.
- If still classed as medically viable, hormone stimulation begins. The commissioning mother requires 1-2 daily injections from day 1-10 of her cycle.
- Further blood tests are taken & ultrasound is required when eggs are considered to be mature.

All of the above could take place within a licensed Victorian clinic. However, in some cases the couples in the current study have reported being required to travel interstate for the above procedures and or have had an IVF nurse flown down from Canberra or Sydney to administer injections.

Commencement of IVF

At present the following procedural steps happen interstate as these procedures would currently be against the law in the state of Victoria.

- Commissioning mother is sedated & eggs are retrieved vaginally.
- Commissioning father provides semen.
Procedural Steps cont/...

- IVF takes place. Embryos can then be stored in quarantine for up to six months. In some cases fresh embryos will be implanted into the surrogate.
- The gestational surrogate undergoes embryo transfer & may be given daily hormone booster injections.
- Pregnancy test is conducted on approximately day 15 post transfer.

Post Fertility Treatment

- Successful pregnancy monitored in Victoria or in gestational surrogate’s home state.
- Unsuccessful pregnancy results in another ‘round’ of retrieval and transfer.
- Under current Victorian law the baby may be born in a Victorian hospital or Birth Centre.
- Gestational surrogate relinquishes the baby to the commissioning couple.
- The commissioning couple then applies for (or has been in the process of applying for) full legal guardianship leading to an adoption process.
- A birth certificate is issued to the birth (gestational surrogate) mother with either her partner or the commissioning father’s name appearing as the father of the child.

(Adapted from Goble, 2005; p.131)
## Appendix G

### Major Constructs Measured by Subscales of Social Support Measures

<table>
<thead>
<tr>
<th>scale</th>
<th>subscales</th>
<th>constructs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Support Scale (SSS) (Dean et al., 1981)</td>
<td>- Confidant support</td>
<td>- Relationships with three selected confidants</td>
</tr>
<tr>
<td></td>
<td>- Family support</td>
<td>- Marriage &amp; family relationships</td>
</tr>
<tr>
<td></td>
<td>- Community-neighbourhood support</td>
<td>- Satisfaction with neighbourhood &amp; community</td>
</tr>
<tr>
<td></td>
<td>- Instrumental-expressive support</td>
<td>- Problems with money, demands &amp; social living</td>
</tr>
<tr>
<td>Social Support Questionnaire (SSQ) (Norbeck et al., 1981)</td>
<td>- Total functional support</td>
<td>- Affect, affirmation &amp; aid</td>
</tr>
<tr>
<td></td>
<td>- Total network</td>
<td>- Network size &amp; structure</td>
</tr>
<tr>
<td></td>
<td>- Total loss</td>
<td>- Recent losses in social support</td>
</tr>
<tr>
<td>Personal Resource Questionnaire (PRQ) (Brandt &amp; Weinart, 1981)</td>
<td>- Part 1</td>
<td>- Personal coping resources</td>
</tr>
<tr>
<td></td>
<td>- Part 2</td>
<td>- relational functions of support</td>
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<tr>
<td></td>
<td>- Intimacy</td>
<td>- provisions for love &amp; intimacy</td>
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<tr>
<td></td>
<td>- Social integration</td>
<td>- indications of belonging</td>
</tr>
<tr>
<td></td>
<td>- Nurturance</td>
<td>- opportunities for nurturance</td>
</tr>
<tr>
<td></td>
<td>- Worth</td>
<td>- indications that one is valued</td>
</tr>
<tr>
<td></td>
<td>- Assistance</td>
<td>- indications of belonging</td>
</tr>
<tr>
<td></td>
<td>- Self-help</td>
<td>- opportunities for nurturance</td>
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<tr>
<td></td>
<td></td>
<td>- levels of self-reliance</td>
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<tr>
<td>Inventory of Socially Supportive Behaviours (ISSB) (Barrera et al., 1983)</td>
<td>- None</td>
<td>- Frequency of receiving help</td>
</tr>
<tr>
<td>Interpersonal Network Questionnaire (INQ) (Pearson, 1983)</td>
<td>- Mutuality</td>
<td>- Availability &amp; reciprocity of significant relationships</td>
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<td></td>
<td>- Network size</td>
<td>- Confidant &amp; crisis supports</td>
</tr>
<tr>
<td></td>
<td>- Frequency of contact</td>
<td>- Social participation</td>
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<tr>
<td></td>
<td></td>
<td>- Contact with friends &amp; family</td>
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</table>

(Sourced from Pearson, 1981; p.393).
# Appendix H

## Table 3 Means, SD, F and p values for comparisons of parental functioning between family types

<table>
<thead>
<tr>
<th>Family type</th>
<th>Mean</th>
<th>SD</th>
<th>Mean</th>
<th>SD</th>
<th>Mean</th>
<th>SD</th>
<th>F</th>
<th>p</th>
<th>B vs. NC</th>
<th>B vs. SD</th>
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<tr>
<td>Mothers</td>
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<td>Psychological state</td>
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<tr>
<td>Parenting Stress Index</td>
<td>56.82</td>
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<td>62.98</td>
<td>13.06</td>
<td>63.50</td>
<td>13.36</td>
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<tr>
<td>Vulnerable Child Scale</td>
<td>54.87</td>
<td>5.75</td>
<td>52.33</td>
<td>5.08</td>
<td>56.09</td>
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<td>Trait Anxiety Inventory</td>
<td>32.06</td>
<td>6.49</td>
<td>36.05</td>
<td>8.28</td>
<td>35.55</td>
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<td>Edinburgh Depression Scale</td>
<td>4.57</td>
<td>3.11</td>
<td>5.61</td>
<td>5.83</td>
<td>5.15</td>
<td>3.82</td>
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<td>Marital relationship</td>
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<td>GRISS</td>
<td>23.83</td>
<td>9.53</td>
<td>24.17</td>
<td>11.24</td>
<td>20.69</td>
<td>10.16</td>
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<td>Relationship quality</td>
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<td>1.76</td>
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<td>1.92</td>
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<td>Conflict</td>
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<td>Parent affective experience</td>
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<td>Degree of anger</td>
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<td>Acknowledgement of support</td>
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<td>1.52</td>
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<td>Satisfaction with support</td>
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<td>Joy</td>
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<tr>
<td>Competence</td>
<td>3.30</td>
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<td>3.10</td>
<td>.42</td>
<td>3.06</td>
<td>.62</td>
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### Appendix I

| Table 1: Sociodemographic information by family type |
|---------------------------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|
|                                | Semenacry       | Donor insemination | Cryopreserved   | Naturally conceived | $p$  | $p$  |
|                                | Mean SD         | Mean SD           | Mean SD        | Mean SD          | Mean SD        | Mean SD        | Mean SD         | Mean SD        |
| Age of child (months)          | 38.29 1.29      | 36.39 0.83        | 36.76 1.04     | 36.63 0.83       | 1.87 NS        |
| Age of mother (years)          | 41.96 5.36      | 39.66 3.62        | 43.05 6.73     | 37.13 3.14       | 18.68 $<0.001$ |
| Child’s sex                    |                |                  |                |                 |                |                |                  |                |
| Boy                             | 18              | 24               | 26             | 22              | 2.84 NS        |
| Girl                            | 16              | 17               | 15             | 15              |                |
| Social class                   |                |                  |                |                 |                |                |                  |                |
| Professional                    | 22              | 16               | 22             | 22              | 24.73 $<0.01$  |
| Managerial                     | 6               | 11               | 14             | 17              |
| Skilled/semi-skilled           | 3               | 9                | 3              | 3               |
| Semi-skilled                   | 5               | 5                | 2              | 2               |
| Unskilled                      |                |                  |                |                 |                |                |                  |                |
| Number of siblings             |                |                  |                |                 |                |                |                  |                |
| Note                           | 18              | 13               | 26             | 11              | 30.41 $<0.001$ |
| One                            | 17              | 22               | 11             | 46              |
| Two                            | 2               | 4                | 4              | 10              |

NS, not significant.
*Includes one donor insemination child with three siblings.
Dear

As you may recall we met when you attended for a psychological assessment prior to commissioning surrogacy treatment. I discussed with you at that time the possibility of your involvement in a research project looking at the experiences of commissioning gestational surrogate couples. The project has now been approved by the Ethics Committee responsible for human research projects and we are looking for approximately 20 couples to take part. In my role as Senior Lecturer I am currently working with one of my Doctoral students, Jacqueline Tracey, in establishing research in this area.

Presently there are no published systematic investigations in Australia looking at the psychological experiences of commissioning gestational surrogate couples. The whole area of surrogacy is not well understood and it is hoped that the findings of our research will provide potential commissioning parents with improved services, including those provided by the legal and medical fraternities.

If you are interested in taking part in the study your participation would involve being interviewed by Jacqueline, the interview will take approximately 60-90 minutes to conduct. The information that you share would be treated confidentially and carefully, as per the strict guidelines laid out by the Ethics Committee. Eventually an academic report would be prepared incorporating the information collected from all couples; all of this information would be non-identifiable.
If you would like to be involved Jacqueline will telephone you to set up an interview time and organise a location. The interviews can be conducted at any convenient place and can be agreed upon during the initial telephone call. Please find enclosed a letter from Jacqueline that explains the project in more detail and that outlines the style of questions that you would be asked. This also contains a reply slip that asks for some of your contact details so that an interview time can be negotiated.

Thank you for considering participating in this important work. If you have any questions about the project or about your potential involvement I can be contacted by telephone or email (see below). If you do not wish to take part in the study, please ignore this letter.

Best Wishes

Roger Cook

☎ 03 9214 8358
Fax 03 9819 6857
Email rcook@swin.edu.au
Dear

My name is Jacqueline Tracey and I am currently working with Roger Cook looking at the experiences of commissioning gestational surrogate couples. We are hoping to gain a much deeper understanding of how couples are affected by the gestational surrogacy process as there has been little work conducted in this area to date in Australia.

I have undertaken this research project as I am interested in presenting a systematic investigation that gives a clear picture of the psychological experiences of couples leading up to the decision for gestational surrogacy and their experience of the actual process of surrogacy. If you decide to take part in this study you will be given a Form of Disclosure and Informed Consent that clearly describes the intricacies of the project and states the potential benefits for participating couples and for the wider community.

I would like to conduct an audio taped interview with you both where I intend to cover questions concerning:

- The process for you both leading up to the decision for surrogacy.
- Your thoughts and feelings about the actual process.
- The effect on your immediate relationship.
- The effect on your relationships with others, such as with the medical and legal personnel involved in your surrogacy arrangement; with your surrogate and with your family and friends.
- The process for you negotiating current Victorian guidelines and laws that govern fertility treatment and surrogacy arrangements.
- Your thoughts and feelings in retrospect about the process and whether you have any words of wisdom for potential commissioning couples.
- You may also wish to raise other things that played an important part in this area of you life.

The findings from the interviews conducted with approximately 20 couples will become a doctoral thesis. As outlined by Roger in his letter, none of the information that you share will be identifiable, this is also a requirement of the Ethics Committee that governs human research projects.
The findings presented in the thesis could be published in psychology or medical journals so that health care workers in the area of fertility and sub-fertility are better enabled to understand the experiences of commissioning couples. It is also intended that the results will be presented to the Victorian Law Reform Commission as part of this organisation’s review of the guidelines and laws for fertility treatment and surrogacy arrangements in Victoria. Again all information shared would be non-identifiable.

If you are willing to be contacted to set up an interview time, please return the slip below in the stamped addressed envelope provided. I can also be contacted by telephone on 0425 782 369.

Thank you for taking the time to consider your involvement in this project.

Kind regards

Jac Tracey MAPS. Assoc.

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Please detach and return in the addressed envelope. Thank you

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We....................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................

are willing to be interviewed by Jacqueline Tracey for the purposes of the project entitled, ‘An Exploration of the Psychological Experiences of Commissioning Gestational Surrogate Couples’. In returning this slip we agree to Jacqueline telephoning us to arrange an interview time.

Contact Details....................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................
Swinburne University of Technology
Form of Disclosure and Informed Consent

Project Title
An Exploration of the Psychological Experiences of Commissioning Gestational Surrogate Couples.

Investigators
First Investigator: Dr. Roger Cook
Second Investigator: Mrs Jacqueline Tracey

Explanation of Project
This project is being undertaken for the purpose of the Second Investigator obtaining a Professional Doctorate in Counselling Psychology at Swinburne University of Technology in Melbourne.

Thank you for taking the time to read this statement. It contains detailed information about this research project. Its purpose is to explain to you as clearly and concisely as possible all the procedures involved before you decide if you wish to participate in this research.

Please read this statement carefully. Once you are sure that you understand it you will be asked to sign the enclosed Consent Form. In signing this form you will be indicating that you understand the information and that you are willing to participate in the project.

You will be given a copy of this statement and the Consent Form for your records.

Description of the project
This project is has been designed to explore the psychological experiences of commissioning gestational surrogate couples. Previous postgraduate studies at Swinburne University of Technology have investigated the experiences of surrogates and of the heterosexual partners of surrogates. This project will look more particularly at your experiences, therefore hopefully completing the picture of the experiences of all of the heterosexual adult clients involved in the surrogacy process.
To date there have been no published systematic Australian investigations of the psychological experiences of commissioning couples. It is intended that the information collected during this study will help commissioning couples in the following areas:

- To provide a professional publication outlining the experiences of commissioning gestational surrogate couples in Victoria.
- To provide those who make the laws and regulations governing surrogacy in Victoria with human insight into the potentially rewarding outcomes of surrogacy and the complications and difficulties often faced by commissioning couples during the process.
- To provide information about the psychological experiences of commissioning couples to legal personnel to help in legal processes such as the adoption of the biological child by the commissioning gestational surrogate parents.
- To provide invaluable information for health and medical and other professionals in improving the services offered to commissioning couples.
- To provide information for commissioning couples in Australia in order to improve the process and experiences for these couples.

Your participation in this project will involve an audio taped interview with you both which is expected to last about one and a half hours. During this time you will be asked questions about your experiences leading up to the decision for surrogacy and your experiences of the surrogacy arrangement itself. It is intended that none of the information recorded on the audio tape will be processed until you have had the opportunity to read through the typed transcript of your interview and been able to make any comments or changes.

A total of 20 couples (40 participants in all) will be asked to participate in this project.

**Possible Risks of this project**

While every effort has been made to ensure your safety during the process of asking you to share information about your experiences it is possible that you may experience some psychological distress as you remember what the experience was like for you both. If this does happen the Second Investigator of the project will endeavour to help you in the following ways:

- Give you the opportunity to discuss with the Second Investigator how you are being affected.
- Discuss possible short term solutions for this distress.
- If necessary process with you your withdrawal from the project.
- Suggest possible counsellors for you to contact.
Possible time requirements of you the participants
It is anticipated that the following time requirements may be as follows:

- An audio taped interview of approximately one and half hours.
- 60-90 mins
- Your review of the transcribed interview.
- 30-40 mins
- Possible response to the transcribed interview if you require any changes.
- 30 mins
- Any telephone contact during the process of collecting the information.
- 15 mins

Possible benefits of this project
It is considered that there are possibly three benefits for the participants of this project:

- The opportunity for couples to talk about and process their experience of their gestational surrogacy arrangement with a professional who was not part of the actual process.
- The opportunity to participate in a project that may lead to legal reform making the experiences of subsequent commissioning couples safer and more regulated.
- The opportunity to ask questions and perhaps further process thoughts and feelings about the psychological experiences of the surrogacy process.

More generally it is hoped that the information that you share may be able to benefit those commissioning couples still going through or yet to go through, the process of surrogacy in order to have a child.

Withdrawal of consent and discontinuing in the project
Your participation in this project is voluntary and therefore if either of you do not wish to take part you are not obliged to. If you do decide to take part and then later either of you wish to withdraw from the study you are free to do so.

Prior to deciding to take part in the project you are encouraged to discuss any questions with the Second Investigator. Likewise if you wish to withdraw at any stage form the project the Second Investigator will be available to discuss any of your concerns with.

Ethical guidelines
This project will be conducted according to the National Statement on Ethical Conduct in Research Involving Humans (June 1999) produced by the National Health and Medical Research Council of Australia. This statement has been developed to protect the interests of participants who agree to take part in human research studies.

The ethical considerations of this study have been approved by the Human Research Ethics Committee of Swinburne University of Technology.
Further information or concerns
Any questions regarding the project entitled, ‘An Exploration of the Psychological Experiences of Commissioning Gestational Surrogate Couples’ can be directed to the First Investigator or Supervisor of this project, Dr. Roger Cook, or the Second Investigator Mrs Jacqueline Tracey (telephone numbers are listed below):

Dr. Roger Cook
Senior Lecturer
Faculty of Life and Social Sciences
Swinburne University of Technology
☎03 9214 8358

Mrs Jacqueline Tracey
Doctoral Student
Faculty of Life and Social Sciences
Swinburne University of Technology
☎0425 782 369

Privacy statement
All identifiable information that you share will be kept confidential. All information collected will be used in the publication of the Doctoral Thesis of the Second Investigator and in any subsequent Psychology or Medical publications. This can only occur where you have given written permission for the information to be used in this way and any identifying information will be removed prior to publication.

During the processing of the information that you have shared you as a couple will be allocated a code number that will only be identifiable to the First Investigator (Dr. Cook, the Supervisor of this project) and to the Second Investigator (Jacqueline Tracey, the Interviewer of this project).

Complaint procedure
If you have any concerns or complaints about the conduct of this project please contact:

Research Ethics Officer
Office of Research & Graduate Studies (H68)
Swinburne University of Technology
Hawthorn
Victoria 3127
☎03 9214 5218
Swinburne University of Technology

Form of Agreement and

Informed Consent

An Exploration of the Psychological Experiences of Commissioning Gestational Surrogate Couples

I………………………………………………………………………………………………………………

have read and understood the information above in the Swinburne University of Technology Form of Disclosure and Informed Consent. Any questions that I have asked have been answered to my satisfaction.

I have been given a copy of the Form of Disclosure and Informed Consent to keep by the Second Investigator of the project.

I agree to participate in this project, realising that I may withdraw at any time.

I agree that the interview may be recorded on audio tape as data on the condition that no part of it is included in any presentation or public display.

I agree that research data collected for the study may be published or provided to other researchers on the condition that anonymity is preserved and that I cannot be identified.

Name of Participant:…………………………………………………………………………………

Signature:…………………………………………………………………………………………………

Date:………………………………………………………………………………………………………..

Names of Principal Investigators:……………………………………………………………….

Signatures:………………………………………………………………………………………………

Date:………………………………………………………………………………………………………..
Swinburne University of Technology

Form of Agreement and

Informed Consent

An Exploration of the Psychological Experiences of Commissioning Gestational Surrogate Couples

I…………………………………………………………………………………………………………………………………………………………

have read and understood the information above in the Swinburne University of Technology Form of Disclosure and Informed Consent. Any questions that I have asked have been answered to my satisfaction.

I have been given a copy of the Form of Disclosure and Informed Consent to keep by the Second Investigator of the project.

I agree to participate in this project, realising that I may withdraw at any time.

I agree that the interview may be recorded on audio tape as data on the condition that no part of it is included in any presentation or public display.

I agree that research data collected for the study may be published or provided to other researchers on the condition that anonymity is preserved and that I cannot be identified.

Name of Participant:……………………………………………………………………………………………………………………

Signature:……………………………………………………………………………………………………………………………………

Date:……………………………………………………………………………………………………………………………………

Names of Principal Investigators:……………………………………………………………………………

Signature:……………………………………………………………………………………………………………………………………

Date:……………………………………………………………………………………………………………………………………
Follow Up Letter

An Exploration of the Psychological Experiences of Commissioning Gestational Surrogate Couples

Dear

Recently we sent to you a letter from Dr Roger Cook and an introductory letter from Jacqueline Tracey regarding your potential participation in the project entitled, ‘An Exploration of the Psychological Experiences of Commissioning Gestational Surrogate Couples’. If you are still interested in participating in this project please contact Jacqueline on 0425 782 369 to arrange an interview time.

If you have not already received an introductory pack outlining the project and explaining your part in it we can arrange to forward this on to you. If you are no longer interested in participating please ignore this letter as this will be our final follow up contact.

Thank you for your time and for considering taking part in this project.

Kind regards

Roger Cook
Principal Investigator
☎ 03 9214 8358
Fax 03 9819 6857
Email rcook@swin.edu.au

Jacqueline Tracey
Student Investigator
☎ 0425 782 369
Email aggelos@iinet.net.au
**APPENDIX L**

**CODES USED BY TRANSCRIBING SERVICE**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>F</td>
<td>Female member of the couple being interviewed</td>
</tr>
<tr>
<td>M</td>
<td>Male member of the couple being interviewed</td>
</tr>
<tr>
<td>B</td>
<td>Baby whose birth has come about through a surrogacy arrangement</td>
</tr>
<tr>
<td>B1</td>
<td>Another child of the couple</td>
</tr>
<tr>
<td>B2</td>
<td>Another child of the couple</td>
</tr>
<tr>
<td>S</td>
<td>Surrogate</td>
</tr>
<tr>
<td>SS</td>
<td>Surrogate spouse</td>
</tr>
<tr>
<td>R</td>
<td>Roger Cook</td>
</tr>
<tr>
<td>P1; P2...</td>
<td>Other people mentioned on tape</td>
</tr>
<tr>
<td>Dr 1; Dr 2...</td>
<td>For any doctors mentioned</td>
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<tr>
<td>X, Y, Z</td>
<td>Other children (in this case children of the surrogate)</td>
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### APPENDIX M

### COUPLE CODES

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<tr>
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<th>Pseudonym</th>
<th>Transcript No.</th>
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<tr>
<td>1</td>
<td>Ann &amp; Adam</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>Bett &amp; Bob</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>Catt &amp; Colin</td>
<td>3</td>
</tr>
<tr>
<td>4</td>
<td>Delia &amp; Doug</td>
<td>4</td>
</tr>
<tr>
<td>5</td>
<td>Elise &amp; Edward</td>
<td>5</td>
</tr>
<tr>
<td>6</td>
<td>Feroze &amp; Filippe</td>
<td>6</td>
</tr>
<tr>
<td>7</td>
<td>Gia &amp; Grant</td>
<td>7</td>
</tr>
<tr>
<td>8</td>
<td>Hannah &amp; Hal</td>
<td>8</td>
</tr>
<tr>
<td>9</td>
<td>Ivy &amp; Isaac</td>
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<td>10</td>
<td>Jo &amp; Jack</td>
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<tr>
<td>11</td>
<td>Kara &amp; Keith</td>
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<tr>
<td>12</td>
<td>Lara &amp; Larry</td>
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<tr>
<td>13</td>
<td>Mel &amp; Moe</td>
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<tr>
<td>14</td>
<td>Nell &amp; Neil</td>
<td>14</td>
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<tr>
<td>15</td>
<td>Olivia &amp; Oscar</td>
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</tr>
<tr>
<td>16</td>
<td>Pearl &amp; Peter</td>
<td>16</td>
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<tr>
<td>17</td>
<td>Queenie &amp; Quan</td>
<td>17</td>
</tr>
<tr>
<td>18</td>
<td>Rachel &amp; Roger</td>
<td>18</td>
</tr>
</tbody>
</table>
APPENDIX N

RETURN REPLY SLIP

Jacqueline Tracey
C/o Assoc. Prof. Roger Cook
Faculty of Life and Social Sciences
Swinburne University of Technology
Hawthorn 3122

Dear

As I may have mentioned to you when we conducted our recent interview, many of the participants involved in the study entitled ‘An Exploration of the Psychological Experiences of Commissioning Gestational Surrogate Couples’ have asked for their contact details to be released to other couples within the study. Individuals and couples have suggested that they might benefit from talking to and sharing resources with other people who have gone through, or who are about to go through similar experiences to their own.

If you are still interested in being placed on a database to be circulated amongst the couples in the study only, please complete the form below and return it in the SAE provided. At this stage Assoc. Prof. Cook will contact those individuals privately who have stated that they would like to be available to new couples embarking on a commissioning gestational surrogacy arrangement.

Thank you once again for being involved in the study. I have just about finished collecting all the data and then will begin the mammoth task of analysis. I will keep you posted with regard to my progress.

Kind Regards

Jac Tracey

..................................................................................................................................................................................

I .......................................................... & I.......................................................... give permission for my contact details to be released to other couples in the study entitled, ‘An Exploration of the Psychological Experiences of Commissioning Gestational Surrogate Couples’.

<table>
<thead>
<tr>
<th>Name:</th>
<th>Contact Details</th>
<th>Information Outstanding</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

Signature of Participant 1: ..........................................................Date:.........................

Signature of Participant 2: ..........................................................Date:.........................
APPENDIX O  Norbeck’s (1981) Social Support Questionnaire

There is a special person who is around when you are in need.
1=Strongly agree
2=Agree
3=Slightly agree
4=slightly disagree
5=Disagree
6=Strongly disagree

There is a special person with whom you can share joys and sorrows.
1=Strongly agree
2=Agree
3=Slightly agree
4=slightly disagree
5=Disagree
6=Strongly disagree

Your family really tries to help you.
1=Strongly agree
2=Agree
3=Slightly agree
4=slightly disagree
5=Disagree
6=Strongly disagree

You get the emotional help and support you need from your family.
1=Strongly agree
2=Agree
3=Slightly agree
4=slightly disagree
5=Disagree
6=Strongly disagree

You have a special person who is a real source of comfort to you.
1=Strongly agree
2=Agree
3=Slightly agree
4=slightly disagree
5=Disagree
6=Strongly disagree

Your friends really try to help you.
1=Strongly agree
2=Agree
3=Slightly agree
4=slightly disagree
5=Disagree
6=Strongly disagree

You can count on your friends when things go wrong.
1=Strongly agree
2=Agree
3=Slightly agree
4=slightly disagree
5=Disagree
6=Strongly disagree
You can really talk about your problems with your family.
1=Strongly agree 2=Agree 3=Slightly agree 4=Slightly disagree 5=Disagree 6=Strongly disagree

You have friends with whom you can share your joys and sorrows.
1=Strongly agree 2=Agree 3=Slightly agree 4=Slightly disagree 5=Disagree 6=Strongly disagree

There is a special person in your life who cares about your feelings.
1=Strongly agree 2=Agree 3=Slightly agree 4=Slightly disagree 5=Disagree 6=Strongly disagree

Your family is willing to help you make decisions.
1=Strongly agree 2=Agree 3=Slightly agree 4=Slightly disagree 5=Disagree 6=Strongly disagree

You can talk about your problems with your friends.
1=Strongly agree 2=Agree 3=Slightly agree 4=Slightly disagree 5=Disagree 6=Strongly disagree

Your spouse/partner supports (or would support) your efforts not to smoke.
1=Strongly agree 2=Agree 3=Slightly agree 4=Slightly disagree 5=Disagree 6=Strongly disagree

You have some family or friends who help you (or would help you) not to smoke.
1=Strongly agree 2=Agree 3=Slightly agree 4=Slightly disagree 5=Disagree 6=Strongly disagree
<table>
<thead>
<tr>
<th>NO.</th>
<th>INTERPRETATIVE LABEL</th>
<th>UNITS OF PSYCHOLOGICAL MEANING</th>
</tr>
</thead>
</table>
| 1.  | Anxiety                                    | • That the process won’t work  
• About the reactions of others  
• During the process concerning aspects of the process |
| 2.  | Confusion                                  | • About the lack of information  
• About conflicting information |
| 3.  | A Desire for Change                        | • No travel  
• Less cost  
• Medical rebates  
• More available information  
• Process available in Victoria  
• Reform to birth certificates |
| 4.  | Determination & Commitment                 | • Being completely focused on having a child |
| 5.  | Desperation & Hopelessness                 | • About failed transfers  
• About having to stop the process |
| 6.  | Disempowerment & Lack of Control           | • At the apparent lack of information before and during the process  
• At being ‘at the mercy’ of professionals in the process |
| 7.  | Excitement                                 | • About any possible transfer success  
• At the birth of a child |
| 8.  | Exhaustion                                 | • Emotional exhaustion  
• Physical exhaustion |
| 9.  | Financial Stress                           | • At the mounting costs  
• At not being able to predict future costs |
| 10. | Frustration & Anger                        | • With the system  
• With interstate travel  
• At the lack of information  
• At varying information  
• At difficulties surrounding issue of birth certificate |
| 11. | Gratitude                                  | • Toward the surrogate |
| 12. | Guilt                                      | • For what the surrogate goes through  
• Regarding the process seemingly being pushed ‘underground’ |
| 13. | Isolation                                  | • As a couple in the process  
• As a male in the process |
| 14. | Philosophical Acceptance                   | • Of the decision for surrogacy  
• Of the decision to stop surrogacy |
| 15. | Positive Experience & Support              | • From the surrogate  
• From family & friends  
• From legal profession  
• From medical profession  
• From wider community |
| 16. | Stress                                     | • At the system  
• At the process  
• At the logistics during the process |
| 17. | Strong Relationship with Partner           | • Between the individuals in each couple |
| 18. | A Traumatic Experience                     | • At the long process  
• At the failed process following a long process |
| 19. | Vulnerability                              | • About what others might think  
• At having to divulge personal information to medical/legal/ethics professionals |
REFERENCES


www.feministe.us/blog/2008/06/25/surrogate-exploitation


George, Kaplan & Main. (1985). *The Adult Attachment Interview*. Berkley: University of California,


McIntosh, D. N., Silver, R. C., & Wortman, C. B. (1993). Religion’s role in adjustment to a negative life event: Coping with the loss of a child.


