Facing Decisions in an Artificial Insemination by Donor Programme

Alison Bonython
Social Worker
Royal Womens
Hospital — Melbourne.

FACING DECISIONS IN AN ARTIFICIAL INSEMINATION BY DONOR PROGRAMME:
Alison Bonython

A couple's experience and social work support.

A service offering artificial insemination with Donor semen (A.I.D.) commenced in June 1976 at the Royal Women's Hospital. This service was established mainly because adoption is no longer readily available to anyone with problems of infertility, the number of adoptable children having been dramaticaly reduced over the last 3 years. Twenty-five percent of infertile couples are so due to the husband's infertility. With the advent of programmes such as at the Royal Women's Hospital, these couples are able to consider an alternative means to having a family, especially if they can extend their view of parenthood beyond the biological aspect, to the rearing of children.

WAITING LIST

Already there is a waiting list of 12-18 months as the programme becomes more widely known. To meet such a demand new donors are constantly needed. A donor is screened medically and tested for his own fertility, then his donated sperm is frozen and stored in a sperm bank. The donor will then be matched with a particular couple and inseminations with the donated semen will begin.

For a social worker actively involved in such a programme, it seems important to look at the steps the couples take before coming onto the programme and the subsequent stages. With each step there may be predictable problem areas but the responses to each experience will obviously vary with each couple. Individual differences will infuence their handling of subsequent experiences. The degree to which a couple will cope will depend largely on the strength of their marital relationship.

OUTLINE OF STEPS: STAGE 1.

1. Attempt by couple to achieve pregnancy.
2. Action towards medical help.
3. Discovery of low fertility or sterility, the existence of an hereditary disease or incompatibility of blood groups.
4. Reaction.
5. Alternatives to be considered.

STAGE 2.

6. Decision to apply for A.I.D.
7. Referral to Gynaecologist in charge.
8. Referral to Social Worker (subsequent interviews).
9. Signing of consent form.
10. Waiting period.

STAGE 3.

11. Preparation.
12. Commencing Inseminations.

STAGE 4

13. When Pregnancy is achieved.
    a. Pregnancy
    b. Delivery
    c. Early Childhood
    d. Child Grows up
14. When Pregnancy is not achieved.
    a. Decision to re-commence inseminations by doctor
    b. Decision to cease inseminations.

STAGE 1.

Any problems the couple may face during this initial stage would be prior to seeing the Social Worker. However, many of these problems are still evident when the couple present to the Social Worker and are often not resolved. Some problems are resolved in the early stages but some problems are not ever resolved.

Attempt for pregnancy:

When the couple makes an actual decision to try for a pregnancy and this doesn't occur, they may have feelings of disappointment and as time goes on, anxiety. This can lead to accusations within the couple.

There is an external pressure that society deems it normal for a couple to have children, and as time goes on family and friends begin to become curious and sometimes a couple may become defensive when parenthood is discussed.

Infertility:

Most couples after a variable time span will seek medical advice. They may then be subjected to many tests, referrals to specialists and expense. In the majority of cases the husband is tested and found to be either oligospermic, that is very low sperm count, or azoospermic — no count at all. Sometimes a couple, or perhaps just a husband, is prepared for this. Mostly they are not and experience feelings of shock, anger, frustration and depression. For some men there is a strong sense of failure to themselves and to their wife. Sometimes a wife may interpret the situation as the "fault" of her husband.

At this point there is strain on the marriage. Some couples even talk of separation; a husband gives his wife the chance to remarry and possibly have children. By the time they see the Social Worker this problem is probably resolved sufficiently for them to consider A.I.D. However, if a pregnancy is not achieved following A.I.D., the possible solution of separation may again be considered. The couples' sexual relationship is often disrupted, particularly if the husband has a strong sense of failure. It is sometimes a joint reaction of "why has this happened to us?" and then "what's the point of a sexual relationship if we can't have children?". These feelings are usually resolved jointly. Again there is the added problem of feelings about the "outside world" and most couples will do anything to prevent their problem becoming common knowledge, feeling that it makes them different from other people.

Reactions:

Reactions of a couple to the problem of reduced fertility vary tremendously. Most of them would go through some of the feelings already mentioned. Some couples are able to accept the situation and move on to the next step fairly quickly, whereas, others need time to think about it and come to terms with it. A couple with a good relationship and communication can help each other at this stage — but they often have to face it alone. This is a time when a Social Worker could assist but is unlikely to be involved.

Occasionally a husband will not accept the doctor's decision that there is nothing more to be done medically, and will seek more tests, operations and treatment with a sense of hope. Most husbands explore all possible avenues in their strong desire to be a fertile partner for their wife. As time passes and there is no improvement, frustration sets in and a feeling of hopelessness.

Alternatives:

Doctors who are aware can discuss with the couple the possible alternatives to be considered if they cannot have children naturally. Adoption is usually the first suggestion. However, the medical profession is now aware of the very long and often inaccessable waiting lists that exist at adoption agencies. Artificial insemination, although practiced for at least 30 years in Melbourne by private doctors, is still a relatively new idea for the general community. It is an unknown area, but as time progresses, more couples who come onto the programme seem to be better informed because of more literature being available and the fact that it has been widely publicised on radio, television and in the press. When A.I.D. is first suggested to a couple, sometimes there are hesitations. The majority of couples feel it is the best solution to their problems. However, if they make a choice not to tell their families or friends, they find themselves increasingly isolated and frustrated at not being able to share with people who matter to them, their feelings about A.I.D. If a couple cannot accept the concept of A.I.D. and cannot accept or get onto a waiting list for adoption, then they may be faced with a childless future, and for some that may in fact be the best choice.

STAGE 2

Areas of Anxiety:

Once a couple feels that A.I.D. is an acceptable alternative to having children naturally, they often face a whole new area of anxieties. Religion could be one. The Roman Catholic Church, the Greek Orthodox Church, the High Church of England and others are opposed to the idea of A.I.D. However, there are active working members of all those churches who take a more liberal view. Ultimately, it is the couple's decision as to whether religion is a barrier or not. Some problems of legality have been overcome by recent changes in the area of Family Law in Victoria. For example, a child conceived by A.I.D. can no longer be considered illegitimate but is legally a child of the marriage. However, some couples still worry about A.I.D. being an "adulterous situation"; some are concerned about the possibility of consanguinous marriages; others wonder what a child could inherit from a donor. These anxieties need to be discussed and worked through. The social worker can be a reassuring support offering factual information and helping the couple to test their own feelings on these issues, and sharing in their concerns. Issues, not yet thought of by the couple, can be raised and discussed.

If a couple can accept parenthood in its widest sense, that is the rearing of children, then they will probably cope with the concept of A.I.D. where one parent is not a biological parent of the child. Frequently it is a woman's strong desire to be pregnant and her husband's understanding of this need that determines their decision on A.I.D.

Referral to Doctor:

When a couple are finally referred to the gynaecologist in charge of the programme, it is their first positive step in the direction of A.I.D. They could present with anxieties wondering — whether they will be accepted or not, or whether the woman's fertility is high enough, as some of the women have their own problems of fertility. If this is so, provided it is treatable, they can be considered for A.I.D. It is an additional barrier of course. At that time also they are told how long it may be before they are likely to start inseminations after all of the intervening steps are completed. At the moment it is about 18 months before a woman is likely to begin inseminations which is another set back for a couple who have already faced delays in starting their family.

Referral to Social Worker:

Following the doctor's initial interview the couple are referred to the Social Worker. The explanation of the Social Worker's role is vital as up to now most couples have faced only members of the medical profession in relation to this problem of fertility. Couples frequently present as very anxious in their first interview with the social worker. They can go through a series of emotionally disturbing experiences relating to being assessed, and to confidentiality. They have varied expectations of the interview. They are concerned that a Social Worker who has not been in this situation herself will not understand what they feel but may look at it from an intellectual angle. Certainly it is my experience that the hypothetical situation (the wife becoming pregnant) discussed during these interviews, could release suppressed feelings or fears when the wife actually begins inseminations. Obviously it is important that a Social Worker is able to allay a lot of these fears and frequently much time in the first interview is spent on these matters.

Consent:

The couple are seen jointly initially and then have subsequent separate interviews. If further interviews are indicated either jointly or separately, they occur. If additional outside expert consultations are required, for example,psychiatric or marriage guidance counselling, referrals are made. Provided there are no contraindications the couple would then proceed to the next step where they sign a consent form allowing us to proceed with the programe. This form offers protection for the couple, for a child who may be born following A.I.D., for the doctors at the hospital, and for the donor. There are usually no problems at this point. For most couples it is the final formal step required and therefore is awaited eagerly.

Ailson Bonython

Once the couple have signed this form they then face an indeterminate wait. Frustrations mount up

at varying stages during this waiting time. Some couples find it difficult to accept that they have to wait, they want to start now. If a woman is into her 30's she is worried about her age and the fact that she will be older again by the time she starts insemination. Obviously all through Stage 2 the couple are subject to external pressures — family and friends who want to know why they haven't any children, what have they done about it, why do they keep going off to the doctor or to the hospital, why do they need time off from work, should they take a holiday to relax; and other aggravating questions and helpful hints.

STAGE 3

Frequently, when a couple first attends the clinic or gynaecologist to begin the process towards being assessed for the programme, the wife will undergo tests. If she requires treatment this will be carried out and could possibly be occuring throughout Stage 2. This applies to women who have problems with ovulation and low fertility.

Once a donor has been selected and matched with the husband of the couple racially, physically and for similar blood group, the couple are contacted. The wife then needs to keep in very close contact with the Sister on the programme, who determines when the patient should present for various tests which precede ovulation, the actual inseminations, and the subsequent tests. This all involves time off work if a woman is working, which creates difficulties with explanations. This could be an anxious time, as the inseminations are about to begin and the wife is required for the tests for several consecutive days.

Insemination begins:

Once the inseminations begin, the couple have finally reached a most critical point, the practical and real situation. Feelings about A.I.D. which may not have been resolved earlier could re-appear at this stage. Perhaps a husband has not fully accepted the concept of A.I.D. and could find it difficult to let his wife proceed; "This is happening because I failed her." Husbands are encouraged to be present at the inseminations and the couple are encouraged to lead a normal sex life during this time. The wife's role at this time is vital. If she helps to make the A.I.D. a mutual process, this could help an uncertain husband. However, there is always the problem that a husband could feel left out, which would heighten feelings of failure, worthlessness, and inability to be a man. The idea of A.I.D. being adulterous may be felt and expressed; "I might as well let her go with another man."

Frequently a woman who is ovulating regularly prior to insemination, begins to have disrupted ovulation once on the programme, thought to be due to psychological and hormonal disturbances. This seems to be a frequent occurrence in our programme. Once inseminated, there is the anxious time while waiting the end of the month's cycle. If pregnancy is not achieved in the first two or three cycles, a couple may become very depressed. It is desirable that a Social Worker will be available at these times for counselling and reassurance. One must remember at all times that most couples are unable to discuss their experience with family or friends as most choose not to tell anyone else that they are undergoing A.I.D.

STAGE 4

When a pregnancy is achieved. The initial feeling is usually one of delight, but with every pregnancy there are unknown risks and it is possible that these would be heightened by a woman knowing that her baby is not her husband's. Once the pregnancy is common knowledge the couple may again be in conflict as to whether or not they should tell their families of the A.I.D. They may themselves deny that A.I. occurred and they talk about trying again in a few years time. All through the pregnancy there may be anxious anticipation as to what the child will look like.

Birth:

Once the child is born there seems to be a great desire for couples to find likenesses to their families. If the child does not appear to match either side of the family the facts of the child's conception could return as a problem. Most woman suffer a let down feeling post-natally. With a child born following A.I.D., additional feelings could be involved. A husband who may have accepted a pregnancy may find he has feelings of rejection when the child is born, as here is living proof of his inability to give his wife a child, and it is "another man's child".

The wife's role again becomes a vital one. She can try to help her husband in his relationship with a child; or she could become possessive and exclude him.

It may take a husband some time to accept the child. It may take his wife some time also. There seems to be some evidence from studies overseas that the acceptance of the child after birth is usually satisfactory.

Even though the couple may not have told anyone of their problem of infertility and subsequent artificial inseminations, the situation exists where a woman who has borne a child will know that her husband is not the father.

Should a marital breakdown occur at a later date this information has the potential to be a weapon for a wife against her husband, and vice versa.

Knowledge of Origin:

One other major conflict area which is discussed with the Social Worker during the series of interviews, is whether or not the couple

intend to tell a child of its conception following A.I.D. Most couples at this discussion stage feel that they will not tell their child. However, they need to prepare a child should they change their minds or be forced into telling the child later. There are different schools of thought within the Social Work field. Do the parents have a right not to tell their child if they so choose, or does the child have a right to know? Should the couple be forced to face reality or should they be allowed to live with their "secret?" Unlike most adoptions, there would be no available details of the donor to share with the child, if they did tell him.

When a pregnancy is not achieved. If a woman has reached the end of five good cycles of insemination where she has ovulated each time and has not become pregnant, that is the point at which inseminations will cease and the situation will be reviewed. If a decision is made by the doctor that they will recommence inseminations, there will no doubt be further anxieties in the couple that they will face another five cycles with no success. At the time of review, a woman may be further examined and possibly have further treatment should this be indicated. A change of donors may also occur.

If the decision is made by the doctor that there is no point in proceeding with inseminations because it seems unlikely that the woman will become pregnant, we are back to stage one. One could anticipate disappointment, anger and depression. Thoughts of separation may recur and indeed become fact. In Victoria at this stage the couple would probably have no opportunity to adopt, and may need to be helped to accept a future of childlessness.

Comments: Once a couple have been referred to a Social Worker, they have the chance to talk at length about their feelings and their hopes, and the complex social expectations and pressures confronting them daily. Thus, the medical service being provided in response to a fundamental human desire, is offered in a balanced professional team. Throughout the subsequent stages, the Social Worker can be a support and a sounding board. The further we go in the work of this clinic the more we realise there are points at which a Social Worker's intervention is vital. One must remember that all through these stages the relationship of the couple is under a great deal of strain. Problems with appear to be resolved, re-appear at various points of tension. With migrants there is sometimes the added barrier, of language. Because an interpreter is often required, it is yet another person who knows of the situation.

Focus:

For a Social Worker, the most difficult task experienced is in the assessment of a couple as to whether they are suitable to be accepted onto the programme for artificial insemination. Do we have the right to refuse a couple the chance of having a child, even though it is by artificial means and they require help from other people to achieve this? Where should our focus be — on the couple applying who have already faced a lot of problems, or on the child who may be conceived following A.I.D.? The most important criterion to me as the Social Worker is that a couple have a stable, mutually satisfying relationship. If this is not evident then I would have grave doubts that they could cope with A.I.D., or parenthood. Other ceiteria are desire for children, acceptance of infertility and the whole concept of A.I.D., and certainly mutual desire for this alternative path to parenthood.

I do feel the need to protect children, and feel that not all couples have the right to go onto the programme as potential parents. This is certainly my feeling in the adoption field, and so far I have applied the same to A.I.D.

One last point — A.I.D. is not magical. A decision to try A.I.D. can be a good or bad one for a couple, and a child. It will depend on attitudes, values and feelings of the couple, and how they solve problems that arise, as to how the venture turns out. The same applies to natural parenthood.

BIBLIOGRAPHY

1. Atallah, L: *Report from a Test-Tube Baby.* The New York Times, Sunday, April 18, 1976.
2. Beck, W. W. Jr: *Artificial Insemination and Semen Preservation.* Clinical O & G. Vol. 17, No. 4, December 1974.
3. De Stoop, D. F. J. J: *Human Artificial Insemination & the Law in Australia.* Law Journal, Vol 50, June 1976.
4. Goss, D.A.: *Current status of artificial insemination with donor semen.* Am. J. Obstet. Gynaecol. Vol, 122., No.2 May 15, *1975.*
5. Iizuka, R., Sawada, Y Nishina, N., Ohi, M.: *The physical and mental development of children born following artificial insemination.* Int. J. Fertil. Vol. 13 No.1. *1968.*
6. Kraus, J., Quinn, P.E.: *Human Artificial Insemination — Some social and Legal issues.* Med. J. Aust. Vol. 1 *May 1977.*
7. Lovset, J: *Artificial Insemination:— Attitudes of patients in Norway.* Fertil. & Steril. Vol.2. No.5, *1951.*
8. Mayo, M: *The Legal Status of the A.I.D. child In Australia:—* Aust. Law J. Vol 50. Nov 76.
9. Rubin, B: *Psychological Aspects of human artificial insemination.* Arch. Gen. Psychiat. Vol. 13, *1965.*
10. Schaad, G: *Medical and psychological preliminaries for artificial insemination.* Fertil. & Steril. proc. of *VII* World Congress, Tokyo & Kyoto, Japan, 1971.
11. Tekavcic, B: *Psychological Consequences of A.I.D.* Fertil. & Steril. proc. of *VII* World Congress, Tokyo & Kyoto, Japan *1971.*
12. Weinberger, A.D.: *A partial Solution to Legitimacy arising from the use of artificial insemination.* Indiana Law J. Vol. 35. *1959-60.*