Surrogacy: The Psychological Issues

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Surrogacy: the psychological issues

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Abstract *Surrogate motherhood arrangements have increased in recent years and yet the practice remains controversial. The present paper evaluates the limited available research evidence. Issues discussed include: psychological stressors associated with surrogacy, attitudes towards the practice, motives of surrogate and commissioning couple and issues pertaining to their relationship, the question of the surrogate relinquishing the child to the commissioning couple and the child's subsequent development, and what the children are told of their origin. With regard to motives of surrogates, comparison is made with motives expressed by donors in other fertility-related and biomedical contexts. The question of the surrogate relinquishing the child she bears is discussed in relation to attachment during pregnancy. Finally, with regard to the children conceived in this way, comparison is made with research findings relating to children conceived from IVF and DI. From the limited research and anecdotal evidence available a generally positive picture emerges of surrogates motivated largely by altruism, who express few concerns about separating from the child conceived as a result of the arrangement, with parents who are functioning well and the children themselves subsequently showing good adjustment. It is concluded that further systematic research is required to verify whether this picture is indeed correct.*

Introduction

Infertility is usually defined as the failure to conceive after 12 months of regular sexual intercourse without the use of contraception (Benson, 1983; Cook, 1987; Valentine, 1986; WHO, 1992). There are no general population-based surveys of the incidence or prevalence of infertility; however, according to a regional investigation undertaken in the UK in the 1980s, at least one in six couples will require specialist help for an infertility problem at some time in their lives (Hull *et al.*, 1985). This estimate is at the upper end of general estimates which suggest that between 8% and 15% of couples in the Western world will experience problems with infertility at some stage of their reproductive lives (Berkowitz, 1986; van Balen *et al.*, 1997).

The indications are that infertility in the Western world has increased among younger people. There are a variety of reasons for this including problems posed by sexually transmitted diseases, exposure to occupational hazards and environmental toxins and postponing child-bearing, hence increasing vulnerability to age-related

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biologic risk of infertility. As a result, the period for attempting conception has been condensed into a shorter time period and is likely to take longer (Aral & Cates, 1983).

Yet, the opportunity to become a parent has been described as one of the most important developmental milestones in a person's life (Heinecke, 1995). Indeed, most young adults assume that at some point in their lives they will have children and raise a family (Regan & Rowland, 1985). Thus, an encounter with a personal fertility problem is likely to come as a surprise (Andrews *et al.*, 1991). Once confronted with such an issue, couples may face years of uncertainty as to whether or not they will be able to have a child of their own. In this regard it is perhaps not surprising that reproductive failure can be a particularly distressing experience; indeed, some authors have referred to infertility as a life crisis (Cook, 1987; Menning, 1975).

These factors, allied with the development of technology intensive treatments and, in the UK, the decline in the availability of adoption as an alternative to infertility, has fuelled the demand for infertility-related investigations and treatments (Taub, 1988); a similar picture is evident in other parts of Western society (Leiblum, 1997). Indeed, it is estimated that between 72% and 95% of couples experiencing fertility difficulty will seek medical help (Templeton *et al.*, 1995). One of the more recent and, perhaps, most controversial methods of becoming a parent and achieving a family is via surrogate motherhood arrangements.

Surrogacy raises a range of psychological issues and yet there is a general lack of research on the topic (Brazier *et al.*, 1998). From the search for a surrogate through to concerns that the surrogate may not relinquish the child, the commissioning couple are faced with a number of stressors in addition to those posed by their fertility difficulties alone. How will the surrogate relate to the commissioning couple and visa versa? What should the surrogate tell her own children and what will the commissioning couple tell their hoped for child? In order that they can both counsel and give appropriate advice to families and surrogates seeking such an option it is important for psychologists and other mental health professionals to understand the issues involved. The present overview evaluates the available psychosocial research undertaken to date in relation to surrogacy drawing where appropriate on research findings in relation to donor insemination (DI), in-vitro fertilization (IVF) and related procedures and other branches of medical science where biomedical donations occur.

Surrogacy arrangements

While surrogacy has undoubtedly increased in the past two decades, the incidence is impossible to estimate due to the many informal arrangements which take place (BMA, 1996). By the 1990s many hundreds of children were known to have been born through surrogacy arrangements in the USA (Bartels, 1990) while the number of live births from such arrangements in the UK were thought to exceed 100. By 1998 up to 8000 women had approached surrogacy agencies in an attempt to have a child (van den Akker, 1998a).

Surrogacy arrangements vary considerably. Some may involve a relative of the commissioning woman such as her sister (Kirkman & Kirkman, 2002), a mother carrying a child for her daughter or a daughter carrying a child for her mother (Brazier *et al.*, 1998). Other instances involve a known friend, although most involve a surrogate unrelated and unknown to the commissioning couple until she is sought out by them. In some cases the surrogate mother carries a baby who is biologically related to the commissioning parents, as a result of IVF using the commissioning women's egg

and her partner's spermatozoa. This has been termed gestational surrogacy (ASRM, 1990). In other cases, the child may be related genetically to the surrogate mother and not to the mother who adopts and brings up the child. This has been referred to as genetic surrogacy (ASRM, 1990). The success rates from surrogacy procedures are likely to be highly variable with good success rates from the technically more straightforward (insemination of surrogate with the commissioning males' semen) and lower rates from the technically more complex (any procedure involving IVF). The two arrangements raise comparable but also some differing psychological issues. The former procedure has to be undertaken within a health care context and hence contact with mental health professionals is likely and counselling may be available. The latter procedure can be undertaken informally. This, allied with the genetic link of any resultant child with the surrogate, may increase the risk of problems which could have been aired had mental health professionals been involved.

Although controversies surrounding surrogacy arrangements have raged for the past two decades, the notion of such arrangements is not entirely new, having been documented from biblical times. In the Book of Genesis Abram's wife Sarai, who had no children, instructed her husband to sleep with her servant Hagar so that Sarai might have a family through such means. It could perhaps have served as a salutary lesson for more recent times to note that subsequently Sarai (the social mother) drove Haga (the biological mother) and the resultant child Ishmael from Abram's house!

The earliest reported contemporary surrogate mother case is generally agreed to have been in 1980 (Holder, 1988). In the UK the 1985 Surrogacy Arrangement Act legalized surrogacy, provided it was non-commercial, although a subsequent act rendered any arrangements and contracts unenforceable in law (HFEA, 1990) (for a full review of the development of law and practice in relation to surrogacy in the UK see Brazier *et al.*, 1998).

The public profile of surrogacy has been highlighted in the UK by the case of Baby Cotton (Cotton & Winn, 1985) and in the US by the case of Baby M. In the former case Social Services intervened and court action was required in order that the child could be placed with its 'new' parents some 5 days after the birth. In the latter instance the biological mother initially handed over the child to the commissioning couple taking it back some 3 days later. After 3 months on the run with the child, a court order gave custody of the child to the commissioning couple. Moral, ethical and legal issues raised by the Baby M case have been debated in numerous publications (e.g. Lichtendorf, 1989; Steinbock, 1988).

In addition, such cases have highlighted psychosocial concerns in relation to surrogacy. Arguments against surrogacy focus on a number of issues including the need to protect the potential surrogate from a choice she may later regret; the risk of exploiting a surrogate who is undertaking a risk for financial gain; and the observation that children are not property to be bought and sold (Brazier *et al.*, 1998).

Infertility and psychological distress

While treatment options have increased so has the emotional investment and time required of couples seeking such treatment (van Balen *et al.*, 1997). Edelmann *et al.* (1994) report that of their sample of 152 couples attending an IVF clinic, the period over which they have been attempting to conceive ranged from 6 months to 15 years, while the time they had been undergoing infertility-related investigations ranged from 3 months to 14 years. In a further study van den Akker (2001a) reports that her

sample of 42 women recruited from three UK infertility clinics had known about their infertility for an average of 5 years (ranging from 1 to 19 years). Of the treatments they had received, six had undergone GIFT (Gamete IntraFallopian Transfer), 17 IVF (in-vitro ferilization) and ICSI (intra-cytoplasmic sperm injection), six had received pharmacological treatment and eight had tried egg donation. In the case of couples seeking surrogacy arrangements most tend to be older, have known of their difficulty conceiving for many years and have undergone many prior investigations and treatment procedures. Blyth (1995) notes that his sample of 20 commissioning couples all recounted histories of significant gynaecological problems and/or unsuccessful attempts to start a family as well as experiences of repeatedly unsuccessful IVF attempts.

While some studies suggest that the longer the known period of infertility the more distress such couples will experience (O'Moore *et al.*, 1983) other studies have not found such an effect (Connolly *et al.*, 1987; Edelmann *et al.*, 1994). Indeed, Edelmann *et al.* (1994) found that the longer the period of time over which couples had been attempting to resolve their problems the stronger their marital relationship. One issue here may be that, for some couples at least, time leads to a resolution of their difficulties (either with successful conception or a decision to remain childless), while for others it may lead to an increasingly desperate search for a medical solution to their difficulties; in many instances surrogacy offers them a last chance of having a child of their own. Those seeking surrogacy arrangements may then be potentially more vulnerable psychologically. It is worth noting, however, that research tends to indicate that while the experience of infertility is undoubtedly distressing (e.g. Freeman *et al*, 1985; van Balen & Trimbos-Kemper, 1993), those seeking treatment for infertility are generally well adjusted (Connolly *et al.*, 1992; Edelmann *et al.*, 1994). Indeed, most clinic populations of infertile couples are likely to be a self-selected set who feel able to cope with the emotional demands entailed (Edelmann *et al.*, 1994). There is no reason to assume that this will not also apply to those pursuing surrogacy arrangements.

Finding a surrogate

A further additional stressor in relation to surrogacy relates to the difficulty involved in finding a compatible surrogate. Van den Akker (2000) reports that, of her 29 women seeking surrogacy arrangements, eight had negotiated with two potential surrogates, three had negotiated with three and one had negotiated with four different surrogates.

Clearly in such contexts the reasons for the failure to proceed with a given surrogate can have differential effects psychologically. A realization at an early stage of negotiation that common views are not shared or that the parties are not going to be able to 'work together' is likely to be little more than a minor setback. An initial attempt to proceed with a surrogate, who then changes her mind (hopefully prior to conception having occurred), is likely to result in a greater degree of psychological turmoil. It is at this stage that an opportunity to discuss matters with a mental health practitioner could be most helpful. Although this may not eliminate problems altogether at least potential differences and concerns could be aired. In relation to this it is worth bearing in mind that with genetic surrogacy, that is, where the child is related to the surrogate and where self-insemination is used, the parties concerned can proceed in the absence of any medical contact and hence without the need for the involvement of any health care provider. Any counselling or supportive therapy is thus dependent upon their initiative and many may not be aware of whom to approach or

may consider it superfluous to their needs. It is thus in such instances where there is the greatest likelihood that problems might occur.

Psychological assessment

Particularly in the USA, psychologists and other mental health professionals are asked to screen and counsel both couples seeking surrogacy arrangements and women volunteering to be surrogate mothers (Franks, 1981; Slovenko, 1985). In the USA, selection procedures are more stringent partly because the practice is more regulated and commercial (Ragone, 1994). In the UK 'screening' does not occur and arrangements are often based on trust between people who start as complete strangers (van den Akker, 1999). Given that we know very little at present about the consequences of surrogacy, the most important role of assessment is to anticipate what the reactions and responses might be (Harrison, 1990). The main aims being to judge whether problems will occur in the relationship between donor couple and host and to judge whether the host will feel able to part with the child after the birth (Edelmann, 1995, 2003).

The limited research examining the psychological profile of surrogates tends to suggest that they are well adjusted (Franks, 1981; Hanafin, 1987). In both studies the MMPI was administered to small samples of surrogates with both finding that the profiles were unremarkable with little deviation from the norm.

Attitudes towards surrogacy

It has been suggested that surrogate motherhood raises 'intense feelings of endangering the family and society, evoking adultery and incest taboos and raising legal concerns and theological objections' (Shiloh *et al.*, 1991). Some have argued that women who do not require surrogacy for reasons of infertility may want access to it because of career demands, convenience or a simple fear of or distaste for pregnancy (Field, 1988). While there is no evidence that this has occurred, concerns remain that surrogacy serves to increase commercialization and the co-modification of pregnancy and childbirth.

Indeed, the results of two studies investigating attitudes towards surrogacy reflect this negative view. In a survey of over 5,000 women of reproductive age living in Canada, three-quarters disapproved of commercial surrogacy (Krishnan, 1994). A smaller survey of 400 randomly selected residents in the US also indicated that the majority disapproved of surrogate motherhood (Wiess, 1992).

This clearly impacts upon potential surrogates who report awareness of the ambivalence and potential hostility that other people might have towards surrogacy arrangements. They also tend to receive less familial and social support than non-surrogate mothers (Fischer & Gillman, 1991). Given that there is consistent evidence for the relationship between emotional support and psychological well-being (Cohen & Wills, 1985) one could argue that the relative lack of such support for surrogate mothers may leave them particularly vulnerable. Anecdotal evidence suggests that some may receive support from their partners although this may not always be the case (Edelmann, 1994).

Motives for acting as a surrogate

Biomedical donation is common place in health care. The free donating of blood has sustained health care provision in Western society while bone marrow donation and

organ donation are increasing. Payment for such actions is generally viewed in a negative light. In relation to blood donation, altruism and humanitarian motivation remain the reasons most often cited for donation (Pallianin & Callero, 1991); similar reasons are cited by bone marrow donors who also emphasize empathy for the recipient (Switzer *et al.*, 1997).

Donation is also widespread in the treatment of infertility (Sauer & Paulson, 1992). Semen donation has been widely practised for over half a century although doubts have often have been raised about the motives of such donors. Haimes (1993), reports that members of the Warnock Committee frequently raised such concerns. However, the results of research studies indicate that altruism and knowing someone who is infertile are frequently cited motives (Daniels, 1989), although for younger donors financial recompense can also be of importance (Daniels *et al.*, 1996). Similarly with regard to female oocyte donors a desire to help infertile couples and knowledge of the difficulties of infertility are frequently cited motives (Fielding *et al.*, 1998; Power *et al.*, 1990; Schover *et al.*, 1991).

While egg donation clearly involves a greater physical investment in the donation process than is the case for semen donation, the donation of one's body for 9 months of pregnancy, together with tests and treatments which may be required, clearly necessitates a major life investment on the part of the surrogate. Given that most surrogates have children of their own (Blyth, 1994; Edelmann, 1994; Franks, 1981; Parker, 1983) it is not surprising that most express a general awareness about the negative as well as the positive aspects of pregnancy.

The limited research which exists indicates that, as for other forms of biomedical donation, altruism is a prime motivating factor reported by most women acting as surrogates; many also perceive surrogate motherhood as a way of obtaining a sense of value and achievement (Blyth, 1994; Edelmann, 1994). Again as for oocyte donation, few refer to money as a prime motivating factor and, indeed, most surrogates themselves think that it should not be (Blyth, 1994). While reimbursement for the discomfort, inconvenience, risk and costs incurred is expected, one might suspect that if financial factors were the major motivation for a surrogate she may well have underestimated the demands of the task at hand. Unfortunately, as Brazier *et al.* (1998) note, payment may operate as an inducement to enter into surrogacy for some women suffering financial hardship. Such co-modification of child-bearing relates to negative attitudes towards surrogacy and is unlikely to create the most favourable environment for such an arrangement.

A very few surrogates see surrogacy as a way of dealing with feelings of guilt or anxiety about past actions such as the loss of a child or their own placement for adoption (Parker, 1983). Steadman and McCloskey (1987) rightly raise a note of caution about such women acting as surrogates.

Motives for seeking a surrogate

It has been argued that childlessness makes couples feel like 'second-class' citizens and that this drives the desire of many to become parents. A more intrinsic motive is their desire to continue the family's genetic line (Schwartz, 1990). A number of studies have noted the expressed desire of infertile couples to have a biological connection between the child and one of the prospective parents rather than to adopt an unrelated child (Kane, 1988; Langdridge *et al.*, 2000). Langdridge *et al.* (2000) note that couples in their study stated that they wanted a child that is part of both of them or 'one's own'.

With regard to basic intrinsic reasons for wanting children those factors most often cited are the need to give and receive love and to experience the enjoyment of children (Callan, 1982; Langdridge *et al.*, 2000). These tend also to be the motives expressed by commissioning couples in surrogate arrangements (Edelmann, 1994).

As Schwatz (1990) also notes, however, with regard to surrogacy, other possible and somewhat more questionable motives relate to possible health risks or convenience. The Warnock Report (1984) voiced strong concerns about the prospect of surrogacy for convenience. However, such instances are unlikely to occur in relation to licensed treatment centres. The HFEA in its code of conduct stresses that surrogacy should only be considered when it is 'physically impossible or highly undesirable for medical reasons for the commissioning mother to carry the child'. The BMA (1996) offers a similar statement. Inevitably such constraints cannot be exercised in cases of self-insemination by the surrogate with the commissioning males' semen. However, Blyth (1995) in the one study seeking to address this issue, reports that none of his sample commissioned surrogates due to possible health risks or convenience. It is likely that such instances will be rare.

The relationship between the donor couple and surrogate

While some surrogate arrangements are between friends or family members, the majority of surrogacy arrangements involve individuals who are total strangers at the outset. In relation to this Blyth (1994) reports that surrogates clearly regard the arrangement as more than a simple 'business' arrangement which will terminate once the baby has been delivered to the commissioning couple. As he also notes, however, the relationship between surrogate and commissioning couple is also not a commonplace friendship but a relationship which is closely inter-related with their views about the welfare of the surrogate child.

It is of interest to note that of her 29 participants, van den Akker (2000) reports that only four expected that there would be some difficulties during the surrogacy process. Thirteen of the commissioning couples were using the surrogate's egg so that the resultant child would be genetically related to her. Although problems are the exception rather than the rule, the few which do arise tend to involve genetic surrogacy.

Blyth (1995) notes that in his sample of 20 commissioning couples it was generally agreed with the surrogate mother that the commissioning mother would be present at the birth of the child.

While some commissioning couples and surrogates prefer to have no contact after the baby has been born, many make arrangements for continuing contact including exchange of photographs, letters, cards, telephone calls and visits. Van den Akker (2000) reports that of her sample of 29 commissioning women almost half expected to have a committed relationship with the surrogate mother and to get on well with each other. As Blyth (1995) points out, however, despite positive intentions, such continuing contact could be problematic. The surrogate mother would be constantly reminded about the child she has given up and the commissioning parents may fear interference in the upbringing of 'their' child. A similar point is made by Brazier *et al.* (1998). Steadman and McCloskey (1987) note that there may be occasions when the surrogate and the commissioning couple have developed a strong personal relationship prior to the baby's birth but that the commissioning couple then terminate the relationship abruptly after delivery. As they further note, such issues and concerns

strengthen the argument in favour of mandatory counselling for the surrogate mother before, during, and after the pregnancy (Steadman & McCloskey, 1987).

The issue of relinquishing the child

Given the issues and concerns raised on both sides of the Atlantic (Lichtendorf, 1989) about surrogate mothers relinquishing the baby subsequent to its birth, it is perhaps not surprising that the question of separating from the child is a central issue. Some commissioning couples are naturally concerned that it might be emotionally difficult for the surrogate to relinquish the baby (van den Akker, 2000). Blyth (1994) notes that the surrogate mothers he interviewed spoke of their sorrow and distress about parting with the child. However, these emotions were mixed with a sense of happiness for the commissioning couple and a sense of satisfaction for the part they had played.

Theoretical descriptions of the psychology of pregnancy suggest that women develop varying degrees of attachment during pregnancy (e.g. Leifer, 1990; Rubin, 1984). This prenatal attachment is influenced by a number of variables including maternal age and their attitude towards the pregnancy (Siddiqui *et al.*, 1999). These latter factors may be of importance in relation to the surrogate's ability to separate from the baby after its birth. Most surrogate mothers tend to be in their late twenties or thirties having usually raised a family of their own (Blyth, 1994; Edelmann, 1994). In addition, there is evidence that surrogate mothers exhibit less of an attachment to the foetus than is the case with non-surrogate mothers (Fischer & Gillman, 1991). As these latter authors also note, a common explanation given by surrogates in response to the question of how their surrogate pregnancy differed from previous pregnancies is that the surrogate knows the baby is not hers and considers it the adoptive couple's baby from the very beginning of the process. As a result, the surrogate mother reports feeling less attached toward the resultant child.

How many surrogates subsequently change their mind and refuse to part with the child is unknown. Brazier *et al.* (1998) state that 'such evidence that we have been able to obtain suggests that only in a handful of cases (perhaps 4–5% of surrogacy arrangements) does the surrogate refuse to hand over the child'. However, as these authors also comment 'The small number of "unsuccessful" surrogacy arrangements does not in any sense minimise the acute pain such circumstances must generate' (p. 26).

The children

The Warnock Report's (1984) concerns that surrogacy might be psychologically damaging or degrading to the child, particularly if there was a financial arrangement involved raises the spectre of the co-modification of children. Clearly, the interests of children born as a result of fertility treatment should be paramount. This is recognized both by the British Medical Association who have stated that while surrogacy is an 'acceptable option of last resort', 'the interests of the potential child must be paramount' (1996). The HFEA (1990) have also stated that one of the conditions of a treatment licence for centres offering fertility treatment is that 'a woman shall not be provided with treatment services unless account has been taken of the welfare of any child who may be born as a result of the treatment (including the need of that child for a father) and of any other children who may be affected by the birth'. This is included in the HFEA's Code of Conduct (p. 17). Clearly it is not possible to exercise such

control in the case of surrogacy arrangements undertaken without the aid of health case organizations.

Most surrogates choose to inform their children of their plans if they consider them old enough to understand (Blyth, 1994; Edelmann, 1994). In this context, it has been suggested that surrogate arrangements may engender anxieties in the surrogate's own children (Brazier *et al*, 1998; Holder, 1988) although there is no data pertaining to this possibility.

The child's development and parenting issues

A number of authors have argued that assisted conception may have adverse consequences for children's psychological development and for parenting. For example, Burns (1990) argues that parents who have experienced difficulty conceiving may over invest in their longed for child while others have suggested that such parents mat be overprotective of their children or have unrealistic expectations of them (Hahn & DiPietro, 2001; van Balen, 1998). In the context of donor insemination some have argued that because of the lack of genetic link between the 'father' and the child they could be expected to be more distant from their child (Snowden & Snowden, 1998).

In spite of such concerns, research to date evaluating the impact of being a child conceived via the new reproductive technologies suggest few, if any, psychological differences between children conceived by such means and those conceived naturally with regard to emotions, behaviour, the presence of psychological disorders or their perceptions of the quality of family relationships (Colpin & Soeren, 2002; Golombok *et al.*, 1995, 1996, 1999, 2001). Studies of IVF families indicate that the parents are well adjusted and with a good relationship with their children. Intriguingly, research assessing parents tends to suggest that quality of parenting in families conceived by assisted conception is superior to parenting in families with a naturally conceived child (Golombok *et al.*, 1993). Mothers of children conceived via IVF show greater warmth and emotional involvement (Hahn & DiPietro, 2001). The studies summarized here involved families created by donor insemination, egg donation or invitro fertilization; no studies to date have specifically assessed children born to surrogate mothers.

Although Steadman and McCloskey (1987) have suggested in relation to surrogacy that 'the feelings of inadequacy that usually accompany infertility may be magnified and may have seriously deleterious effects on the development of the child from infancy onward' (p. 548), there are no data to substantiate such a view. Indeed, the research findings noted earlier tend to suggest a very positive outlook in terms of child development.

Informing the children

There is limited data relating to the question of whether parents are likely to inform children born of surrogate parents about their origin (Edelmann, 2000). Van den Akker (2001a) reports that of a group of adoptive parents, over 80% of whom were subfertile, 65.5% reported that they would tell a child his or her origin if they were conceived via a surrogacy arrangement, 59.6% would inform their family but only 42.5% would inform friends. This compares with 59% who would tell their child his or her origins if they were conceived via Donor Insemination and 77.8% who would tell their child if they were conceived via IVF. In a further study with a small group of 42 women attending infertility clinics 42.9% reported that they would tell a child his or

her origins if they were conceived via a surrogacy arrangement (21.4% were unsure and 35.7% would not tell), 50% would tell their family (16.7% were unsure and 33.3% would not tell), while only 33.3% would tell their friends (26.2% were unsure and 40.5% would not tell). This compares with 40.5% who would tell their child his or her origin if they had been conceived via donor insemination and 71.4% would tell if their child was conceived via IVF (van den Akker, 2001b).

Research in relation to children born as a result of DI and IVF suggests that in the former case parents are likely to keep their child ignorant of its origin while they are less likely to do so in the latter instance (Cook *et al.*, 1995; Edelmann, 1989, 1990; McWhinnie, 1996). When male infertility becomes an issue, secrecy seems to be preferred; such secrecy seems to be less prevalent in the case of female infertility and in most cases involving surrogacy arrangements. Indeed, in a small sample of women ($N=29$) who were or had been actively engaged in surrogate arrangements, 28 said they would tell their child of his/her origins. Only 10 said they would tell their child its origins if they had had to use donor sperm or donor eggs (van den Akker, 2000). In a further comparable sample of 20 women actively involved in surrogacy arrangements all believed that the child should be told the full truth about his or her genetic origins (Blyth, 1995), a commitment shared with the surrogate mothers (Blyth, 1994).

If secrecy is preferred there is inevitably the possibility that this might be harmful to the child. As Menning (1981) comments, family secrets are among the most pernicious and destructive forces in the family. Certainly with regard to adoption, the benefits of disclosure have been noted (Howe *et al.*, 2000). However, if the decision is to tell the child there are no hard and fast rules about how they should be informed, when and with what message. Appropriate counselling can clearly help in this regard (Edelmann, 2000).

Counselling

The importance attached to psychological support and counselling for involuntarily childless couples has increased in the past two decades. However, there has been little by way of systematic appraisal of need, and issues such as who might require additional assistance and what form it should take are important in planning services. Particular questions which should be explored include the motivation of the surrogate, the anticipated future relationship between commissioning couple and surrogate and the views of the parties wider family network and what they intend to tell the hoped for child.

The specific aim of counselling is not to limit psychological disturbance. As noted, studies tend to suggest that infertile couples are generally well adjusted (Connolly *et al.*, 1992; Edelmann, 1994) and counselling in relation to reproductive technologies does not further reduce general anxiety (Connolly *et al.*, 1993). Counselling can, however, help to ease specific anxieties, facilitate decision making and ensure that issues are resolved at an early stage before difficulties have a chance to arise. In their report, Brazier *et al.* (1998) concluded that counselling and follow-up procedures should be made available to all parties.

Concluding comments

As van den Akker recently noted (1998b) surrogate motherhood is a 'hot topic' for discussion in the media, the medical and scientific community and in government.

While there are very evident psychological issues which need to be addressed in relation to surrogacy, research is still limited and much 'evidence' is anecdotal or drawn from evaluations of psychological issues in relation to other reproductive technologies. That research which exists is based upon interviews with small samples of either commissioning couples or surrogates. There has been little by way of systematic data collection and no comparative or follow-up studies.

Little is known about the impact of surrogacy on the parties concerned either during the process of securing the arrangement, the pregnancy, or the hoped for birth of the child. There has been no research evaluating any possible longer term effects. Little is known of the nature of either the relationship between surrogates and commissioning couples or the form of relationship which is most (or least) desirable. At present it is only possible to speculate about the circumstances under which surrogates might experience problems. Longitudinal studies assessing surrogate and commissioning couple from the outset of the arrangement to the time of the hoped for birth and then subsequently as the child develops are required. Such research would highlight both profiles and circumstances under which problems might arise.

The motives of the surrogate, her support network and her attachment to the unborn child during pregnancy are all likely to be factors of importance. Again there is limited systematic research evaluating these issues. There is also an absence of research to date evaluating any possible psychological consequences for the surrogate's own family of her actions.

At present the media and the limited available research present conflicting views of surrogacy. The former inevitably highlight the dramatic and newsworthy and hence publicize instances when problems arise. The more mundane picture, which it is possible to draw from available evidence, is of surrogates, motivated largely by altruism, who establish good rapport with the commissioning couple, and have little difficulty separating from children born as a result of the arrangement, with the children themselves subsequently showing good adjustment. Research is required to establish both whether this latter impression is indeed accurate and to establish those variables most likely to predict when difficulties will arise.

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