Infertile Couples' Attitudes Towards Reproductive Alternatives:

A Survey of the Members of the Infertility Awareness Association of Canada, Toronto Chapter

by

Dianne May Ross

School of Social Work, McGill University, Montreal

August, 1996

A thesis
submitted to the
Faculty of Graduate Studies and Research
in partial fulfilment of the requirements of the degree of
Master of Social Work

ISBN 0-612-19701-8

Canada

Abstract

Social workers are increasingly being called upon to work with clients who wish to have a child but are unable to do so without medical intervention. This study, a cross-sectional survey design, examines the attitudes of couples towards donor insemination (DI), in vitro fertilization (IVF), contractual pregnancy, adoption and living child free. A random sample of 200 names was drawn from the membership of the Infertility Awareness Association of Canada, Toronto Chapter. Surveys were completed by 74 participants (37 couples). Participants were generally well educated, affluent and ranged in age from 26 to 63 years. Women were one third more likely to report feeling pressure to have children than were men. The source of this pressure was most often reported to be external/interpersonal relationships (e.g., friends, family, partner). Women were significantly more likely to strongly agree that they would use DI or IVF if they were infertile; whereas, men were more likely to only agree when considering DI, and to be unsure or neutral when considering IVF. The possibility of living child free was an alternative that very few participants had seriously considered, as many were still pursuing one or more reproductive alternative. Although significant differences were found within couples for DI, IVF and living child free in the vignettes, unexpectedly an overall theme of agreement between women and men was found as well. In addition, participants revealed a desire for support in their consideration of, and decision making regarding, the reproductive alternatives they may pursue. Clearly, the findings point to the need participants have to receive counselling, and/or follow-up to help them cope with their infertility and the possibility that they may not be able to have children.

Résumé

Les travailleurs sociaux sont de plus en plus appelés à travailler avec des gens qui souhaitent avoir un enfant mais qui en sont incapables sans intervention médicale. Cette recherche, un sondage transversal, porte sur l'attitude des couples face à l'insémination artificielle, à la fertilisation in vitro, au phénomène des mères porteuses, à l'adoption et à l'éventualité de vivre sans enfant. Un échantillon de 200 personnes a été créé à l'aide de la liste des membres du chapitre torontois de l'*Infertility Awareness Association of Canada*. Les répondants ont été choisis au hasard parmi les membres inscrits sur la liste. Un total de 74 répondants (37 couples) ont accepté de répondre à un questionnaire. Les participants, âgés de 26 à 63 ans, avaient dans l'ensemble un haut niveau de scolarisation et étaient à l'aise financièrement. Les femmes ont indiqué, et ce dans une proportion 30% plus élevée que les hommes, qu'elles ressentaient une pression sociale d'avoir des enfants. Cette pression sociale provenait dans la majorité des cas de membres de leur entourage (parents, ami(e)s, conjoint, etc.). Les femmes étaient beaucoup plus enclines à se prononcer "totalement en faveur" d'un recours à l'insémination artificielle ou à la fertilisation in vitro en cas d'infertilité. Par contre, les hommes étaient plus enclins à se prononcer "en faveur" d'un recours à l'insémination artificielle et à se dire "incertain" quant à un recours à la fertilisation in vitro. Vivre sans enfant n'était pas une option que la majorité des couples envisageaient sérieusement, la grande partie d'entre eux ayant déjà entrepris des démarches pour devenir parents. Bien que des opinions différentes aient été exprimées par des membres d'un même couple quant à l'insémination artificielle, à la fertilisation in vitro et à l'éventualité de vivre sans enfant, il ressort de notre recherche que les hommes et les femmes partagent plusieurs opinions sur les questions liées à l'infertilité. Les répondants ont également manifesté un désir profond d'appui et d'assistance dans leurs démarches respectives. Il ressort en effet de notre recherche que les participants souhaitent non seulement être encadrés et suivis lorsqu'ils tentent d'avoir des enfants mais aussi lorsque leurs tentatives n'aboutissent à rien.

Acknowledgements

The process of writing and completing my thesis involved the support, guidance, and encouragement of many people. I would like to take this opportunity to acknowledge and thank them.

Carol Cumming Speirs, my thesis advisor, I would like to thank you for your willingness to go that extra mile. The fact that I am now in Edmonton and you are in Montreal has required us to employ more creative ways to exchange information and ideas. Carol, your compassion and sensitivity to the issues involved has motivated me to consider a wider range of possibilities, and therefore, I think, to write a better thesis. Your insight and patient guidance throughout the research process has been much appreciated.

Julia Krane, my friend and mentor, I would like to thank you for encouraging me to pursue a research topic that I am passionate about. I have been reminded repeatedly throughout this research process of the critical importance of researching and writing about a subject that is meaningful to me.

Sydney Duder, my guide in completing my statistical analysis, I am grateful for your insight, knowledge and thorough understanding of SPSS and how to apply different statistical procedures. Your clear instruction enabled me develop a more complete appreciation of what my data were revealing.

Sherry Franz and Diane Allen, my contacts at the Infertility Awareness Association (IAAC), Toronto Chapter, I would like to express my sincere gratitude to both of you for your willingness to give of your time and expertise, and for enabling me to send my survey to the members of IAAC. I also wish to sincerely thank all of the individuals who participated in this research project; without your thoughtful input, this study would not have been possible.

Abby Lippman, the external reader of my thesis, your thoughtful comments and feedback have been sincerely appreciated.

Also, I would like to thank the School of Social Work at McGill University for granting me the Keefer Fellowship in 1993/94. Receiving this fellowship was a great honour.

I wish to sincerely thank my family. Berenice you offered support when I needed it. Shirley your willingness to listen to me talk about my work and offer thoughtful insights helped me keep the process going. Heather thank you for your invaluable French translation of my abstract. Tim your certainty that I could finish this thesis made all the difference. Thank you for editing and printing my final draft.

Table of Contents

Chapter *Page*

Abstract i

Résumé ii

Acknowledgements iii

List of Tables vii

I. Introduction 1
1. Setting the Stage 5
A. Creating the Idealized Family 5
B. Unable to Attain The Family Ideal 12
C. Reproductive Alternatives as Socially Constructed Choice 13
D. Socially Constructed Response to Infertility 15
2. Reproductive Alternatives: A Review of the Literature 18
A. Donor Insemination 18
a. Success, Cost and Risk of Donor Insemination 18
b. Employing Donor Insemination 20
c. Controlling Donor Insemination 20
B. In Vitro Fertilization 21
a. Success, Cost and Risk of In Vitro Fertilization 22
b. Employing In Vitro Fertilization: Discrimination in the Screening Process 24
c. Controlling In Vitro Fertilization 25
C. Contractual Pregnancy 25
a. Success, Cost and Risk of Contractual Pregnancy 27
b. Employing Contractual Pregnancy 27
c. Controlling Contractual Pregnancy 28
D. Adoption 30
a. Employing Adoption 30
b. Success, Cost and Risk of Adoption 32
c. Controlling Adoption 34
E. Living Child Free 35

II. Method 39
1. Design and Sample 39
2. Data Collection Instrument 41
3. Data Analysis 44

III. Findings 42
1. Survey Return Rate 42
2. Sample Description: Salient Demographic Factors 43
3. Pressure Felt by Participants to Have Children 45
4. Reproductive Alternatives Participants Would Use 49
5. How Adequately Informed Participants Feel About These Reproductive Alternatives 51
6. Child Access to Information About Birth/Genetic Parents 53
7. Reproductive Alternatives Participants Have Considered/Pursued 55
8. Agreement Between Female and Male Attitudes Towards The Reproductive Alternatives 57
9. Outcome If Participants Considered Any Reproductive Alternatives? 58
10. Considering the Possibility of Living Child Free 61

IV. Discussion 65
1. Summary of Key Findings 65
2. Limitations of the Study 70
3. Implications of the Research Findings 73
A. Further Research 74
B. Social Work Education 76
C. Social Work Practice 78
a. Advocate 79
b. Educator 81
c. Counsellor 83
D. Social Policy Development 85

Bibliography 88

Appendix A: Reproductive Alternatives Attitude Survey 94

Appendix B: Survey Cover Letter 108

Appendix C: Survey Follow-Up Letter 110

Appendix D: Development of the Reproductive Alternatives Attitude Survey 112
1. Case Vignettes 112
2. Psychosocial Issues 114
3. Demographic Information 115

List of Tables

Table 1

Do You Feel (Have You Ever Felt) Pressure to Have Children? 45

Table 2

If I Were Infertile I Would Use These Reproductive Alternatives 49

Table 3

Do You Feel Adequately Informed About These Reproductive Alternatives? 51

Table 4

A Child Conceived Using A Reproductive Alternative Should Have Access to Information About Birth/Genetic Parents 53

Table 5

Have You Ever Considered Pursuing Any of These Reproductive Alternatives? 55

I. Introduction

"Conception, as it occurs today, has itself been transformed at the same time as it is transforming our values and beliefs" (Basen, Eichler, Lippman, 1993, p. 26). In the past 15 years human reproduction has been significantly impacted by technological developments in the area of new reproductive technologies (NRTs). From the birth of Louise Brown, the first test-tube baby, in 1978 (Basen, 1992; Feders, 1994; Holbrook, 1990) to the development of procedures that allow doctors to fertilize a human egg with sperm that have, on their own, been unable to penetrate the egg membrane (Feders, 1994), reproduction has continued to increase in medical sophistication. The medical, ethical and social complexities of each of the new reproductive technologies and reproductive alternatives available have been well documented (Baran & Pannor, 1989; Basen, Eichler & Lippman, 1993 & 1994; Corea, 1985; Daniels, 1986 & 1993; Holbrook, 1989; Miall, 1989; Overall, 1987; Raymond, 1990 & 1993; Rowland, 1984; Sherwin, 1992). At the present time, there is no reason to believe that the move toward greater biomedical sophistication in the area of reproduction will decrease in the future (Basen, Eichler & Lippman, 1993 & 1994; Corea, 1985; Miall, 1989; Overall, 1987; Raymond, 1990 & 1993; Sherwin, 1992 Walther & Young, 1992). One result of this biomedical advancement has been the emergence of wide-ranging debates surrounding the moral and ethical justifiability and desirability of new reproductive technologies (Corea, 1985;

Overall, 1987; Raymond, 1990 & 1993; Rowland, 1984; Sherwin, 1992; Wajcman, 1991).

Regardless of one's position within the ethical debates surrounding NRTs and the reproductive alternatives available, the consequences of these procedures are of particular relevance to the social work profession. Social workers are increasingly being called upon to work with clients who wish to have a child but are unable to do so without medical intervention. The social work profession can offer a wholistic approach to infertility by considering the diverse psychosocial issues involved: responding to the emotional needs of the client both personally and socially; working with social networks; acting as an advocate; educator and counsellor; organizing and utilizing self-help and support groups; linking the client with the appropriate counselling services; actively participating within a multi-disciplinary team approach; contributing to the scholarly debates surrounding NRTs and the reproductive alternatives available; conducting research; and contributing to the development of sound social policy in this area (Daniels, 1993). In addition, as is the case in adoption, the role of the social worker must include working to serve the best interests of the children involved (Baran & Pannor, 1989; Bell, 1986; Daniels, 1986; Edwards, 1991; Sanschagrin, Humber, Speirs, & Duder, 1993; Sokoloff, 1987). This is particularly important in the area of NRTs and the resulting reproductive alternatives, because as Sokoloff (1987) states, "the literature is replete with the technological advances in this field, but questions are seldom raised about the well-being of the children so conceived" (p. 11). In fact, Sokoloff (1987) specifically

comments on the "paucity of information" (p. 11) regarding the well-being of children conceived employing NRTs and various reproductive alternatives. In this regard, Bell (1986) states that "genetic social workers could assist 'new reproductions' parents in preparing for the different family roles and expectations..." (p. 434). Social workers could endeavour to assist newly forming families in the process of individualizing their children and in the recognition that the best interests of their children are of primary concern (Bell, 1986).

In order to work more effectively with infertile clients considering their use of various reproductive alternatives, it is necessary to examine their attitudes towards these alternatives, thus facilitating an appreciation of how these attitudes are shaped and impacted by social and cultural expectations regarding family creation, infertility and reproduction. Using this premise as a starting point, the framework for this study is based on the following questions. First, what are the salient demographic factors that describe this sample? Second, are there any gender differences with regard to pressure felt to have children? Third, to what extent are various types of reproductive alternatives supported or opposed by those considering their use? Fourth, do participants feel adequately informed about reproductive alternatives? Fifth, do participants believe that a child conceived using a reproductive alternative should have access to information about her/his birth/genetic parents? Sixth, which reproductive alternatives would participants use, or consider using, and which reproductive alternatives have participants already tried? Seventh, if participants have pursued a reproductive alternative what was the

outcome? Finally, what are the attitudes and beliefs of participants towards the possibility of living child free?

I begin my thesis by discussing the social context within which reproductive alternatives have developed. I, first, examine of the social creation of the ideal family and the resulting impact this family ideal has on female and male expectations with respect to family creation and having children. Next the issue of infertility, resulting in the inability to attain the family ideal, is explored. This is followed by a brief overview of a range of the possible responses to infertility. This overview includes an analysis of the salient historical, technical, ethical, and psychosocial aspects of donor insemination (DI), in vitro fertilization (IVF), contractual pregnancy, adoption and living child free. A discussion of the methodology follows, after which, the findings are presented and analyzed, along with an outline of the key findings and limitations of the study. Finally, I consider a number of the implications of these findings for further research, social work education, practice and social policy development.

1. Setting the Stage

A. Creating the Idealized Family

Traditionally in North America, the nuclear family, consisting of a sole male breadwinner with a stay-at-home wife who devotes her energy to caring for her husband and children, has been considered the ideal family form (Anderson, 1991; Baker, 1984; Ferree, 1990; Mackie, 1991; Rich, 1986; Richardson, 1993; Rothman, 1989; Spallone, 1989). In fact, Mackie (1991) and Anderson (1991) use the term "monolithic" to more accurately convey the inherent all encompassing assumptions embodied within the nuclear family ideal. In North America, the idealized family as it is usually constructed is very race- and class-based (Lippman, 1996).

The establishment of the nuclear family as the ideal family structure is indicative of patriarchy; "the traditional form of family organization in which men are dominant over women" (Mackie, 1991, p. 225). Rich (1986) theorizes that the nuclear family is at the core of patriarchy, and came about as a result of the "idea of property and the desire to see one's property transmitted to one's biological dependents" (pp. 60-61).

Over the years the nuclear family has been idealized "as the only normal, healthy family arrangement" (Mackie, 1991, p. 281). In explanation of this premise, Baker (1984) states that, "certainly there has never been one type of family, but in the North American literature there has not been enough effort until recently to delineate the variety

of family structures" (p. 3). Baker (1984) goes on to state that, "although cultural variation has been discussed in previous textbooks,...these ethnic families are often compared to some idealized notion of the Canadian family" (pp. 3-4). These comparisons have, by and large, resulted in the negation of the significance, legitimacy, and viability of culturally and ethnically diverse family forms. Until recently researchers did not acknowledge, much less attempt to examine, family forms which did not match the idealized family.

The research indicates that the nuclear family is not the norm for all, or even most Canadians (Anderson, 1991; Baker, 1984; Mackie, 1991). In fact, Mackie (1991) reports that in North America only about 7% of the population actually lives in a traditional nuclear family. In spite of this fact, the nuclear family ideal is deeply woven into the social fabric of our society, as a result; this idealized family form significantly impacts female and male expectations regarding desirable family structure (Mackie, 1991).

In order to better understand the influence of the nuclear family on women and men, it is necessary to make explicit the implicit assumptions embodied within this idealized family form. First, the nuclear family assumes that in order for a woman to be part of a family she must be in a married heterosexual relationship. Richardson (1993) states that "in our society, women's emotional and psychological dependence on men is strongly encouraged by the fact that not having a man, and not having his child, are both seen as representing a failure of 'femininity'" (pp. 26-7). The importance of having a man is reflected in society's reaction to women who choose not to have a man in their

lives (Richardson, 1993). For example, an examination of the treatment of lesbian and gay families by British law, "with reference to the Human Fertilization & Embryology Act (1990)," reveals the privileged position heterosexuality occupies in society (Cooper & Herman, 1991, p. 41).

A second assumption embedded within the nuclear family ideal is that children will result. This assumption has a two-fold implication for women and men. First, it takes for granted the role of parenthood for the couple, the meaning of which is particularly relevant for women. Richardson (1993) clearly articulates this point.

> Motherhood is a central fact of many women's lives. It shapes their relationship with other people, their opportunities for paid employment, their leisure activities, and their individual identities.... That women should have babies and provide childcare is generally regarded as the norm in our society. It is 'what women do'. It is regarded as *natural*: the expression of a maternal instinct to want and care for children which all 'normal' women are deemed to possess. (p. ix)

Morell (1994) points out that the "dominant culture naturalizes motherhood" through beliefs and values that collapse "woman" and "mother" (p. 2). Consequently, as Richardson (1993) states, "it is perhaps not difficult to understand why women should 'choose' motherhood in a society in which the efforts to socialize girls into wanting babies are so pervasive" (p. xi). At the same time, it is instructive to note that "the social role of mother provides women very positive opportunities for loving relationships and social contributions" (Morell, 1994, pp. 5-6); and that although, there is significant social pressure on women to become mothers, that social pressure "operates on women to varying degrees" (Richardson, 1993, p. ix). Richardson (1993) states that "the

opportunities and constraints concerning motherhood will differ according to 'race,' class, and sexuality, as well as the vagaries of individual upbringing" (p. ix).

The second implication of the taken for granted presence of children within the nuclear family is that of a biological relationship between parents and their children (Miall, 1989). Kirk (1964), in his ground breaking research into adoption, found that "while age and socio-economic status of respondents influenced their replies, adoptive kinship was generally regarded as inferior to consanguineal kinship, a 'second best' decided on last" (p. 22-23). Almost three decades later, Daly and Sobol (1992) found that, "Canadian culture continues to place a strong emphasis on 'blood ties' for defining families. As a result, adoptive parenthood is often experienced as 'second best'" (p. 6). In addition, Williams' (1992) research into the actions and attitudes of couples seeking in vitro fertilization found that, "like most people, the childless couples in this study preferred to have their own biological child rather than adopt. This preference was especially strong in the husbands" (p. 110). At the same time, Williams (1992) acknowledges the dynamic nature of the process involved. Williams (1992) states that "their infertility forced these couples to constantly evaluate, usually over a period of several years, an ever-changing spectrum of parenthood options, each with its own set of rewards and costs" (p. 110). Although it may be commonly argued by some researchers and child experts that adoption is perceived to be a "second best" parenting alternative, it is important to remember that the children who are adopted are not, nor should they be considered, second best.

Nevertheless, the biological relationship between parents and their children is regarded as quite important in our society. Furthermore, given the advances being made in the area of NRTs, giving birth to a child no longer guarantees a biological relationship. For example, in the case of IVF or contractual pregnancy using donated eggs, the birth mother will not be biologically related to the child she gives birth to. Consequently, even though NRTs and the resulting reproductive alternatives enable medical specialists to manipulate the union of sperm and egg in such a way as to remove and/or confuse the biological relationship between mother and child, one should not conclude that this arrangement is inherently unproblematic. It is important to remember that reproductive technologies and their subsequent use are *not* neutral (Basen, 1992). Baran and Pannor (1989) succinctly point out that "because science shows us that a new direction is possible, it does not mean that this direction should be taken" (p. 164), or even that this direction is right.

Moreover, social acceptance of the absence of a biological relationship between parents and their children, as in the case of IVF and contractual pregnancy or adoption, fostering and step-parenting, is partially dependent upon the degree to which the traditional family structure remains unchallenged by the new family arrangement, while also remaining a function the social meaning ascribed to the actual form of parenting undertaken. For example, Richardson (1993) summarizes the dynamics and expectations of the biological relationship when the traditional family structure is challenged.

> Generally speaking, women who adopt or foster a child or who become a 'stepmother' through marrying someone who already has children are socially

> accepted and recognised as 'mothers'. Other non-biological mothers, however, are not. This especially applies where a women is involved in mothering another women's child outside marriage (the collective household, for example) or without the involvement of a man (the lesbian couple, for example). What this shows is a concern with maintaining a certain type of family form rather than the biological ties of kinship. Clearly, certain forms of non-biological motherhood challenge traditional assumptions about the family. It also demonstrates that the person who cares for the child need not be the person who went through the pregnancy and birth. (p. 17)

Although the nuclear family ideal assumes a biological relationship between parents and children, it is apparent that in some cases the actual family structure supersedes the biological relationship in importance in maintaining the status-quo. In many ways, Richardson's (1993) summary demonstrates the inherent contradiction of the nuclear family and begins to shed light on alternate parenting arrangements and some of the dynamics involved. At the same time, Richardson's analysis is focused on one end of the continuum regarding deviation from the ideal family. It is instructive to note that these parenting arrangements are not stigmatized in parallel ways.

Despite the contradictions of the nuclear family, this ideal "continues to exert a powerful influence on commonsense ideas about what is normal, as well as on the construction of social policy" (Richardson, 1993, p. 27). As will be made clear throughout this discussion, the reproductive choices and alternatives available to women and men are very much determined and defined within a taken for granted understanding of what the ideal family should look like. As Anderson (1991) cogently points out, "in the face of structural changes, the traditional family ideal no longer describes actual family experiences if, indeed, it ever did. Yet, data on the beliefs and behaviour indicate

that people still hold to the ideal, though changing family values are neither uniform nor consistent" (p. 236).

B. Unable to Attain The Family Ideal

The celebration of parenthood and encouragement to reproduce are fundamental cultural values in Western societies, "particularly as a valued role for women" (Miall, 1989, p. 44). As a result, most people assume that when they decide to have children they will be able to do so without any type of medical intervention (Pannor & Baran, 1984; Richardson, 1993). Unfortunately, this is not true for everyone. In fact, Dulberg and Stephens (1989) estimate that "the current prevalence of infertility among married or cohabiting Canadian women aged 18-44 was 8.5% over the previous year" (p. 84), and if all individuals who have undergone sterilization procedures are excluded from the analysis the one year infertility rate increases to 15.4% which supports the widely reported one in six incidence of infertility among couples (Baker, 1994; Bell, 1986; Dulberg & Stephens, 1989; Matthews & Matthews, 1986; Sokoloff, 1987; Zimmerman, 1982). Infertility is most commonly defined "as the inability or failure to conceive within 12 months with regular sexual intercourse" (Baker, 1994, p. 783; Clamar, 1989; Holbrook, 1990).

Herz (1989) states that "in the public eye, the onus [to reproduce and have children] still rests predominantly with the woman" (p. 117). Clamar (1989) states that

"until recently the major emphasis on fertility research has been on detecting and correcting abnormalities in women" (p. 112) which has resulted in women being held principally responsible when infertility is diagnosed (Miall, 1989). This is true even though research indicates that male infertility contributes to 30-40% of all infertility problems (Baker, 1994; Clamar, 1989; Conseil du statut de la femme, 1989; Herz, 1989; Richardson, 1993), and that a "combination of male and female subfertility" (Herz, 1989, p. 117) accounts for 15-20% of infertility problems (Conseil du statut de la femme, 1989).

C. Reproductive Alternatives as Socially Constructed Choice

Although a number of reproductive alternatives exist that can be used to circumvent infertility, the actual availability of these alternatives is dependent on several factors beyond the basic desire to have a child (financial and social resources, sexual orientation, socially deemed suitability for parenthood, and flexibility of time, for example).

Social expectations play an important role in shaping the types of reproductive alternatives that are developed, and made available; social expectations also play a role in determining to whom reproductive technologies are made available. Sherwin (1992) states that "unless we recognize that a person's desires, needs and beliefs are formed only within human society, we may mistakenly imagine ourselves and or interests to be

independent from others and their interests" (p. 53). The reproductive alternatives available are very much linked to fundamental societal assumptions about what is appropriate and acceptable when creating a family. This in turn, has significant implications for women and men who are infertile and are considering the reproductive alternatives available to them. Wajcman (1991) clearly articulates this point.

> Indeed, the emphasis placed on women's right to use these technologies to their own ends tends to obscure the way in which historical and social relations are built into the technologies themselves. While recognizing the social shaping of women's choices in the sense of motivations, few participants in the debate see that the technologies from which women choose are themselves shaped socially.
>
> Women are in fact selecting from the very restricted range of technological options which are available to them. (pp. 62-63)

The reproductive choices available reflect the prevalent beliefs, values and attitudes within society. Reproductive choice is socially constructed and depends largely on that which individuals "know" and "believe" to be possible. The widespread notion that NRTs and reproductive alternatives should be developed to address infertility offers a vastly different perspective than the idea that we should address the social issues that often compel women to delay childbearing until after age thirty. This is but one example of how the way a problem is defined, by and large, determines how it will be solved. The very concept of choice implies the equal availability of a range of alternatives. This assumption is erroneous. Not all reproductive alternatives are equally available, nor do these alternatives represent an inclusive range of possible responses to infertility.

D. Socially Constructed Response to Infertility

As the reproductive alternatives available continue to grow in number and medical sophistication, infertility is increasingly seen as a condition that can and *should* be circumvented. Edwards (1991) states that "ultimately, the high value society places on parenthood drives the demand for the new reproductive technologies. The desire for a child is so intense for many that, in the fact [*sic*] of difficulties, they will go to any lengths to achieve their goal" (p. 354). Miall (1989) states that in Canada and the United States, "two major norms predominate with regard to fertility. One states that all married couples should reproduce, the other that all married couples should want to reproduce" (p. 43). Due to the gendered nature of society's response to infertility, the way it is defined, researched and treated, infertility cannot be understood to have the same consequences for women and men. Matthews and Matthews (1986) report that

> Miall (1985: 393-396) found that the majority of infertile women in her sample labelled themselves as 'failures' even without being aware of any form of outside rejection or disapproval. This suggests that infertility [and the resulting involuntary childlessness (emphasis added)] (at least for women) may have a greater effect on social identity than many other types of stigma. (p. 646)

Richardson (1993) states that "this is exemplified by the negative way that women who are infertile are generally regarded. They are often labelled as barren, sterile, childless, women to be pitied" (p. 86). Hence, the discovery of infertility is often a major life crisis and usually has a significant impact on the lives and the relationships of the individuals involved (Clamar, 1989).

The meaning of infertility, whether occurring in a postmenopausal women or a women in her, "childbearing years," "is that it is a failing, an inadequacy, and the specialists are the 'technological fixers' who will save women from their own nonfunctional bodies by giving them the longed-for product, a baby" (Overall, 1987, p. 158). In fact, because infertility is increasingly seen as circumventable, a great deal of pressure may be exerted on individuals "to have their condition treated by technical means even though the success rates of medical intervention in this area remain significantly low" (Finkelstein, 1990, p. 16).[1] Even if the specific cause of the infertility is discovered there is no guarantee that the treatment will work.

Certainly, circumventing infertility may be important for many individuals. However, when circumventing infertility is presented as the norm, to which all infertile individuals are expected to aspire, one must question how much real choice is involved and how much choice is being manufactured by individuals who have a vested interest in certain responses to infertility (Finkelstein, 1990; Lippman, 1994; Overall, 1987; Richardson, 1993; Sherwin, 1992). Richardson (1993) states, "if the idea of women not having children was socially more acceptable, then infertility would no longer be regarded as such a problem, nor would the infertile have as great a need to their own pressure groups" (p. 86).

---

[1] This is particularly true in cases involving in vitro fertilization where the success rate is estimated to be anywhere from 10% or less (Richardson, 1993) to between 10-20% (Basen, 1993; Miall, 1989).

2. Reproductive Alternatives: A Review of the Literature

A. Donor Insemination

Donor insemination (DI) involves the non-coital placement of semen into the vaginal canal or cervix of a woman in order that she may conceive (Achilles, 1986, 1992; Daniels, 1988; Holbrook, 1990).[2] In most cases the sperm used is obtained from a donor who is not the husband or partner of the woman who wishes to become pregnant. Donors are usually recruited from university student populations or through the practices and personal contacts of physicians (Achilles, 1992). Less often, sperm is obtained from the woman's partner and is inseminated alone or is mixed with donor sperm.

a. Success, Cost and Risk of Donor Insemination

Compared to other forms of assisted reproduction, the success rate for DI is relatively high. DI is reported to be between 60% to 80% successful with an average of

---

[2] Rona Achilles was commissioned, in 1992 by the Royal Commission on New Reproductive Technologies, to research and write a report on donor insemination. This research is particularly relevant because it is the most comprehensive research of its kind to date in Canada. As well, in 1986 Achilles completed her Ph.D. dissertation at the University of Toronto. Achilles examined the social meanings of biological ties and donor insemination.

six cycles (Achilles, 1986, 1992; Edwards, 1991; Holbrook, 1989). This is not surprising given the fact that "both the sperm donor and the recipient are presumably fertile" (Achilles, 1992, p. 11). Compared to other reproductive alternatives, DI is much less expensive. Achilles (1992) summarizes the costs of DI as follows:

> A 1986 U.S. survey reports the range of costs for artificial insemination with the partner's sperm at $30 to $50 for intracervical insemination and $40 to $200 for intrauterine insemination with washed sperm. Donor sperm was reported at $35 to $150 for fresh sperm, and $40 to $350 for frozen sperm. (p. 10)

The research indicates that there may be some differences in the success rate of DI using fresh and frozen sperm (Clamar, 1989). However, given the real danger to the recipient of contracting AIDS through infected semen, freezing the sperm is imperative in order to allow time to quarantine and appropriately screen donor sperm.[3]

b. Employing Donor Insemination

Today DI is primarily used by heterosexual couples experiencing male infertility where there is an inability to produce or deliver sperm "(azoospermia) or a low sperm

---

[3] Achilles (1992) reports that "although every sperm bank and clinic contacted is using frozen sperm, several practitioners mentioned that they are aware that smaller, office-based practices were still using fresh sperm" (p. 34). This is particularly troubling given the Canadian Fertility and Andrology Society and Society of Obstetricians and Gynaecologists of Canada (1990) recommendation "that only frozen semen (after appropriate screening and quarantine) be used for TDI [therapeutic donor insemination] in Canada unless (until) a rapid spot test for the AIDS virus is available" (p. 36).

count (oligozoospermia) in the male" (Canadian Fertility and Andrology Society & Society of Obstetricians and Gynaecologists of Canada, 1990, p. 5). DI is also used to prevent the transmission of serious hereditary or genetic disorders, and may also be employed if the male partner has had a vasectomy, has a medical disorder inhibiting ejaculation, or has "antisperm antibodies in his semen" (Achilles, 1992, p. 4; Zimmerman, 1982). More recently, DI is increasingly being used by lesbian and single women who wish to have a child, but do not have a male partner and do not wish to involve a man in the process (Achilles, 1992; Hornstein, 1984; Richardson, 1993).

c. Controlling Donor Insemination

Control and regulation of DI by the medical profession is largely impossible because DI is not in itself a medical procedure. DI can be performed successfully at home. In fact, Klein (1984) reports that

> in October 1978 a small group of lesbian feminists met together through an 'ad' in the London Women's Liberation Newsletter to talk about artificial insemination and to work out ways of getting pregnant through insemination by organising it ourselves. We called our process Self Insemination. (p. 382)

Although poor and incomplete record keeping coupled with a desire for secrecy make it difficult to obtain precise numbers of DI births, the Canadian Fertility Society estimates that there are 1500 births annually (Miall, 1989). In light of the evolution of DI, Bell (1986) states that "in important respects, artificial insemination, the most widely

used reproductive aid, is paralleling the course that adoption followed regarding secrecy, recording procedures, and access to the adopted individual's medical and background records" (p. 422).

B. In Vitro Fertilization

In vitro fertilization (IVF) involves the removal of a number of human eggs from a woman, usually the one who wishes to become pregnant. The eggs are then mixed with the sperm of the women's male partner.[4] From this procedure it is anticipated that a number of embryos will develop which can be transplanted into the woman's uterus. Hormone drugs are taken by the woman throughout the pregnancy in order to maintain the pregnancy.

a. Success, Cost and Risk of In Vitro Fertilization

In vitro fertilization is a new technology that is still in the experimental stage (Sherwin, 1992). The actual success rate of IVF is quite low (Black, Walther, Chute &

---

[4] At this time, the medical profession does not consider it appropriate to offer IVF to women who are not married or at least in a committed heterosexual relationship. This means that single women and lesbian women do not have access to this procedure (Richardson, 1993).

Greenfeld, 1992; Holbrook, 1990; Miall, 1989; Richardson, 1993). Estimates of actual live births resulting from IVF range from 10% or less (Richardson, 1993) to between 10-20% (Basen, 1992; Miall, 1989).[5] As well, IVF is a very costly and time consuming procedure, thus making it inaccessible to the poor and those without schedule flexibility to attend numerous medical appointments (Richardson, 1993). Williams (1992) summarizes the issues involved in pursuing IVF as follows:

> Fees of $5,000 to $6,000 per attempt are the norm in most Western countries, and most couples make several attempts. A single IVF attempt lasts approximately 3 weeks and is extremely physically stressful, because it involves surgery, repeated ultrasounds, and blood drawing. The fertility drugs used can produce a wide range of distressing and potentially dangerous side effects. IVF is also very emotionally stressful, because it may fail at any point in the procedure, and the attempt will be cancelled. (p. 101)

Unfortunately many women who undergo IVF are not made fully aware of the low success rate, or the largely experimental nature of this procedure (Basen, 1992; Daniels, 1989; Sherwin, 1992). Some clinics have actually published misleading information about their success rates (Holbrook, 1990) while others simply withhold relevant information from their clients (Sherwin, 1992). Sherwin (1992) states that this "calls into question the informed nature of patients' choices and the degree of control that women actually exercise when receiving this technology" (p. 129).

---

[5] There is some confusion surrounding the notion of success because many scientific studies consider IVF successful if a live embryo is transplanted into the woman's uterus regardless of whether a fetus is actually carried to term (Sherwin, 1992).

The physical risk and potentially dangerous side effects of IVF have not been adequately studied (Sherwin, 1992). Sherwin states that the chemical manipulation of ovulation, "the use of ultrasound and the dangers associated with administering a general anaesthetic for egg collection and embryo transfer have not been deemed worthy of attention in the nonfeminist bioethics literature" (Overall, 1987; Raymond, 1993; Sherwin, 1992, p.125). In addition, women who do become pregnant as a result of IVF have a higher rate of surgical deliveries. This has generally been regarded as an acceptable outcome of a high-tech procedure even in light of the fact that surgical deliveries present a higher risk to both the woman and the fetus (Sherwin, 1992). Finally, the high emotional costs to women undergoing IVF have generally been ignored or inadequately addressed (Abramson, 1990). Overall, the risks posed to women by IVF have largely been disregarded, minimized and considered unworthy of serious scientific study (Sherwin, 1992).

b. Employing In Vitro Fertilization: Discrimination in the Screening Process

Research into IVF indicates that the vast majority of the women who undergo this procedure are white married heterosexuals who are generally well educated and affluent (Black, Walther, Chute & Greenfeld, 1992; Lippman, 1994; Overall, 1987; Sherwin, 1992; Walther & Young, 1992). The discrimination that is part of the social structure that

offers IVF to women is also inherent in the screening process for IVF (Lippman, 1994; Overall, 1987; Sherwin, 1992; Wajcman, 1991). This means that "IVF is usually unavailable to single women, lesbian women," (Sherwin, 1992, p. 127) poor women, women of colour and women with disabilities (Overall, 1987; Sherwin, 1992). Although infertility is much higher in the Black community in the United States than among the White community, infertility treatments are "overwhelmingly directed toward the latter group" (Sherwin, 1992, p. 133).

c. Controlling In Vitro Fertilization

Because women have unequal access to social, political and economic power, IVF and other NRTs, including contractual pregnancy, may introduce the beginning of women's reduced control over their reproductive capacity (Walther & Young, 1992). In fact, the economic position of women in society is significantly related to the dangers posed to them by medical and scientific developments in NRTs. Wajcman (1991) states that "access to the benefits of expensive techniques such as in-vitro fertilization is heavily related to the ability to pay. Women who are poor and vulnerable will not have access to these techniques and furthermore, they will be least able to resist abuses of medical power and techniques" (1991, p. 61).

C. Contractual Pregnancy

Before outlining the details of contractual pregnancy, I wish to clarify the terminology I will be using and offer an explanation as to why it has changed since I started this research project. Eichler (1994) points out that "most feminists do not use the term surrogate mother, because—as has been observed again and again—these women are real mothers, even though they are planning to give up their child at birth" (p. 196). Sherwin (1994) succinctly states that "the term 'surrogate mother' is a misnomer; the woman who is assigned this position is the birth mother, and she is, therefore, the biological mother of the child in question, having (usually) both conceived and gestated it in her body" (p. 183). The Conseil du statut de la femme (1989) concludes that

> if the 'contracting mother' is indeed a substitute for someone, it is not the mother of the child, but the spouse of the father.... This shift in meaning tends to minimize the role of the 'contracting mother', reducing her to a surrogate, a mere 'receptable' [*sic*], and denying the important biological (she the genetic and uterine mother) and emotional links she has with the child. (p. 19)

The term surrogate motherhood does not convey the meaning I wish to impart. Therefore, I will be using the term contractual pregnancy instead, because, as Sherwin (1994) states, "this terminology makes explicit the relationships at work and the centrality of women's reproductive role to these arrangements" (p. 184).

A contractual pregnancy "is an arrangement whereby a woman who gives birth to an infant intends—through a contractual agreement—to give that baby to another couple" (Erlen & Holzman, 1990, p. 319). Contractual pregnancy can be as medically

straightforward as DI, "the most commonly practised form...where a women not only agrees to have the baby, but also donates the egg" (Conseil du statut de la femme, 1989; Richardson, 1993, p. 16), or it can be as medically complex as IVF, where the eggs of another woman are removed and mixed with the sperm of the man commissioning the pregnancy and the resulting embryos are placed in the uterus of the commissioned woman.

a. Success, Cost and Risk of Contractual Pregnancy

Generally, the success, cost and risk involved in contractual pregnancy depend on the reproductive alternative employed (DI or IVF, for example). In addition to a fee typically paid to the commissioned woman, there is usually an equal fee paid to a broker plus, medical and legal expenses (Conseil du statut de la femme, 1989).[6] All of these expenses are paid by the commissioning man and his partner (Conseil du statut de la femme, 1989; Eichler, 1994).

b. Employing Contractual Pregnancy

---

[6] "The fee received by commissioned women upon the surrender of a baby was in 1988 generally $10,000 and is now described as ranging from $10,000 to (in exceptional cases) $20,000" (Charo, 1992 as cited in Eichler, 1994).

The actual number of babies born as a result of contractual pregnancy, like other reproductive alternatives, is hard to establish. Nevertheless, by the mid-1980s it was estimated that over 500 babies had been born in the United States as a result of contractual pregnancy arrangements (Edwards, 1991).

Due to the significant expense involved in contractual pregnancy, only people with a middle class or higher level of income have the financial resources necessary to access this reproductive alternative. In this way, contractual pregnancy, like many other NRTs, serves to reinforce existing social inequalities rather than reduce them.

c. Controlling Contractual Pregnancy

Contractual pregnancy clearly separates the genetic, biological and social roles of parenthood; and as a result, helps to bring into focus the profound double standard regarding genetic relatedness which underlies much of the debate surrounding NRTs (Eichler, 1994). Eichler summaries the complexities of the genetic relatedness debate quite eloquently.

> So do genetics determine parental status? It depends on whether you are commissioned or commissioning. If you are the commissioning party, your sperm or eggs—if they were used—establish parentage beyond any doubt. If they were not used, the person whose egg, uterus or sperm was used was only a 'substitute' and her or his genetic relationship to the child is only of interest if it will help produce a 'gloriously healthy, plump and squalling newborn'. Genetic relations, after all, seem to be endowed with or stripped of importance to service other interests. (p. 211)

Not only does contractual pregnancy focus the issue of genetic relatedness, it also brings to the fore how fundamentally women's control over their reproductive capacity is being challenged, and usurped by patriarchal social structures, like the medical and legal professions, which develop, support and control NRTs. Perhaps, the greatest ethical debate surrounding contractual pregnancy involves the moral justifiability of this procedure given the many inequalities that exist within society. Sherwin (1994)

> argue[s] that when we are trying to determine the ethical acceptability of a practice, we must attend to its role within the existing patterns of *oppression* in our society. Following Iris Young, I understand oppression to be a form of injustice that is characterized by any combination of exploitation, marginalization, powerlessness, cultural imperialism and violence that are directed at an identifiable social group. '...oppressions are systematically reproduced in major economic, political, and cultural institutions'. (p. 184)

From Sherwin's starting place, gender and social class are two contexts in which contractual pregnancy must be placed and examined. Eichler's (1994) research, into Canadians' use of contractual pregnancy agreements, indicates "that both in terms of class and gender the commissioned women are in an inferior socio-economic situation compared to the commissioning men" (p. 204). U.S. agencies report a similar demographic pattern (Charo, 1988, as cited in Eichler, 1994). As a result, instead of being viewed as a liberating procedure, contractual pregnancy can more accurately be understood as a mechanism that "reinforces existing patterns of inequality," and consequently serves to perpetuate these patterns (Eichler, 1994, p. 204).

D. Adoption

Social workers, in association with the churches, pioneered the adoption process which "has consistently been seen as a contribution to the welfare of children and families" (Brandon & Warner, 1977, p. 337). Adoption, unlike DI, IVF and contractual pregnancy, focuses on, and has been shaped in such a way as to meet the needs of existing children (Lippman, 1996; Pannor & Baran, 1984; Bell, 1986; Daly & Sobol, 1992), instead of being "a solution to the needs of couples who are unable to have their own children" (Haimes & Timms, 1985, p. 96). Lippman (1996) points out that it is questionable whether these reproductive alternatives are a response to an actual "need" or whether, more accurately, they are a response to a "desire" to have children. As discussed earlier, adoption is often experienced as a second best solution when compared to having children that are biologically related (Daly & Sobol, 1992; Kirk, 1964; Miall, 1989; Sokoloff, 1987; Williams, 1992). At the same time, children who are adopted cannot, nor should they be considered second best.

a. Employing Adoption

Adoption, as part of the larger child welfare field, is administered by a range of public and private social service agencies (Brandon & Warner, 1977). Adoption has changed quite significantly over the past decade, "where once adoption was a matter of

approaching an agency in order to 'choose' a child, now couples must investigate a range of options, including public compared to private adoptions, hard-to-place, or older child compared to an infant, and international compared to domestic adoptions" (Daly & Sobol, 1992, p. 2). In Canada, persons wishing to adopt a child have three avenues they can pursue; public, private and international adoption.

Social expectations regarding the idealized family are reflected by adoption criteria (Richardson, 1993) which "[tend] to reinforce a model of the family that is characterized by a married, heterosexual couple with one major wage earner" (Daly & Sobol, 1992, p. 6). This fact has had a significant impact on who is most likely to be successful in adopting a child (Richardson, 1993). Daly and Sobol (1992) point out that the "typical applicant is Caucasian, married, Protestant, between 31 and 35 years of age, infertile, with at least high school education and no prior parenting experience" (p. 5). Private adoption applicants tend to be older and to have more years of education. Adoption applicants who do not meet the idealized family standard are likely to experience difficulty trying to adopt; for example, gay and lesbian couples, single women and men, individuals of a different race and people over 40 years of age (Daly & Sobol, 1992; Richardson, 1993). As well, in the case of private adoptions, sufficient financial resources are also necessary (Richardson, 1993).

b. Success, Cost and Risk of Adoption

There are a number of significant differences between public, private and international adoptions. First, although the number of public adoptions still exceeds that of private adoptions, there has been a significant decrease in the overall number of public adoptions while private adoptions have remained relatively stable over the past 10 years. Daly and Sobol (1992) observe that "because [public] adoptions have decreased overall, the decline is even more dramatic in absolute terms" (p. 3). In 1981, public adoptions represented 82.6% (4,441) of domestic adoptions, while private adoptions represented only 17.4% (1,100). By 1990, public adoptions decreased to 61% (1,731) while private adoption numbers remained relatively constant, comprising 39% of all domestic adoptions. This has translated into longer waiting lists for prospective adoptive parents. Williams (1992) reports that waiting periods can range from 2 to 7 years to adopt a White healthy infant through the Children's Aid Society in Ontario. In addition, approximately 12% of the waiting lists for adoption are closed.

Daly and Sobol (1992) report that it is difficult to compare public and private adoption with international adoptions because, until 1991 record keeping was inconsistent in every province except Quebec. At the same time, Canadians appear to be utilizing international adoption in greater numbers than ever before. It is estimated that three international adoptions occur for every two domestic adoptions (Daly & Sobol, 1992).

A shorter waiting period for international adoptions is one likely explanation for this shift. Daly and Sobol (1992) point out that "although adopting a child privately happens faster, costs are higher. In 1991, couples who adopt privately wait an average of two years and can expect to pay between $3,000 and $4,000 on average" (p. 3). International adoption can be very costly as well. Richardson (1993) states that "although it is illegal to buy children in Britain, travel and other costs amounting to several thousands of pounds are paid by adoptive parents" (p. 85).

Finally, the type of baby that is usually available for adoption differs depending on the type of adoption pursued. Private and international adoptions almost always "involve the placement of healthy infants" (Daly & Sobol, 1992, p. 3). Williams' (1992) research concurs with this finding, but she adds that "this route to parenthood is difficult, uncertain, and expensive" (p. 110). On the other hand, "the typical adoptable child in the public domain has special needs (over the age of one and/or physically or mentally challenged)" (Daly & Sobol, 1992, p. 3).

c. Controlling Adoption

A declining birth rate (Brandon & Warner, 1977) resulting from improved contraception and increased access to safe legal abortions (Speirs & Baker, 1994), coupled with an "increase in the number of single women who have chosen to parent their child" have led to a reduction in the number of infants being placed for adoption

(Speirs & Baker, 1994; Daly & Sobol, 1992, p. 4). If this trend continues, and there is no reason to believe it will not, "there may be even fewer infants available to adopt in the future than at present and it seems likely that requests for [DI, IVF, contractual pregnancy and other NRTs] will increase" (Brandon & Warner, 1977, p. 335). Given this likelihood, it would be prudent to utilize what has already been learned through experience with the adoption process in order to respond more effectively and humanely to the needs of people considering their reproductive alternatives. In addition, researchers and social workers must not overlook the interests of postnatal children in the realm of reproductive technologies. For example, Daly and Sobol (1992) point out that:

> There are implications from what has been learned about adoptive relationships for those new reproductive technologies where there is no genetic link between parents and their children. The social parents and offspring of new reproductive technologies where a donor is involved face many of the same identity challenges that adoptive children and their parents encounter.
>
> By openly acknowledging that the social parent of a child conceived through these new reproductive technologies with donor eggs or sperm does not share a genetic connection to the child, the necessity of maintaining a false narrative of the child's origins and the resulting negative side effects are lessened. (p. 7)

The needs of the child must be more explicitly acknowledged and examined in the development of NRTs and their subsequent application.

E. Living Child Free[7]

---

[7] I wish to draw attention to the inability of the English language to designate the role of women who are not mothers in a non-judgemental and unbiased way. Morrell (1994) clearly conveys the complexity of this dilemma when she states that, "words not only name objects, they convey attitudes....'childless' 'child-free,' 'non-mother.' Each

If the choice to mother is not made freely within an environment where reproduction is encouraged and enforced, then the decision not to mother must be equally constrained (Morell, 1994). Miall (1989) states that "childlessness is viewed as a form of deviant behaviour in that it violates prevailing norms or rules of acceptable conduct" (p. 43). Morell (1994) succinctly describes the social construction of deviance that results from remaining childlessness.

> Maintenance of patriarchal power requires discrediting or marginalizing ways of giving meaning to experience which re-define hegemonic gender norms. For example, the notion that women who are not mothers are as normal as women who are threatens a central patriarchal norm. Diversity must be constructed as deviancy in order to maintain the association of womanhood with motherhood. Given this fact, the work of 'normalizing' motherhood is carried on through the production and distribution of discourses that depreciate childless women. In this way the modern construction of deviance works to create hierarchies among women based on reproductive difference. (1994, pp. 15-16)

---

term is politically and analytically problematic.... 'Childless' and 'non-mothering' not only tell us a woman is not a mother; they tell us that a void exists. Each word reinforces the mother standard, emphasizes absence—something is missing....

'Child-free' is a word some feminists use who wish to contradict patriarchal meaning[!]....

My preference would be for the creation of a new word, as we use the term 'single' (not marriedless or marriage-free) or 'lesbian' (not manless or male-free) (p. 21)."

This would be my preference as well. For, as I continue to employ the word or words presently used to describe a women who is voluntarily or involuntarily childless my thoughts and meaning will also continue to be understood and interpreted within the oppressive patriarchal structure which created these words and their meaning. However, until a new word is conceived I will continue to articulate the inherent constraints of the English language. Reluctantly, I have chosen to use the term "living child free" in an attempt to illuminate the potential for other meaning without adding unnecessary complexity to the discussion.

Thus, motherhood is highly prized and sought after while childlessness whether voluntary or involuntary is seen as deviant and is stigmatizing for women.

The pressure experienced by women to have children varies considerably depending on their particular life circumstance. Some women are actively encouraged to become mothers while others are not. For example, "being childless by choice is seen as selfish in a married couple while to choose to have a child as a single heterosexual women or as a lesbian is to invite disapproval" (Richardson, 1993, p. xi). Richardson (1993) goes on to argue that "the married woman who does not want children will have to be determined if she is going to achieve her aim, and not give way to the pressures on her to change her mind" (p. 64).

Achieving "control over fertility through contraception and abortion" (Richardson, 1993, p. 83) has been one of the primary issues undertaken by feminism. The importance of this endeavour cannot be understated. At the same time, it represents only one dimension of reproductive freedom (Richardson, 1993). The right to choose not to have children is another dimension , and consequently must also be regarded as a viable and reasonable alternative.

The number of women who remain childless has continued to rise gradually, even "while the culture of motherhood is everywhere being rekindled, and remaining childless seems barely thinkable as an option" (Morell, 1994, p. 11). For the greater part of this century the childless rate for women 40-44 years old was between 5-10%, however by 1988 this rate had risen to 15%, well above the average childless rate of the past. Morell

(1994) states that

> demographer Amara Bachu finds that working women are more likely to decide to remain childless and that this phenomenon cuts across class lines. Bachu does not find much difference between professional women choosing not to mother and those women employed in lower-paying service and factory jobs who make the same choice. The 1988 census figures also show that the desire to be childless crosses racial lines. (pp. 11-12)

Many of the personal challenges faced by women who choose not to mother are embodied within their contradictory relationship to patriarchal ideology and social organization (Morell, 1994). Hence, as Morell (1994) clearly points out, "women who remain childless must forge and live out an alternate path" (p. 144). As a result, they must actively redefine their social role as women who are not mothers.

II. Method

1. Design and Sample

This study was a cross-sectional survey design. A random sample of 200 names was drawn from the approximately 2000 names in the database maintained by the Infertility Awareness Association of Canada (IAAC), Toronto Chapter. A sample of 200 represents 10% of the population and was the largest sample size that could be realistically managed. This research is intended to be a preliminary examination of the beliefs and attitudes of couples towards five reproductive alternatives. It is my hope that this research will aid social workers and other health care professionals in order that they may continue to develop their understanding of the complex psychosocial needs of women and men who are infertile and are considering their reproductive alternatives.

Copies of the survey, covering letter, and follow-up letter were submitted for approval at the IAAC Board meeting on March 2, 1995. With a few minor revisions the IAAC Board approved the survey, covering letter, and follow-up letter.

In order to maintain the anonymity of the participants, the surveys were sent to a contact person at IAAC in Toronto. Mail labels were printed, affixed and the surveys mailed. A total of 400 surveys (2 per envelope) were posted on March 9, 1995.

The covering letter explained the purpose of the study and requested that both

members of a couple fill out the survey separately and return them in the stamped, self-addressed envelope provided.[8] Individuals were asked to complete one survey and return it. The School of Social Work at McGill University was the return address used.

A follow-up letter was sent on March 27, 1995, two weeks after the survey was sent, in order to remind participants to complete and return their survey(s).[9] No mechanism to track responses was developed so that participant anonymity could be assured. Respondents were asked to return the survey by April 30, 1995.

[8] Appendix B: Survey Cover Letter.

[9] Appendix C: Survey Follow-Up Letter.

2. Data Collection Instrument

The purpose of this study was to examine the attitudes of individuals who are considering, or have used a reproductive alternative. In order to do this, the *Reproductive Alternatives Attitude Survey*, was developed.[10] It is an adapted version of the survey used by Genuis, Chang and Genuis, (1993).[11] Like their *Survey of Attitudes on Assisted Reproductive Technologies*, this survey was designed so that it would be "easily understood and interesting to a non-medical person and to assist the respondent in recognizing the significance of the various issues" surrounding assisted reproductive technologies (p. 155).

The *Reproductive Alternatives Attitude Survey*, measures the attitudes and experiences of people who are experiencing infertility and are considering the reproductive alternatives that are available to them. This survey includes four vignettes which represent a range of clinical situations.

---

[10] Appendix A: *Reproductive Alternatives Attitude Survey.*

[11] For a complete discussion of the changes made to the *Survey of Attitudes on Assisted Reproductive Technologies* and the rationale for these changes see Appendix D: Development of the *Reproductive Alternatives Attitude Survey.*

Case 1: Donor insemination using donor sperm. A married man in his mid-thirties is diagnosed as infertile and is therefore unable to impregnate his wife.

Case 2: In vitro fertilization using a donated egg and husband's sperm. A 34 year old married woman has been told by her doctor that she is infertile and unable to become pregnant without intervention.

Case 3: Surrogate mother using husband's sperm.[12] An infertile couple wishes to have a child. They decide to engage the services of a surrogate mother who will be inseminated with the husband's semen.

Case 4: Adoption. After a number of years of trying to have a child a couple decides to adopt a child.

A number of statements and questions follow each vignette to which the respondent could answer "Strongly Disagree" (SD), "Disagree" (D), "?" (?) [Unsure or Neutral], "Agree" (A), and "Strongly Agree" (SA). Respondents were encouraged to

---

[12] A revised version of the survey would include changing this vignette to read "Contractual pregnancy using the sperm of the man commissioning the pregnancy. An infertile couple wishes to have a child. They decide to enter into a contractual pregnancy arrangement with a woman who has agreed to be inseminated with the commissioning man's sperm."

comment on the vignettes. For each case, the respondent was provided with space to write her/his thoughts and reactions towards each reproductive alternative described in the vignette.

3. Data Analysis

SPSS® statistical software was used to analyze and describe the survey data using frequency distributions, crosstabs, t-tests, and non-parametric tests, Wilcoxon and McNemar.

The survey was originally designed to accommodate a factor analysis of the results. However, due to the low response rate this method of analysis was not deemed to be appropriate Specifically, the questions, in each of the vignettes (second question through to the fifth question) that asked about the participants comfort depending on whether the person involved was a family member, a close friend, or someone unknown to the participant, were not analyzed. In addition, due to the lack of symmetry in the questioning, the sixth and seventh questions in each of the vignettes ("child's right to know how she/he was conceived" and "I would tell my child how he/she was conceived) were not analyzed either".[13]

In order to develop a detailed description of the participants' social reality, the open-ended questions were analyzed using a qualitative approach. Common themes and ideas were pulled together in order to develop an appreciation for the participants'

---

[13] The lack of symmetry in the questioning is discussed in greater detail in section IV. Discussion: 2. Limitations of the Study.

thoughts and reactions to the reproductive alternatives examined: infertility, reproduction and family creation.

III. Findings

1. Survey Return Rate

A total of 95 surveys were completed and returned. Of these, 37 surveys were completed and returned by couples (35 married; 2 common-law). Twenty-one surveys were returned individually by 20 women and 1 man. The post office returned 17 surveys as undeliverable. In order to compare female and male responses, only surveys returned by both members of a couple were analyzed. Consequently, the return rate for the 74 surveys analyzed was 23%.[14]

---

[14] In order to calculate the return rate of the completed surveys, the number of undeliverable surveys (17) and the number of surveys returned by individuals (21) was subtracted from the total number of addresses to which surveys were sent (200) which equals 162, then the number of surveys returned by couples (37) was divided by 162 which equals a return rate of 23%.

$$\frac{37}{200 - 17 - 21} = \frac{37}{162} = 22.83\% \ (23\%)$$

The overall survey return rate was 32%. The number of surveys returned by couples (37) was added to the number of surveys returned individually (21) which equals 58. Then the number of undeliverable surveys (17) was subtracted from the total number of addresses to which surveys were sent (200) which equals 183. Then 58 was divided by 183 which equals a return rate of 31.69%.

$$\frac{37 + 21 = 58}{200 - 17 = 183} = 31.69\% \ (32\%)$$

2. Sample Description: Salient Demographic Factors

Generally, the participants were well educated, affluent, with the majority aged between 30 and 46 years, representing predominantly Protestant and Catholic religious beliefs. Over half of the participants (40) (54%) had completed an undergraduate or masters degree, while 17 (23%) have attended college or completed a technical training program. A medical doctor and one person with a Ph.D. degree completed the survey. The age of the participants ranged from 26 to 63 years with the majority (55) (74%) falling between 30 and 46. The mean age was 35 years. Two participants were over 46 years of age and 14 (19%) were under 30. The level of income for this group was fairly high, with 19 (26%) of the participants reporting an annual income in excess of $60,000. Forty (54%) of the participants reported earning between $30,000 and $59,999 annually, while 10 (14%) participants indicated that they earn less than $30,000. Thirty-five (47%) of the participants were Protestant, 19 (26%) were Catholic, 5 (7%) were Jewish, and 6 (8%) each reported that they either had other religious beliefs, or that they were agnostic or had no religious beliefs.

Significantly, 15 (40%) couples reported that they have one or more child, and one couple reported that the woman was pregnant at the time she completed the survey. Fifty-seven (77%) of the participants reported that they were considering a reproductive alternative either because they were infertile, their partner was infertile, or both of them had experienced infertility. Generally, males who were identified as infertile by their

female partners were less likely to acknowledge their infertility than were the females who were identified as infertile by their male partners. This observation lends support to other researchers' findings that, although infertility is stigmatizing for women, they are more willing to be identified as infertile than are men. Of the participants who reported knowledge of their own or their partner's infertility, 48 (65%) indicated that they had known for five years or less.

The explanations offered for infertility were more detailed and complex for women than for men. Male factor infertility as explained by low sperm count, low sperm motility and sub-fertility. For women, the explanations for infertility were elaborate and physiologically specific. Of the 51 (69%) participants who defined the nature of female infertility, 24 (32%) identified specific non-functioning body parts as the cause (no or blocked fallopian tubes, non-ovulating or ovulates immature eggs and unformed uterus). A physiological disorder or disease explained female infertility for 17 (23%) participants (Endometriosis, Polycystic Ovarian Syndrome, Pituitaryadema Hyper Prolactenemia, Pelvic Adhesions, and Cancer Treatment - Radiated Ovaries). At the same time, female infertility remained unexplained for 6 (16%) couples, while 4 (11%) incidents of infertility occurred as a result of a tubal ligation, and unexplained recurrent miscarriage.

3. Pressure Felt by Participants to Have Children

Table 1 reveals that almost two thirds (45) of the participants reported that they feel, or have felt pressure to have children.

Table 1

Do You Feel (Have You Ever Felt) Pressure to Have Children?

Gender	Yes		No	
Female	27	(73%)	10	(27%)
Male	18	(49%)	19	(51%)

X^2 (1, $N = 74$) = 4.59, $p < .03$

A significant difference was found between the pressure to have children experienced by women and men. Women were one third more likely to report that they have felt pressure to have children than were men. This finding lends support to the hypothesis that women and men experience social pressure to have children differently, and that women experience greater social pressure to have children than do men.

The source and intensity of the pressure to have children varied a great deal for the participants. Sources of pressure were classified into three categories; internal/personal, external/interpersonal and social/cultural. At the same time, it is necessary to keep in mind the fact that these are heuristic divisions with considerable overlap between categories.

Several female participants reported that the pressure they felt was a self-imposed, internal desire to have children. One woman stated that it is "not so much pressure, however I would term it as a strong DESIRE!" (participant's emphasis) A second woman wrote "pressure isn't a word I'd use. Rather, a deep desire and need is more appropriate." "I have always wanted children" and "for most of my life I thought it was a 'given' that I would have them" were sentiments voiced by several women. When they found out that having children was not a "given," pressure to have children was often interpreted as time running out. As one woman put it, "people make comments about your age and how your biological clock is ticking." Another woman wrote "just my own self-inflicted pressure, clock—ticking etc. Time is always of the essence." A number of participants indicated that the pressure they felt was related to their fear that there was a risk of not having children at all, or not having the desired number of children. The fear of time running out tended to intensify the sense of desperation and reinforce the determination to continue trying. This sentiment is exemplified by the comment of a male participant who expressed his profound feelings of sorrow and loss following the news that his wife had another miscarriage. "Recurrent miscarriages have prevented us from having a third child—revelling in deep personal despair, disappointment and anguish over each failure. Each failure seems to have renewed the determination and pressure to try again."

External/interpersonal sources of pressure included: partner, parents, relatives, in-laws, friends and peers. Again the intensity of the felt pressure varied considerably. In addition, pressure from these sources tended to provoke more intense and heart-felt

emotional responses. A number of female participants felt pressure to have children so they could "feel normal" because "all your friends have kids and talk about them, yet you don't have a child to talk about." Female participants also reported feeling "left out when I see others (known and unknown) with children." As one female participant put it, "six of eight siblings have children; my parents and friends expect children." At the more extreme end of the feeling pressure to have children continuum, one woman indicated that the "pressure from my husband and his family to have children is too much to take. My husband's daily question to me is 'did you phone Dr. C's office?'" Several participants observed that people in their immediate social networks often made thoughtless comments and asked insensitive questions, and "yet they don't know your situation and how much you're hurting and trying to have children." For many participants it is obvious that coming to terms with their infertility is still an important part of the process of considering their reproductive alternatives.

Several participants reported varying degrees of pressure from social/cultural sources. In many cases, social/cultural pressure was reported as a general or free-floating pressure to have children. Participants were able to report the presence of this kind of pressure; however, they were largely unable to articulate a specific source, or give much insight beyond their feeling of its presence in their lives. An example of the ambiguous nature of social/cultural sources of pressure was found in a response from a male participant who wrote, "mostly self-pressure and societal pressure. I badly want children, but also feel societal norms exert pressure too." One female indicated just how intense

and penetrating her sense of being pressured to have children was. "Pressure from the entire world and I felt like screaming at all of them and telling them off because they just have no idea how much not having children is hurting-devastating to the point that living is not worth it!!!!" As the proceeding comments clearly illustrate, the pressure felt to have children varies considerably from participant to participant. The open-ended questions regarding felt pressure to have children elicited a range of responses. Generally, participants who indicated that they felt pressure to have children reported experiencing the greatest amount of pressure from their external/interpersonal relationships. Women tended to elaborate in much greater detail the source and intensity of the felt pressure than did their male partners.

4. Reproductive Alternatives Participants Would Use

Overall, the participants were supportive of adoption, IVF and DI (Table 2).

Table 2

If I Were Infertile I Would Use These Reproductive Alternatives

Reproductive Alternative	G	SD		D		N/?		A		SA	
Donor	F	2	(5%)	3	(8%)	8	(22%)	10	(27%)	14	(38%)
Insemination*	M	5	(13%)	1	(3%)	9	(24%)	15	(41%)	7	(19%)
In Vitro	F	2	(5%)	0	(0)	3	(8%)	9	(34%)	23	(63%)
Fertilization**	M	1	(3%)	2	(5%)	7	(19%)	14	(38%)	13	(35%)
Contractual	F	6	(16%)	8	(22%)	10	(27%)	8	(22%)	5	(13%)
Pregnancy	M	7	(19%)	5	(13%)	9	(24%)	14	(38%)	2	(5%)
Adoption	F	0	(0)	1	(3%)	5	(13%)	10	(27%)	21	(57%)
	M[a]	0	(0)	2	(5%)	4	(11%)	13	(35%)	17	(46%)

Note. G - Gender, SD - Strongly Disagree, D - Disagree, N/? - Neutral/Unsure, A - Agree, SA - Strongly Agree. Responses were coded 1 to 5, with 1 being Strongly Disagree and 5 being Strongly Agree. Pairwise comparison.

[a] $n = 36$, 1 missing value

* Wilcoxon, $n = 37$, $z = -2.12$, $p < .03$ (Female $\underline{M} = 3.84$, Male $\underline{M} = 3.49$)
** Wilcoxon, $n = 37$, $z = -2.37$, $p < .02$ (Female $\underline{M} = 4.39$, Male $\underline{M} = 3.98$)

Table 2 reveals that in each of the vignettes, when participants were asked if they would use a particular reproductive alternative if they were infertile, they agreed or strongly agreed that they would use adoption (83%), IVF (80%) and DI (62%) as a way to bring a

child into their lives. In contrast, only 39% of the participants agreed or strongly agreed that they would use contractual pregnancy.

The Wilcoxon non-parametric test was used to calculate the significance of the differences within couples regarding the use of each of the reproductive alternatives. Significant differences were found between women and men for potential use of DI and IVF. Women were more likely to strongly agree that they would use DI if they were infertile; whereas, men were more likely to only agree when considering the use of DI. In addition, men were more likely to strongly disagree that they would use DI than were their female partners.

In the case of IVF, women were significantly more likely to strongly agree that they would use this reproductive alternative than their male partners. In contrast, men were more likely to report being unsure or neutral about their potential use of IVF than were their female partners.

Interestingly, fewer female participants (35%) indicated they would use contractual pregnancy if they were infertile than their male partners (43%). Finally, virtually no gender difference found between female and male responses to adoption.

5. How Adequately Informed Participants Feel About These Reproductive Alternatives

Table 3 illustrates the findings when participants were asked whether they felt adequately informed about each of the reproductive alternatives (DI, IVF, contractual pregnancy, adoption, and living child free).

Table 3

Do You Feel Adequately Informed About These Reproductive Alternatives?

Reproductive Alternatives	G	Yes		No		Unsure	
Donor Insemination[a]	F	22	(63%)	8	(23%)	5	(14%)
	M	24	(69%)	8	(23%)	3	(8%)
In Vitro Fertilization[a]	F	30	(86%)	5	(14%)	0	(0)
	M	31	(88%)	3	(9%)	1	(3%)
Contractual Pregnancy[b]*	F	7	(19%)	18	(51%)	11	(30%)
	M	16	(44%)	13	(36%)	7	(20%)
Adoption[b]	F	18	(50%)	10	(28%)	8	(22%)
	M	22	(61%)	9	(25%)	5	(14%)
Living Child Free[a]**	F	12	(34%)	13	(37%)	10	(29%)
	M	21	(60%)	7	(20%)	7	(20%)

Note. G - Gender. The categories No and Unsure were collapsed in order to calculate McNemar. Pairwise comparison.

[a] $n = 35$, 2 missing values
[b] $n = 36$, 1 missing value

* McNemar (Binomial) 2-tailed $p < .012$
** McNemar (Binomial) 2-tailed $p < .049$

Surprisingly, 87% of the participants indicated that they felt adequately informed about IVF, perhaps one of the most complex reproductive technologies available. In contrast, only 66% of the participants indicated that they felt adequately informed about DI, which by comparison, is a much simpler procedure than IVF. Table 3 also reveals that, about half of the participants felt adequately informed about adoption (55%) and living child free (47%), and only about one third felt adequately informed about contractual pregnancy (32%).

In the case of living child free, women were almost equally divided between yes (12), no (13), and unsure (10), while men were significantly more likely to indicate that they felt adequately informed about living child free. This finding is noteworthy given the differences reported earlier between women and men regarding felt pressure to have children, and their consideration of the use of different reproductive alternatives.

Only 32% of the participants felt adequately informed about this contractual pregnancy. Women were significantly more likely to indicate that they were unsure, or did not feel adequately informed about contractual pregnancy than their male partners.

6. Child Access to Information About Birth/Genetic Parents

With regard to access to information about biological parents (DI, IVF, contractual pregnancy, and adoption), Table 4 shows that 58 (81%) of the participants agreed or strongly agreed that, when old enough, children who are adopted should have access to this information.

Table 4

A Child Conceived Using A Reproductive Alternative Should Have Access to Information About Birth/Genetic Parents

Reproductive Alternative	G	SD		D		N/?		A		SA	
Donor Insemination	F	6	(16%)	8	(22%)	13	(35%)	7	(19%)	3	(8%)
	M	7	(19%)	6	(16%)	9	(24%)	11	(30%)	4	(11%)
In Vitro Fertilization	F	6	(16%)	8	(22%)	9	(24%)	12	(33%)	2	(5%)
	M	7	(19%)	7	(19%)	7	(19%)	12	(33%)	4	(11%)
Contractual Pregnancy	F	3	(8%)	12	(32%)	5	(14%)	13	(35%)	4	(11%)
	M	6	(16%)	5	(14%)	11	(30%)	10	(27%)	5	(14%)
Adoption*	F	0	(0)	1	(3%)	4	(11%)	20	(54%)	12	(32%)
	M[a]	3	(8%)	2	(5%)	4	(11%)	21	(57%)	6	(16%)

Note. G - Gender, SD - Strongly Disagree, D - Disagree, N/? - Neutral/Unsure, A - Agree, SA - Strongly Agree. Responses were coded 1 to 5, with 1 being Strongly Disagree and 5 being Strongly Agree. Pairwise comparison.

[a] $n = 36$, 1 missing value

* Wilcoxon, $z = -2.14$, $p < .03$ (Female $\underline{M} = 4.16$, $n = 37$, Male $\underline{M} = 3.69$, $n = 36$)

The Wilcoxon non-parametric test was used to calculate the significant differences within couples regarding a child's access (when old enough) to information about her/his birth/genetic parents. Women were significantly more likely to strongly agree that an adopted child should be able to access this type of information, while their male partners were more likely to strongly disagree. There was strong overall agreement by both female and male participants that a child should have access to information about his/her birth/genetic parents, as can be seen in the reported means (female $\underline{M} = 4.16$; male $\underline{M} = 3.69$).

For the other three reproductive alternatives displayed in Table 4, contractual pregnancy, IVF and DI, the support for access to information about the biological parents dropped off sharply. Contractual pregnancy received the next highest level of support with 32 (43%) agreeing or strongly agreeing, and 30 (41%) agreeing or strongly agreeing in the case of IVF. Finally, only 25 (34%) of the participants agreed or strongly agreed that a child conceived using DI should have access to this type of information.

7. Reproductive Alternatives Participants Have Considered/Pursued

When participants were asked if they had ever considered pursuing each of the reproductive alternatives (DI, IVF, contractual pregnancy, adoption, and living child free), Table 4 reveals that 86% of the participants had considered pursuing IVF, and 79% had considered pursuing adoption.

Table 5

Have You Ever Considered Pursuing Any of These Reproductive Alternatives?

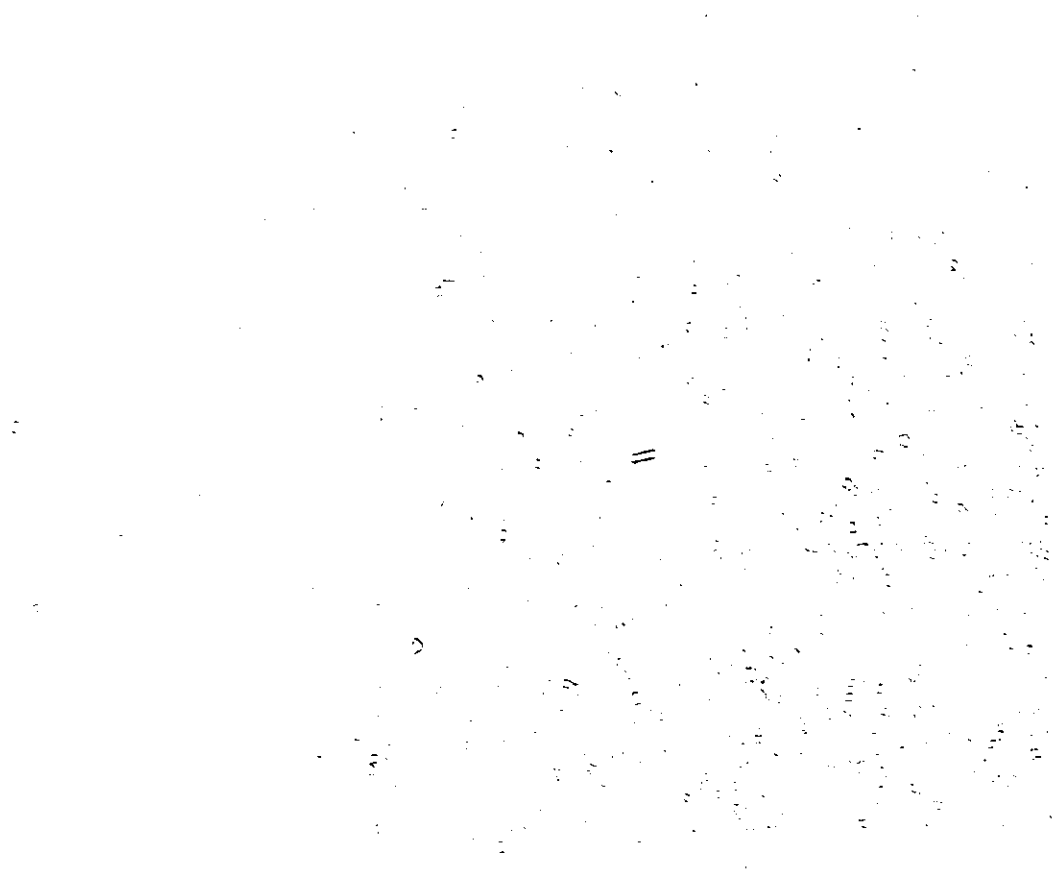
Reproductive Alternative	G	Yes		No		Unsure	
Donor Insemination*	F[a]	13	(36%)	8	(22%)	15	(42%)
	M[b]	10	(30%)	18	(53%)	6	(18%)
In Vitro Fertilization	F[a]	31	(86%)	2	(6%)	3	(8%)
	Mb	29	(85%)	4	(12%)	1	(3%)
Contractual Pregnancy	F[a]	7	(19%)	16	(45%)	13	(36%)
	Mb	8	(23%)	21	(62%)	5	(15%)
Adoption	F[a]	28	(78%)	3	(8%)	5	(14%)
	Mb	27	(79%)	6	(18%)	1	(3%)
Living Child Free	F[a]	13	(37%)	16	(46%)	6	(17%)
	Mb	11	(33%)	15	(46%)	7	(21%)

Note. G - Gender

[a] $n = 36$, 2 missing values
[b] $n = 34$, 3 missing values

* $X^2 (2, N = 70) = 8.04, p < .02$

Comparing women and men within couples, using the McNemar test and collapsing the "no" and "unsure" categories, revealed no significant differences for any of the reproductive alternatives. However, when considering the gender samples as a whole, a significant difference was found for DI. Female participants were significantly more likely to indicate that they were unsure about pursuing DI, while their male partners were more likely to report that they had not considered pursuing DI. Even fewer participants had considered pursuing contractual pregnancy (24%). Again, the support for contractual pregnancy was much lower than for the other reproductive alternatives.



8. Agreement Between Female and Male Attitudes Towards The Reproductive Alternatives

Although significant differences were found between female and male responses for DI, IVF and living child free in the vignettes, unexpectedly an overall theme of agreement was found as well. For example, adoption in Table 2 reveals a similarity in attitude between women and men about whether they would use adoption as a way to bring a child into their lives. In Table 3, with regard to how adequately informed participants felt about the reproductive alternatives, the responses were quite similar for DI, IVF and adoption. In the case of a child conceived using one of these technologies, Table 4 reveals a high level of agreement in female and male attitudes towards IVF with a somewhat lower level of agreement towards DI and contractual pregnancy. Finally, an examination of the reproductive alternatives considered/pursued by participants, Table 5 reveals a high level of agreement within couples for all of the reproductive alternatives. It was only when the gendered sample as a whole was analyzed that a significant difference was found for DI.

9. Outcome If Participants Considered Any Reproductive Alternatives?

When asked, "If you have considered any of these reproductive alternatives what was the outcome? (Question 44), the majority of the participants reported that they had tried one or more. Eight couples had tried intrauterine insemination (IUI), fertility drugs or a combination of these two methods. One couple reported successfully having a child using fertility drugs while another reported success using a combination of IUI and fertility drugs.

IVF was by far the most popular reproductive alternative chosen by this group, which was not surprising given the high level of income reported. Forty-one percent of the attempts to have a child involved numerous cycles of IVF (over 45). Of the 19 couples who had tried IVF, one couple had a child as a result, while a second couple indicated that the woman was pregnant at the time she completed this survey.

Of the participants who had considered using IVF, and had decided not to, cost was most often reported as the primary obstacle to proceeding with this procedure. The following comments made by five female participants are typical; "IVF - can't afford," "we cannot afford IVF, but are saving for the procedure," "still considering IVF, cost is now a big factor," "referred for IVF - due to money we stopped, could not afford IVF" and "IVF - too expensive for success ratio." Interestingly, none of the male participants commented on the cost of IVF. Although on average this group had a high level of

income. the cost of IVF was obviously a significant factor in the decision to go ahead with this procedure.

Twenty-six percent of the attempts to have a child involved DI. Of the 12 couples who have used DI, 4 reported having a child as a result. Overall, the success ratio was higher using DI than it was for IVF. At the same time, there was significant variation in the number of cycles required using DI before a successful pregnancy was achieved. For one couple a pregnancy occurred after the second cycle, while another couple reported using DI in combination with various fertility drugs for over five years before a pregnancy occurred.

None of the participants reported pursuing contractual pregnancy, although 4 couples indicated that they had considered it. One male stated "we were offered surrogacy, but did not accept it." For those who had considered contractual pregnancy it was either too expensive, as one female stated, "money was a big factor," or the fear of losing the child to the contractual mother was too great. One female stated, "we became scared that the surrogate would decide to keep the child and we would lose the child." In the end, these couples chose not to pursue this reproductive alternative.

The remaining 33% of the attempts to bring a child into their lives involved adoption. Fifteen couples reported that they were actively pursuing public, private and/or international adoption. As well, 11 couples were still considering adoption. Of those pursuing adoption, 5 couples have successfully adopted a child (1 private and 1 international adoption, while the other 3 adoptions were public). The majority of the

participants who have, or still are pursuing adoption, have not successfully adopted a child yet.

The lengthy waiting period involved in adoption was cited most often as the biggest impediment to adoption. For many, this was an important factor in their decision whether or not to pursue adoption. One male stated that, "adoption was going to take a long time, but still is not totally out the picture." A number of participants indicated that they have been on an adoption waiting list for a long time. As one female stated "we are trying to adopt, but children that are up for adoption are few and far between. We have been trying for five years."

10. Considering the Possibility of Living Child Free

The possibility of living child free was an alternative that very few participants had seriously considered. One woman was very clear about this. She stated that, "I am still in the 'trying' period, so I am not ready to consider this option although I know I would be very sad about it. I would feel incomplete in a way." Another woman reiterated this sentiment when she stated, "I am not yet ready to make that decision and at this point am still unwilling to let go of hope." By far the majority of participants were unwilling to consider living child free and were still pursuing reproductive alternatives that have the potential to bring a child into their lives. This position was illustrated by a woman who revealed what she has given up in her pursuit to have a child and the lengths to which she would still be willing to go if she could be guaranteed that she could have a child.

> I think about it sometimes. I would put up with all this (the drugs, the Dr.'s appointments) forever if at the end I was guaranteed to have a child, but no one can promise that. Sometimes I think back to before we began trying to conceive and I remember how happy we were.

Frequently, the losses resulting from infertility were profound and had altered the lives of the participants quite significantly. One woman thoughtfully shared how the quest for a child put more strain on her marriage than it could withstand. She revealed, in her story, a sense of compassion and insight for what she and her husband have been through.

> Infertility is very hard to accept when all I wanted was children. We tried every possible alternative in order to have children. The emotional roller coaster of infertility was the last straw for our marriage. We are now separated after 8 years. Six and a half years of infertility. Our names are still in for adoption. The separation and pending divorce is the best thing that has happened to me even though I will probably never have children. It's hard to sum up one's thoughts with infertility. It is an experience that I will always carry with me. I have learned a lot about many things over the years due to infertility. Summing it up: yes I did enough to bring a child into my life.

For several participants, accepting the possibility that they may never have children was often a difficult and painful process which involved a certain amount of grieving. One woman stated, "child free, I'm still making my way through the grieving process." While another woman felt that,

> you can't let infertility consume your life for more than 10 years or so, or you end up spending an ever growing percent of your lifespan focused on a single issue. This stunts personal growth. At some point you have to grieve and move on - just like the death of a spouse.

Many of the women reported that they would feel incomplete if they could not have a child. This sentiment is revealed in the following comment, "I can live with that decision, but I will always feel like something will be missing from my life." By and large, women appeared to be more profoundly impacted by infertility and the ultimate disappointment of being unable to have a child than their male partners. One woman wrote, "I think I could live a happy, fulfilling life, but do believe I would be missing so much not having a child in my life."

The extent of the emotional and psychological trauma experienced when faced with the knowledge that one may never be able to have children, was vividly articulated

by one woman who stated,

> IVF: we have talked about it, but have not met with a specialist as of now. I'm afraid of being disappointed if it didn't work out and I could not deal with such an outcome. I am just starting to slowly accept the fact that I may never carry my own child. I suffered a deep depression for three years, and the way I am, I would find it extremely emotionally difficult if it doesn't work out. I am just starting to accept my destiny of being childless and my husband has as well. We are very close and fortunate to have each other and actually grew a stronger bond as a couple after going through very high emotional stress. I consider myself very lucky that my husband accepts and feels the way I do.

Even when all of the avenues have been exhausted living child free was still not a choice made easily. One woman stated that, "if physically and emotionally drained I would consider this as a last resort." Coming to terms with infertility is in many ways a process which requires a great deal of sensitivity, support and understanding.

A sense of loss and personal disappointment emerged each time a reproductive procedure failed to result in conception and the birth of a child. One woman sounded truly desperate when she stated that,

> after going through many inseminations by my own eggs, now I am desperately waiting for donor eggs. My biological clock is running out and there is not much time left to wait. I am registered with Dr. C and Dr. S's office. I am waiting for donor eggs. As a result, I wait for their call daily. I wonder if I will get a donor egg before my home is torn apart.

Many of the participants, like this woman, were deeply saddened by the inability to have children and indicated that they only held on by a thin thread of hope; if they kept trying they might be able to have a child some day.

Finally, on a more optimistic note, a few women pointed out that it is possible to have meaningful relationships with children who are not your own. One female stated

that, "I felt both IVF and adoption would be too costly, time consuming and emotionally draining. I decided to spend more time and money on the children already in my life - nieces and nephews." A second woman indicated that, "I decided to not raise a child, but this does not mean my life is child free. There are many parents who can use a little help and organizations too." Finally, a third woman stated that she intended to develop stronger relationships with her sister's children. Nevertheless, comments that acknowledged the possibility of developing rewarding relationships with children outside of the traditional parent-child dyad were in the minority.

IV. Discussion

1. Summary of Key Findings

1. Men were less likely to be identified as infertile than women. Generally, men who were identified as infertile by their female partners were less likely to acknowledge their infertility than were the women who were identified as infertile by their male partners.

2. The explanations offered for infertility were more complex and detailed for women than for men. Male factor infertility as explained by low sperm count, low sperm motility and sub-fertility. For women the explanations for infertility were elaborate and physiologically specific.

3. Almost two thirds (61%) of the participants reported that they feel, or have felt, pressure to have children. As well, a significant difference was found in the level of pressure experienced by women and men. Women were one third more likely to report feeling pressure to have children than were men. The source and intensity of the pressure to have children varied considerably, and was classified into three categories; internal/personal, external/interpersonal and social/cultural.

Generally, participants who indicated that they felt pressure to have children reported experiencing the greatest amount of pressure from their external/interpersonal relationships (e.g., friends, family, partner). Women tended to elaborate in much greater detail the source and intensity of the felt pressure than did their male partners.

4. In each of the vignettes, when participants were asked if they would use a particular reproductive alternative if they were infertile, they agreed or strongly agreed that they would use adoption (83%), IVF (80%) and DI (62%), while only 39% of the participants agreed or strongly agreed that they would use contractual pregnancy as a way to bring a child into their lives. The Wilcoxon non-parametric test revealed a significant difference between women and men and their potential use of DI and IVF. Women were more likely to strongly agree that they would use DI if they were infertile; whereas, men were more likely to only agree when considering the use of DI. In the case of IVF, women were significantly more likely to strongly agree that they would use IVF, while men were more likely to report being unsure or neutral about their potential use of IVF.

5. Surprisingly, 87% of the participants indicated that they felt adequately informed about IVF, while only 66% of the participants indicated that they felt adequately informed about DI. About half of the participants felt adequately informed about

adoption (55%) and living child free (47%), and only about one third felt adequately informed about contractual pregnancy (32%). In the case of living child free, women were almost equally divided between yes (12), no (13), and unsure (10), while men were significantly more likely to indicate that they felt adequately informed about living child free.

6. With regard to access to information about biological parents, 58 (81%) of the participants agreed or strongly agreed that, when old enough, children who are adopted should have access to this information. The Wilcoxon non-parametric test revealed a significant difference within couples. Women were significantly more likely to strongly agree that an adopted child (when old enough) should have access to information about his/her birth/genetic parents. Support for access to information about biological parents dropped off sharply for contractual pregnancy 32 (43%), IVF 30 (41%), and DI 25 (34%).

7. When considering the gender samples as a whole, a significant difference was found for DI. Female participants were significantly more likely to indicate that they were unsure about pursuing DI, while men were more likely to report that they had not considered pursuing DI.

8. Unexpectedly, there was a high level of agreement found between female and male attitudes towards each of the reproductive alternatives. Although significant differences were found between female and male responses for DI, IVF and living child free in the vignettes, there was an overall theme of agreement in the responses given.

9. The majority of the participants reported that they had tried one or more reproductive alternative. IVF was by far the most popular. Forty-one percent of the attempts to have a child involved numerous cycles of IVF (over 45). Cost was most often reported as the primary obstacle to proceeding with this procedure. Twenty-six percent of the attempts to have a child involved DI. Of the 12 couples who have used DI, 4 reported having a child as a result. Overall, the success ratio was higher using DI than it was for IVF. None of the participants reported pursuing contractual pregnancy. The remaining 33% of the attempts to bring a child into their lives involved adoption. The lengthy waiting period involved in adoption was cited most often as the biggest impediment to pursuing adoption.

10. The possibility of living child free was an alternative that very few participants had seriously considered. Many were still pursuing one or more reproductive alternative. Frequently, the losses that resulted from infertility were quite profound and had altered the lives of the participants significantly. For several

participants, accepting the possibility that they may never have children was often a difficult and painful process which involved a certain amount of grieving. Many of the women reported that they would feel incomplete if they could not have a child. By and large, women appeared to be more profoundly impacted by infertility and the ultimate disappointment of not being able to have a child than men. A sense of loss and personal disappointment emerged each time a reproductive procedure failed to result in conception and the birth of a child. Even when all of the avenues had been exhausted, living child free was still not a choice made easily.

2. Limitations of the Study

The study has a number of limitations: low response rate, small sample size, and lack of continuity between the questions in each of the vignettes.

The response rate was somewhat low (23%) which is one of the biggest drawbacks to using a mail survey design (Neuman, 1991). Although a follow-up letter was sent to all of the names drawn in the sample, in order to maintain anonymity, no mechanism for tracking participant response was developed. Consequently, there was no way to send a second reminder letter to only those people who had not completed the survey.

There are a couple of factors which may have contributed to the low survey return rate. First, the method of questioning employed meant that the survey took about an hour to complete which may have been too long for some participants. The complexity of the topic examined necessitated that the survey include a range of questions for each reproductive alternative (DI, IVF, contractual pregnancy, adoption, and living child free) which may have resulted in some participants losing interest before completing the survey. Overall, the findings suggest that the case vignettes were successful in outlining the complexity of the issues in a way that was understandable to the participants. Second, a certain amount of self-selection may have occurred given the nature of the topic under examination. A diagnosis of infertility and subsequent consideration of various reproductive alternatives is often a difficult and emotionally demanding experience. This

is particularly true when a person is first diagnosed as infertile. In addition, a person may be reluctant to fill out a survey of this nature if that person is unaware of, or has not yet had the opportunity to work through his or her emotional issues surrounding infertility, and the ramifications this diagnosis is likely to have on the rest of his or her life. As a result, some participants may have refrained from completing the survey because they were still experiencing emotional discomfort around their own, or their partner's infertility.

A second limitation of the study is the small sample size. Given the size of the population from which the sample was drawn (2000 members of the Infertility Awareness Association, Toronto Chapter), Neuman (1991) suggests that the sample should be between 20% to 30% of the population (400 to 600 members). This study was an attempt to begin to describe the attitudes of infertile couples considering their use of a number of reproductive alternatives. As a result, the degree of accuracy required by the study was low (small sample size required). At the same time, the degree of variability in the population is fairly high and there was a high number of variables examined in the study (large sample size required). Both of these factors point to the need for a larger sample. Perhaps a sample of 500 (25%) would be adequate. However, given the financial constraints of a graduate student conducting independent research, the sample size chosen was the largest that could be realistically managed.

A third limitation of the study concerns the structure of the survey. Unfortunately, the importance of continuity between the questions in each of the

vignettes was overlooked. In Case 4, the vignette about adoption, the questions, "An adopted child should have a right to know that he/she was adopted," and "If I adopted a child I would tell my child that she/he was adopted," were not included in the survey. This was an unfortunate oversight in the design of the survey. A great deal of research has been conducted in the area of adoption. Consequently, adoption could have served as an effective baseline from which to measure participant attitudes towards the other reproductive alternatives (DI, IVF, contractual pregnancy, and living child free) examined in the study. This limitation is especially relevant, considering the observation that DI and IVF are at a similar stage in their evolutionary development as adoption was twenty years ago.

3. Implications of the Research Findings

Although the nuclear family is not the norm in Canada, this ideal is deeply woven into the social fabric of our society. This has had a significant impact on female and male expectations with regard to desirable family structure (Mackie, 1991). The idealized nuclear family coupled with the celebration of parenthood and encouragement to reproduce in Western societies has resulted in most people assuming that when they decide to have children they will be able to do so without the need for any type of medical intervention (Pannor & Baran, 1984; Richardson, 1993). Unfortunately, this is not true for everyone. As many as one in six couples will experience infertility at some point in their relationship (Baker, 1994; Bell, 1986; Dulberg & Stephens, 1989; Matthews & Matthews, 1986; Sokoloff, 1987; Zimmerman, 1982). Consequently, social workers have a significant role to play in helping women and men respond effectively to the challenges and opportunities presented by an increasing infertility rate, the development of reproductive technologies and the subsequent use of these reproductive alternatives. The following discussion outlines a number of the implications of the proceeding research findings for further research, social work education, practice and social policy development.

A. Further Research

Social workers have expertise in assessing psychosocial adjustment; hence, it is logical for them to conduct research in an area where psychosocial adjustment is a key factor in client well-being. To date, only a few studies have been conducted which have attempted to examine the psychosocial impact of infertility, reproduction, reproductive technology and the reproductive alternatives available on the individuals involved (Black, Walther, Chute & Greenfeld, 1992; Daniels, 1989; Miall, 1989, for example).

Social workers have pioneered much of the research on the importance of genetic record keeping for adoptees and children born using DI. This research has raised awareness, helped to focus policy issues, and inform the creation of new laws (Bell, 1986). This study found that there was a significant amount of support for access to information for adopted children. These findings are congruent with current thinking and research regarding what is in the best interests of the adopted child, adoptive parents and the birth parents. Unfortunately, support for access to information dropped off sharply for children conceived using the other reproductive alternatives. Consequently, there is a need for social workers and other health care professionals to increase awareness of the benefits to children who have access to information concerning their birth/genetic parents when they are old enough. Within this educational process, a research component could be implemented which would allow social workers and other heath care professionals to

develop a more systematic understanding of the mechanisms that increase parent comfort with the child's right to access information about her/his biological parents.

Longitudinal research into the outcomes of reproductive alternatives would be a logical next step for social workers as well. For example, social workers could examine the growth and development of children born using various reproductive alternatives, the formation of parent-child relationships, or parental adjustment/reaction to their non-traditional parenting roles. With regard to non-traditional parenting roles, future research could include an examination of DI as asymmetrical adoption. For example, the question "Does a power imbalance in the marital relationship result because the mother is biologically related to the child and the father is not?" could be examined.

Although a number of significant female and male differences were found for these reproductive alternatives, the degree of within couple agreement for these reproductive alternative is also noteworthy. Women and men who were considering, or who were actually pursuing a reproductive alternative, were likely to share similar views regarding each of the reproductive alternatives. Examination of how this within couple support can be cultivated and maintained in a therapeutic environment would, no doubt, benefit couples who find that they are unable to have children without some type of intervention.

Social workers need to take an active role in research surrounding NRTs and the application of these reproductive alternatives by offering their input and expertise in the

research being conducted by other health care professionals, and by actively undertaking their own research initiatives.

B. Social Work Education

The complexities of the issues surrounding infertility, reproductive technology, and the reproductive alternatives available, require that social workers engage in multi-disciplinary learning.

In order to respond creatively and effectively to the challenges presented by NRTs and the resulting reproductive alternatives, social workers will need to have access to high quality education, thus enabling them to enhance their understanding and appreciation of the range of psychosocial issues involved when working with people who are infertile and/or considering their reproductive alternatives. This education should include a basic level of knowledge and understanding regarding the medical and scientific procedures that are available; as well as, the legal concerns that are often present. In addition, a thorough appreciation of the moral and ethical debates surrounding NRTs and their application is necessary.

Opportunities for social workers to specialize in the area of NRTs requires that social work students have access to an inter-disciplinary selection of courses in order that they may choose the ones that will enable them to explore psychosocial issues as they

relate to infertility, reproductive alternatives, scientific medical procedures, legal concerns, and the moral and ethical issues that are present when working in this field.

Social workers need to be able, as they have in other areas of specialization, to cut across arbitrary and artificial boundaries in order to effectively meet the diverse needs of their client group. For example, Holbrook (1989) states that "schools of social work should develop courses to train social workers and others such as lawyers and medical practitioners to deal with the range of adoption and infertility issues, with special emphasis on the ethical concerns raised by the new reproductive technologies" (p. 336). As well, education into the relevant legal issues is required in order that social workers might develop an appreciation of the legal complexities of some of the reproductive alternatives available. In the case of contractual pregnancy, for example, the man commissioning the pregnancy must usually engage the services of a broker or lawyer, who will draw up a contract for the parties involved to sign.

In summary, it is recommended that schools of social work continue to address the educational needs of social workers wishing to practice and already practising in this field. Schools of social work could offer this learning opportunity in the form of advanced degrees, thus enabling social workers to specialize in this area if they wish. By coordinating the inter/multi/trans-disciplinary learning required, schools of social work can create, and maintain a direct link between social work education, research and direct practice application.

C. Social Work Practice

The pressure to have children reported by the participants, particularly women, tends to exemplify social expectations regarding the creation of the ideal family, and the roles of women and men in this social arrangement. This in turn makes it difficult for individuals to address, much less come to terms with their infertility and the possibility of not having children.

Working with both members of the couple ensures that both are actively involved and informed throughout the reproductive decision making process. In addition, as other related issues arise they can be dealt with more quickly and effectively because both partners are already committed participants in the reproductive decision making process.

Understanding the importance and dynamic nature of social systems and social networks, how they work and their impact on the lives of infertile women and men, is one of the areas of expertise of the social work profession. Within a social work perspective there is recognition of the inherent value and dignity of each individual; as well as, an appreciation for the interdependence of all individuals within the social systems of which they are a part. This is a 'person-in-environment' perspective (Collins, 1986). This reflects a holistic perspective which focuses on the interface between the individual and their social systems at the economic, psychological, psychosocial, social, and political levels (Collins, 1986).

Helping women and men to better manage personal issues and understand how these issues impact interactions with other people is another area where social workers can work constructively with women and men who are considering their reproductive alternatives. Social work practitioners must enable their clients to create choices and alternatives for themselves, weighing the consequences of each possibility, and then acting on their decision within a framework that clearly articulates the need for "'effecting an optimal ecological exchange balance'" (Collins, 1986, p. 216). There is a need to work towards the development of solutions that are workable for all parties involved while recognizing and acknowledging the social pressure on both women and men to have children.

a. Advocate

The discussion of the pressure participants felt to have children underlies the importance of the advocacy role of the social worker. This is particularly important as the dignity of the individual may be superseded "by the press of technology that loses track of its purpose" (Abramson, 1990, p. 12). Forty-five of the participants reported that they have felt pressure to have children, and the open-ended responses clearly reveal that when infertile women and men are considering their reproductive alternatives, they are making choices that will have a tremendous impact on their lives.

Certainly, circumventing infertility may be important for many women and men. However, when circumventing infertility is presented as the norm, to which all infertile individuals are expected to aspire, one must question how much real choice is involved and how much choice is being manufactured by individuals who have a vested interest in certain responses to infertility (Finkelstein, 1990; Lippman, 1994; Overall, 1987; Richardson, 1993; Sherwin, 1992). Richardson (1993) states, "if the idea of women not having children was socially more acceptable, then infertility would no longer be regarded as such a problem, nor would the infertile have as great a need for their own pressure groups" (p. 86).

For couples considering their use of a reproductive alternative the potential exists to disempower them as they begin to consider and/or eventually undergo various medical procedures in an attempt to have a child. As a result, it would be advantageous if social workers could aid their clients in finding solutions that help prevent them from feeling disempowered during the decision making process. For clients, having control in the therapeutic relationship is often a first step in gaining control over other aspects of their lives. Clients must be given responsibility for themselves, be encouraged to take charge of their own lives and be aware of the processes by which they relinquish their power.

Miall (1989) states that "social workers must be alert to the potential for abuse of their clients by an overzealous medical profession" (p. 50). Because social workers are not responsible for the actual application of the technology employed, as are doctors and other health care personnel, they are in a good position to remain aware of the need for

continued respect for the autonomy and dignity of the client undergoing the treatment or procedure. Abramson (1990) states that "by questioning the purpose of the technology, by encouraging dialogue and negotiation amongst all the participants, and by advocating for the patient when s/he is not able to do so for him/her self" (p. 13) the social worker can ensure that the autonomy of the client is respected and that medical abuses are avoided (Miall, 1989).

b. Educator

The importance of the role of the social worker as an educator is exemplified in the findings regarding how adequately informed participants felt about each of the reproductive alternatives. Participants were asked if they felt adequately informed about a particular reproductive alternative. The responses may more accurately reflect participant's acceptance of that reproductive alternative, rather than actual knowledge about that alternative. For example, 87% of the participants indicated that they felt adequately informed regarding IVF, a medically complex procedure, while only 66% indicated that they felt adequately informed about DI, a fairly straightforward procedure.

Social workers acting as educators can enhance the decision making capacity of their clients by encouraging infertile individuals to raise questions about the procedures involved including; success rate, duration of treatment, side effects, and the risks involved. In addition, social workers should facilitate discussion and examination of the

psychosocial issues involved in a decision to employ a reproductive alternative. All of this should be done in an environment that is supportive, open, and encourages questions from the client. This will result in clients being better equipped to make decisions that are more suitable to their particular situation. Miall (1989) states that "medical social workers in particular should ensure that their clients are aware of the benefits and risks involved in a procedure, the success ratio of a program, and their right to withdraw from a program at any of its stages" (p. 50). Bell concludes that "the social worker in the education model would help people screen out themselves rather than act as a gatekeeper" (p. 433). Possessing accurate information with which to make an informed decision is critical to client well-being. The importance of informed consent cannot be overstated, especially when both the underlying and overt social pressure to conform to the idealized family form is recognized and acknowledged.

Another aspect of the educator role of the social worker is to inform clients about the moral and ethical issues involved when considering and/or proceeding with any one of the reproductive alternatives available. For example, the findings of this study indicate that participants who have considered employing contractual pregnancy have little appreciation for the impact this arrangement would have on the woman who agreed to carry the child to term for the couple. This lack of understanding and appreciation for the complexity of the issues involved, when considering a reproductive alternative, serve largely to perpetuate and reinforce the subordinate status of women in our society. Consequently, the educator role of the social worker is critical if the attitudes and

behaviour of clients are to be changed through increased awareness and sensitivity to the moral and ethical debates. Increasing the clients' awareness and understanding of the range of moral and ethical issues involved when considering reproductive alternatives is likely to increase the number of informed and socially conscious decisions made.

c. Counsellor

When the participants were asked which of the reproductive alternatives they had considered pursuing, or whether they felt adequately informed about each of the reproductive alternatives, the responses obtained point to a need for some form of counselling, and/or follow-up in order to help many of the participants to come to terms with their infertility and the possibility that they may not be able to have children. This can be done by demonstrating sensitivity, understanding and support while guiding clients on the emotional roller coaster that is so often a part of a diagnosis of infertility.

The role of the social worker as counsellor is also important in planning and delivering services to infertile clients and their partners. Counselling not only helps couples work through the emotional turmoil of a failed treatment, but it also helps people to come to terms with their infertility, and eventually to consider the reproductive alternatives available to them. In addition, counselling throughout this process can help in the early detection and treatment of sexual dysfunction that may result from either the infertility diagnosis, or at any time during the treatment process.

Social work counselling can take several forms. For example, several authors have documented the positive experience many clients have reported following support group participation (Greenfeld, Diamond, Breslin & DeCherney, 1986; Daniels, 1989). The opportunity to share their experiences and frustrations gives many clients the chance to normalize their experience of being infertile. With regard to the range of social work counselling that can be offered, Greenfeld, Diamond, Breslin and DeCherney (1986) state that by being "knowledgeable about and skilled in a variety of modalities including group therapy, marital therapy, crisis intervention, adoption counseling, and sex therapy, the social worker can provide counseling directly or refer clients to appropriate resources" (p. 79).

For clients not deemed suitable for a particular procedure (IVF, for example), or for the many clients who do undergo treatment procedures, but whose attempt(s) are unsuccessful, there is a need for follow-up counselling. Follow-up counselling can help these clients cope with the psychosocial distress they may be experiencing and could be a helpful step in coming to terms with their infertility. Greenfeld, Diamond, Breslin and DeCherney (1986) state that,

> resolving the problems of infertility is sometimes choosing to accept the infertility and to live a 'child-free life.' Sometimes, the resolution comes when couples find that after years or months of exhausting medical treatment, they have become pregnant. In other cases, the resolution is in choosing an alternative to biological parenting. (p. 77)

Finally, a number of participants indicated that it is possible to have a meaningful relationship with a child outside of the traditional parent-child dyad. Richardson (1993)

points out that it is not necessary for adults to have children in order to develop meaningful relationships with them. She clearly articulates how the cultural notion that having one's own children is a necessary pre-requisite to developing meaningful relationships with children. This assumption shapes what is assumed to be natural and therefore possible. There are many other opportunities to have worthwhile contact with children which do not require giving birth to them (Richardson, 1993). From this perspective living child free is seen as a viable reproductive alternative. One which does not have to be absent of the meaningful presence of children.

D. Social Policy Development

The recent rapid technological advances in the area of NRTs have out-paced the development of relevant social policy (Basen, 1992; Sherwin, 1992), which has often led to the creation of conflicting case laws surrounding these biomedical advances (Walther & Young, 1992). Abramson (1991) states that social work has the requisite "knowledge, values and skills to play an active leadership role in the debate that will be necessary to balance the increasingly complicated demands of increasing technology and diminishing resources" (p. 15). Social workers must advocate for their clients, and participate in the creation of social policy that will help to regulate and control the development and use of reproductive alternatives (Abramson, 1991; Walther & Young, 1992) in such a way as to minimize the abuses of these technologies and reproductive alternatives.

Social workers involved in policy development must consider the issues and work towards the creation of humane social policy that supports effective intervention strategies. For example, the findings from this study indicate that although the participants were only moderately supportive of contractual pregnancy (38%) they expressed little awareness of the moral and ethical issues surrounding the use of this procedure. The participants expressed little concern, or insight into the issues that a contractual mother must face. Of paramount concern to them was the cost of this alternative and the possibility that the contractual mother might change her mind and wish to keep the child. This finding points out the importance of the development of policy that protects the interests of all of the parties involved, including the contract mother. The social work professional's understanding of the dynamic psychosocial issues surrounding NRTs and reproductive alternatives, coupled with experience working effectively within complex social networks, will certainly be valuable as social workers continue to contribute to the development of sound, ethical social policy.

In conclusion, as the incidence of infertility increases, and as greater numbers of people consider accessing the reproductive alternatives available, social workers and other health care professionals will be increasingly called upon to help families cope with a range of psychosocial issues related to infertility, reproduction and family creation. Consequently, the development of a more thorough understanding of attitudes towards reproductive alternatives will aid social workers and other health care professionals in the creation of programs and services, and the development of policies that are of greater

benefit to all parties concerned: infertile women and men, their partners, and their children.

Bibliography

Abramson, M. (1990). Ethics and technological advances: Contributions of social work practice. *Social Work in Health Care, 15*(2), 5-17.

Achilles, R. (1986). *The social meaning of biological ties: A study of participants in artificial insemination by donor*. Unpublished doctoral dissertation, University of Toronto, Toronto.

Achilles, R. (1992). *Donor insemination: An overview*. Ottawa: Royal Commission on New Reproductive Technologies.

Andersen, M. L. (1991). Feminism and the American family ideal. *Journal of Comparative Family Studies, 22*, 35-46.

Baker, H. W. G. (1994). Male infertility. *Endocrinology & Metabolism Clinics of North America, 23*(4), 783-93.

Baker, M. (1984). Concerns and controversies within family sociology. In M. Baker (Ed.), *The family: Changing trends in Canada* (pp. 1-20). Toronto: McGraw-Hill Ryerson.

Baran, A., & Pannor, R. (1989). *Lethal secrets: The psychology of donor insemination*. New York: Amistad.

Basen, G. (Director), & Armstrong, M. (Producer). (1992). *On the eighth day: Perfecting mother nature, making babies, and Making perfect babies* [videotapes]. (Parts 1 & 2), National Film Board of Canada.

Basen, G., Eichler, M., & Lippman, A. (Eds.). (1993). *Misconceptions: The social construction of choice and the new reproductive and genetic technologies*. Vol. 1, Quebec: Voyageur.

Basen, G., Eichler, M., & Lippman, A. (Eds.). (1994). *Misconceptions: The social construction of choice and the new reproductive and genetic technologies*. Vol. 2, Quebec: Voyageur.

Bell, C. J. (1986). Adoptive pregnancy: Legal and social work issues. *Child Welfare, 65*(5), 421-436.

Black, R. B., Walther, V. N., Chute, D., & Greenfeld, D. A. (1992). When in vitro fertilization fails: A prospective view. *Social Work and Health Care, 17*(3), 1-19.

Brandon, J., & Warner, J. (1977). A.I.D. and adoption: Some comparisons. *British Journal of Social Work, 7*(3), 335-341.

Canadian Fertility and Andrology Society and Society of Obstetricians and Gynaecologists of Canada. (1990). *Ethical considerations of the new reproductive technologies*. Toronto: Ribosome Communications.

Charo, R. A. (1988). Legislative approaches to surrogate motherhood. *Law, Medicine and Health Care, 16*(1-2), 96-112.

Clamar, A. (1989). Psychological implications of the anonymous pregnancy. In J. Offerman-Zuckerberg (Ed.), *Gender in transition: A new frontier* (pp. 111-121). New York: Plenum Medical Book.

Collins, B. G. (1986). Defining feminist social work. *Social Work, 31*(3), 214-219.

Conseil du statut de la femme. (1989). *General opinion of the Conseil du statut de la femme in regard to new reproductive technologies*. Quebec: Government du Quebec.

Cooper, D., & Herman, D. (1991). Getting "the family right": Legislating heterosexuality in Britain, 1986-1991. *Canadian Journal of Family Law/Revue Canadienne de Droit Familial, 10*(1), 41-78.

Corea, G. (1985). *The mother machine: Reproductive technologies from artificial insemination to artificial wombs*. London: Harper & Row.

Daly, K. J., & Sobol, M. P. (1992). *Highlights from adoption as an alternative for infertile couples: Prospects and trends*. Ottawa: Royal Commission on New Reproductive Technologies.

Daniels, K. R. (1986). New birth technologies: A social work approach to researching the psychosocial factors. *Social Work in Health Care, 11*(4), 49-60.

Daniels, K. R. (1988). Artificial insemination using donor semen and the issue of secrecy: The views of donors and recipient couples. *Social Science and Medicine, 27*(4), 377-383.

Daniels, K. R. (1989). Psychosocial factors for couples awaiting in vitro fertilization. *Social Work in Health Care, 14*(2), 81-98.

Daniels, K. R. (1993). Infertility counselling: The need for a psychosocial perspective. *British Journal of Social Work, 23*, 501-515.

Dulberg, C. S., & Stephens, T. (1989). The prevalence of infertility in Canada, 1991-1992: Analysis of three national surveys. *The prevalence of infertility in Canada* (Vol.2, pp. 61-106). Ottawa: Royal Commission on New Reproductive Technologies.

Edwards, J. N. (1991). New conceptions: Biosocial innovations and the family. *Journal of Marriage and the Family, 53*, 349-360.

Eichler, M. (1994). Reflections on the "temporary use of normally functioning uteri." In G. Basen, M. Eichler, & A. Lippman (Eds.), *Misconceptions: The social construction of choice and the new reproductive and genetic technologies* (Vol. 2, pp. 193-214). Toronto: Voyageur.

Erlen, J. A., & Holzman, I. R. (1990). Evolving issues in surrogate motherhood. *Health Care for Women International, 11*(3), 319-329.

Ferree, M. M. (1990). Beyond separate spheres: Feminism and family research. *Journal of Marriage and the Family, 52*, 866-84.

Feders, S. (Producer), Feders, S., & Miller, L. (Director). (1994). *First person with Maria Shriver: I want a baby.* [television]. National Broadcasting Corporation.

Finkelstein, J. L. (1990). Biomedicine and technocratic power. *Hastings Center Report*, July/Aug. 13-16.

Genuis, S. J., Chang, W. C., & Genuis, S. K. (1993). Public attitudes in Edmonton toward assisted reproductive technology. *Canadian Medical Association Journal, 149*(2), 153-161.

Greenfeld, D., Diamond, M. P., Breslin, R. L., & DeCherney, A. (1986). Infertility and the new reproductive technology: A role for social work. *Social Work in Health Care, 12*(2), 71-81.

Haimes, E., & Timms, N. (1985). *Adoption, identity and social policy: The search for distant relatives.* Aldershot, Hants England: Grower Publishing.

Harding, S. (1987). Introduction: Is there a feminist method? In S. Harding (Ed.), *Feminism and methodology: Social science issues* (pp. 3-14). Bloomington: Indiana University Press.

Herz, E. K. (1989). Infertility and bioethical issues of the new reproductive technologies. *Psychiatric Clinics of North America, 12*(1), 117-131.

Holbrook, A. M. (1990). Adoption, infertility, and the new reproductive technologies: Problems and prospects for social work and welfare policy. *Social Work, 35*(4), 333-337.

Hornstein, F. (1984). Children by donor insemination: A new choice for lesbians. In R. Arditti, R. D. Klein, & S. Minden (Eds.), *Test-tube women: What future for motherhood?* (pp. 373-381). London: Pandora.

Kirk, D. H. (1964). *Shared Fate: A theory and method of adoptive kinships*. British Columbia: Ben-Simon Publications.

Klein, R. D. (1984). Doing it ourselves: Self insemination. In R. Arditti, R. D. Klein, & S. Minden (Eds.), *Test-tube women: What future for motherhood?* (pp. 382-390). London: Pandora.

Lippman, A. (1994). Women's "childbearing age" as biomedical [re]creation: Prenatal testing and postmenopausal pregnancy. In G. Basen, M. Eichler, & A. Lippman (Eds.), *Misconceptions: The social construction of choice and the new reproductive and genetic technologies* (Vol. 2, pp. 137-145). Toronto: Voyageur.

Lippman, A. (1996). Personal communication. 16 January.

Mackie, M. (1991). *Gender relations in Canada: Further explorations*. Toronto: Butterworths.

Matthews, R., & Matthews, A. M. (1986). Infertility and involuntary childlessness: The transition to nonparenthood. *Journal of Marriage and the Family, 48*(3), 641-49.

McWhinnie, A. (1986). AID and infertility. *Adoption & Fostering, 10*(1), 16-18.

Miall, C. E. (1985). Perceptions of informal sanctioning and the stigma of involuntary childlessness. *Deviant Behaviour, 6*, 383-403.

Miall, C. E. (1989). Reproductive technology vs. the stigma of involuntary childlessness. *Social Casework, 70*(1), 43-50.

Morell, C. M. (1994). *Unwomanly conduct: The challenges of intentional childlessness*. New York: Routledge.

Neuman, W. L. (1991). *Social research methods: Qualitative and quantitative approaches*. Needham Heights, MS: Allyn and Bacon.

Overall, C. (1987). *Ethics and human reproduction: A feminist analysis*. Boston, MA: Unwin Hyman.

Pannor, R., & Baran, A. (1984). Open adoption as standard practice. *Child Welfare, 63*(3), 245-250.

Raymond, J. (1990). Reproductive gifts and gift giving: The altruistic women. *Hastings Center Report*, Nov/Dec, 7-11.

Raymond, J. (1993). *Women as wombs: Reproductive technologies and the battle over women's freedom*. New York: Harper San Francisco.

Rich, A. (1986). *Of woman born: Motherhood as experience and institution* (10th anniversary ed.). New York: W. W. Norton.

Richardson, D. (1993). *Women, motherhood and childrearing*. London: MacMillan Press.

Rothman, B. K. (1989). *Recreating motherhood: Ideology in a patriarchal society*. New York: W. W. Norton.

Rowland, R. (1984). Reproductive technologies: The final solution to the woman question? In R. Arditti, R. D. Klein, & S. Minden (Eds.), *Test-tube women: What future for motherhood?* (pp. 365-369). London: Pandora.

Sanschagrin, M. L., Humber, E. L., Speirs, C. Cumming, & Duder, S. (1993). A survey of Quebec pediatricians' attitudes toward donor insemination. *Clinical Pediatrics*, April, 226-230.

Sherwin, S. (1992). *No longer patient: Feminist ethics and health care*. Philidelphia: Temple University Press.

Sherwin, S. (1994). Some reflections on "surrogacy". In G. Basen, M. Eichler, & A. Lippman (Eds.), *Misconceptions: The social construction of choice and the new reproductive and genetic technologies* (Vol. 2, pp. 183-192). Toronto: Voyageur.

Sokoloff, B. Z. (1987). Alternative methods of reproduction: Effects on the child. *Clinical Pediatrics, 26*(1), 11-16.

Spallone, P. (1989). *Beyond conception: The new politics of reproduction.* Granby, MA: Bergin & Garvey.

Speirs, C. Cumming, & Baker, M. (1994). Eligibility to adopt: Models of "suitable" families in legislation and practice. *Canadian Social Work Review/Revue Canadienne de Service Social, 11*(1), 89-102.

Tong, R. (1989). *Feminist thought: A comprehensive introduction.* Boulder: Westview Press.

Wajcman, J. (1991). *Feminism confronts technology.* Pennsylvania: Pennsylvania State University Press.

Walther, V. N., & Young, A. T. (1992). Costs and benefits of reproductive technologies. *AFFILIA, 7*(2), 111-122.

Williams, L. S. (1992). Adoption actions and attitudes of couples seeking in vitro fertilization. *Journal of Family Issues, 13*(1), 99-113.

Zimmerman, S. H. (1982). Alternatives in human reproduction for involuntary childless couples. *Family Relations, 31*, 233-241.

Appendix A: Reproductive Alternatives Attitude Survey

Part I: Hypothetical Case Scenarios

For the purposes of consistency all four scenarios present married couples. This is in no way meant to dismiss the experiences of non-married and single women.

Case 1: Donor insemination using donated sperm

A man in his mid-thirties has been married for five years. After some medical tests, he is diagnosed as infertile and is therefore unable to impregnate his wife. If another man donates a sample of sperm and the infertile man's wife is then inseminated with the donated sperm a child might be conceived. The wife could carry the fetus to term and deliver a baby.

Please respond to each question with:

Strongly Disagree - SD
Disagree - D
Neutral/Unsure - N/?
Agree - A,
Strongly Agree - SA

1.	**Male:** If I were the infertile man I would use donor insemination. **Female:** If the infertile man was my husband I would use donor insemination.	SD	D	N/?	A	SA
2.	**Male:** If I were the infertile man I would want a member of my family to donate sperm. **Female:** If the infertile man was my husband I would want a member of my husband's family to donate sperm.	SD	D	N/?	A	SA
3.	**Male:** If I were the infertile man I would want a member of my wife's family to donate sperm. **Female:** If the infertile man was my husband I would want a member of my family to donate sperm.	SD	D	N/?	A	SA

4.	**Male:** If I were the infertile man I would want a close friend to donate sperm. **Female:** If the infertile man was my husband I would want a close friend to donate sperm.	SD	D	N/?	A	SA
5.	**Male:** If I were the infertile man I would want a man who is unrelated and unknown to me to donate sperm. **Female:** If the infertile man was my husband I would want a man who is unrelated and unknown to me to donate sperm.	SD	D	N/?	A	SA
6.	A child conceived in this way should have a right to know how she/he was conceived.	SD	D	N/?	A	SA
7.	If I had a child using this procedure I would tell my child how he/she was conceived.	SD	D	N/?	A	SA
8.	A child conceived in this way when old enough should have access to information in order to find out who his/her biological father is.	SD	D	N/?	A	SA

9. If you agree or strongly agree with question 8, at what age would the child be old enough? _____

10. **What are your thoughts and reactions to donor insemination as a way to bring a child into your life?** Attach a separate sheet of paper if you run out of room.

Case 2: In vitro fertilization using a donated egg and husband's sperm

A 34 year old woman has been told by her doctor that she is infertile and unable to become pregnant without intervention. She and her husband wish to have children, so they decide to try in vitro fertilization. If a fertile woman donates an egg, to be mixed with the sperm of the infertile woman's husband, an embryo might be conceived which could then be transferred to the infertile woman's uterus. Fertility drugs may have to be taken by the woman initially to sustain the pregnancy in order to carry the fetus to term and deliver a baby.

Please respond to each question with:

Strongly Disagree - SD
Disagree - D
Neutral/Unsure - N/?
Agree - A,
Strongly Agree - SA

11.	**Female:** If I were the infertile woman I would use in vitro fertilization. **Male:** If the infertile woman was my wife I would use in vitro fertilization.	SD	D	N/?	A	SA
12.	**Female:** If I were the infertile woman I would want a member of <u>my family</u> to donate one or more eggs. **Male:** If the infertile woman was my wife I would want a member of <u>my wife's family</u> to donate, one or more eggs.	SD	D	N/?	A	SA
13.	**Female:** If I were the infertile woman I would want a member of <u>my husband's family</u> to donate one or more eggs. **Male:** If the infertile woman was my wife I would want a member of <u>my family</u> to donate, one or more eggs.	SD	D	N/?	A	SA
14.	**Female:** If I were the infertile woman I would want a <u>close friend</u> to donate one or more eggs. **Male:** If the infertile woman was my wife I would want a <u>close friend</u> to donate, one or more eggs.	SD	D	N/?	A	SA

15.	**Female:** If I were the infertile woman I would want a woman who is unrelated and unknown to me to donate one or more eggs. **Male:** If the infertile woman was my wife I would want a woman who is unrelated and unknown to me to donate, one or more eggs.	SD	D	N/?	A	SA
16	A child conceived in this way should have a right to know how he/she was conceived.	SD	D	N/?	A	SA
17.	If I had a child using this procedure I would tell my child how she/he was conceived.	SD	D	N/?	A	SA
18.	A child conceived in this way when old enough should have access to information in order to find out who his/her biological mother is.	SD	D	N/?	A	SA

19. If you agree or strongly agree with question 18, at what age would the child be old enough? _____

20. **What are your thoughts and reactions to in vitro fertilization as a way to bring a child into your life?** Attach a separate sheet of paper if you run out of room.

Case 3: Surrogate mother using husband's sperm

An infertile couple wishes to have a child. They decide to engage the services of a surrogate mother who will be inseminated with the husband's semen. If conception occurs, the surrogate mother carries the baby to term and surrenders it to the couple. The surrogate mother will be paid a specified fee for her services. After the baby is born the wife may then legally adopt her husband's biological child.

Please respond to each question with:

Strongly Disagree - SD
Disagree - D
Neutral/Unsure - N/?
Agree - A,
Strongly Agree - SA

21.	**Female:** If I were the infertile woman I would use surrogate motherhood. **Male:** If the infertile woman was my wife I would use surrogate motherhood.	SD	D	N/?	A	SA
22.	**Female:** If I were the infertile woman I would want a member of my family to be a surrogate mother. **Male:** If the infertile woman was my wife I would want a member of my wife's family to be a surrogate mother.	SD	D	N/?	A	SA
23.	**Female:** If I were the infertile woman I would want a member of my husband's family to be a surrogate mother. **Male:** If the infertile woman was my wife I would want a member of my family to be a surrogate mother.	SD	D	N/?	A	SA
24.	**Female:** If I were the infertile woman I would want a close friend to be a surrogate mother. **Male:** If the infertile woman was my wife I would want a close friend to be the surrogate mother.	SD	D	N/?	A	SA

25.	**Female:** If I were the infertile woman I would want a woman who is unrelated and unknown to me to be the surrogate mother. **Male:** If the infertile woman was my wife I would want a woman who is unrelated and unknown to me to be a surrogate mother.	SD	D	N/?	A	SA
26.	A child conceived in this way should have a right to know how she/he was conceive.	SD	D	N/?	A	SA
27.	If I had a child using this procedure I would tell my child how he/she was conceived.	SD	D	N/?	A	SA
28.	The surrogate mother should have the right to change her mind.	SD	D	N/?	A	SA
29.	A child conceived in this way when old enough should have access to information in order to find out who her/his biological mother is.	SD	D	N/?	A	SA

30. If you agree or strongly agree with question 29, at what age would the child be old enough? ____

31. **What are your thoughts and reactions to surrogate motherhood as a way to bring a child into your life?** Attach a separate sheet of paper if you run out of room.

Case 4: Adoption

After a number of years of trying to have a child a couple decides to adopt.

Please respond to each question with:

Strongly Disagree - SD
Disagree - D
Neutral/Unsure - N/?
Agree - A,
Strongly Agree - SA

32.	If I were in this situation I would adopt a child.	SD	D	N/?	A	SA
33.	If I were interested in adopting a child I would want a closed adoption where I would have no contact with the birth mother and father before, during or after the adoption.	SD	D	N/?	A	SA
34.	If I were interested in adopting a child I would want an open adoption where I could meet the birth mother and/or father prior to the adoption and continue to have contact with them following the adoption.	SD	D	N/?	A	SA
35.	**Male:** If I were interested in adopting a child I would want the birth mother and/or father to be a member of my family. **Female:** If I were interested in adopting a child I would want the birth mother and/or father to be a member of my husband's family.	SD	D	N/?	A	SA
36.	**Male:** If I were interested in adopting a child I would want the birth mother and/or father to be a member of my wife's family. **Female:** If I were interested in adopting a child I would want the birth mother and/or father to be a member of my family.	SD	D	N/?	A	SA

37. **Male:** If I were interested in adopting a child I would want the birth mother and/or father to be a close friend. **Female:** If I were interested in adopting a child I would want the birth mother and/or father to be a close friend. SD D N/? A SA

38. An adopted child when old enough should have access to information in order to find out who her/his birth parents are. SD D N/? A SA

39. If you agree or strongly agree with question 38, at what age would the child be old enough? ____

40. **What are your thoughts and reactions to adoption as a way to bring a child into your life?** Attach a separate sheet of paper if you run out of room.

Part II: Reproductive Alternatives and Living Child-Free

41. Do you feel (have you ever felt) pressure to have children?

1. Yes 2. No 3. Unsure

42. If yes, what form does this pressure take? Describe the pressure to have children.

43. Have you ever considered pursuing any of these reproductive alternatives?

1. Donor Insemination
   1. Yes 2. No 3. Unsure 4. Not Applicable

2. In-Vitro Fertilization
   1. Yes 2. No 3. Unsure 4. Not Applicable

3. Surrogacy
   1. Yes 2. No 3. Unsure 4. Not Applicable

4. Adoption
   1. Yes 2. No 3. Unsure 4. Not Applicable

5. Living Child-Free by Choice
   1. Yes 2. No 3. Unsure 4. Not Applicable

6. Other (please specify) _____

44. If you have considered any of these reproductive alternatives what was the outcome? Attach a separate sheet of paper if you run out of room.

45. People who are considering their reproductive alternatives often tell others.
A. Identify by relationship up to 3 family members you have told. (eg: brother, sister)

1.
2.
3.

B. Identify up to 3 people from your social network you have told. (do not include family, eg: friend, colleague)

1.
2.
3.

C. Identify up to 3 professionals you have told. (eg: doctor, counsellor, clergy)

1.
2.
3.

46. People who are considering their reproductive alternatives often receive support from others.

A. Identify by relationship up to 3 family members who have been supportive. (eg: brother, sister)

1.
2.
3.

B. Identify up to 3 people from your social network who have been supportive. (do not include family, eg: friend, colleague)

1.
2.
3.

C. Identify up to 3 professionals who have been supportive. (eg: doctor, counsellor, clergy)

1.
2.
3.

47. How do you feel about making a decision to live child-free?

48. Is there a point at which you would feel you have done enough to bring a child into your life?

Part III: Demographic Information

49. I am: 1. Female 2. Male

50. My age is : _____

51. Marital Status:
1. Married
2. Common-Law
3. Single With a Partner
4. Single Without a Partner
5. Separated
6. Divorced
7. Widowed
8. Other (please specify) _____

52. If in a relationship, how long? _____

53. Do you have children? 1. Yes 2. No

54. If yes, how many? _____

55. Infertility Experience:

1. Yes, I am infertile.
2. Yes, my partner is infertile.
3. No, I have not experienced infertility.
4. Don't Know

56. If yes, what is the nature of you/your partner's infertility?

_____

57. If either you/your partner have experienced infertility how long have you known?

_____

58. Do you feel adequately informed about these reproductive alternatives?

1. Donor Insemination
   1. Yes 2. No 3. Unsure

2. In-Vitro Fertilization
   1. Yes 2. No 3. Unsure

3. Surrogate Motherhood
   1. Yes 2. No 3. Unsure

4. Adoption
   1. Yes 2. No 3. Unsure

5. Living Child-Free
   1. Yes 2. No 3. Unsure

59. What is the reason you are considering a reproductive alternative?

1. Infertility
2. Sexual Orientation
3. Single Status
4. Sexual Abstinence
5. Other (please specify) _____

60. How would you describe your ethnicity? _____

61. Years of secondary education: _____

62. What level of formal education have you completed?

1. K through Grade 13
2. College or Technical Program
3. CEGEP
4. Undergraduate Degree
5. Masters Degree
6. PhD. Degree
7. Post-Doctoral Degree

63. Into which range does your annual income fall?

1. less than $14,999
2. $15,000 - $29,999
3. $30,000 - $44,999
4. $45,000 - $59,999
5. $60,000 - $74,999
6. $75,000 or more

64. Religion:

1. Catholic
2. Jewish
3. Protestant
4. None
5. Other (please specify) _____

Thank you for completing this survey. Please enclose any comments you may have.
Please return the survey to:

Ms. Dianne Ross
c/o School of Social Work
McGill University
3506 University Street
Montreal, Quebec H3A 2A7

Appendix B: Survey Cover Letter

March 7, 1995

Hello!

My name is Dianne Ross, and I am a graduate student with the School of Social Work at McGill University in Montreal, Quebec. At present I am doing research on new reproductive technologies, and I wish to develop a better understanding of the attitudes of individuals and couples towards a range of reproductive alternatives.

I am aware that any decision you make regarding reproduction is complex and difficult. For this reason, it is very important that research be done so that a full and accurate picture of the attitudes of people who are considering different reproductive alternatives can be developed.

The enclosed Reproductive Alternatives Attitude Survey(s) will take about 30 minutes to complete. For individuals, please fill out one survey and return it. For couples, please fill out the surveys separately and return them together. Please DO NOT discuss your reactions to the survey with your partner before it is completed. For your convenience, I have enclosed a stamped, self-addressed return envelope. **Please return the survey(s) by March 31, 1995.** All responses must be received by the end of April.

Please be assured that I do not know your identity nor do I have any way of learning it. **To protect your privacy** this mail-out has been done by Diane Allen at the **Infertility Awareness Association of Canada (IAAC), Toronto Chapter**. In two weeks a follow-up letter will be sent to you from IAAC, Toronto. You will receive this letter regardless of whether you have returned your survey(s). The intent of the second mailing is to remind and encourage you to take the time to respond. All replies will be kept strictly **anonymous and confidential.**

For your interest, a summary of my findings will be published in an IAAC newsletter this summer.

I hope that you will choose to participate in this study. I am confident that your response will give you a voice in the ongoing debate and discussion surrounding new reproductive technologies and the range of reproductive alternatives available. If you would like more information or have any comments or questions you may reach me at (514) 485-6419 in Montreal, or via e-mail at <bhoi@musicb.mcgill.ca>.

Thank you in advance for your valuable input.

Sincerely,

Dianne Ross, B.S.W.
Registered Social Worker
Master of Social Work Student

Appendix C: Survey Follow-Up Letter

March 27, 1995

Hello!

On March 7, 1995 I sent you two Reproductive Alternatives Attitude Surveys. If you have already mailed your survey(s), I thank you.

If not, please take the time to complete the survey(s) as soon as possible.

Your response to this survey is very important because it will help in the development of a full and accurate picture of attitudes towards a range of reproductive alternatives.

The Reproductive Alternatives Attitude Survey will take about 30 minutes to complete. For individuals, please fill out only one survey and return it. For couples, please fill out the surveys separately and return them together. Please DO NOT discuss your reactions to the survey with your partner before it is completed. For your convenience, please use the stamped, self-addressed return envelope included with the surveys.

Please return the survey(s) by April 15, 1995. All responses must be received by the end of April. As I indicated in my first letter, all responses are **confidential and your anonymity is assured.**

If you require more information or have any questions you may reach me at (514) 485-6419 in Montreal, or via e-mail at <bhoi@musicb.mcgill.ca>. If you have misplaced your survey(s) do not hesitate to call me for another copy.

I hope that you will take the time to participate in this study. I am confident that your response will give you a voice in the ongoing debate and discussion surrounding new reproductive technologies and the range of reproductive alternatives available.

Thank you in advance for your valuable input.

Sincerely,

Dianne Ross, B.S.W.
Registered Social Worker
Master of Social Work Student

Appendix D: Development of the Reproductive Alternatives Attitude Survey

1. Case Vignettes

The modifications made to Section 1 of the survey were as follows: First, Case 1 and 2, describing DI and IVF were included with some changes to the wording in each of the vignettes. For example, the original Case 1 read, "After some medical tests were done, it was discovered that, because of medical problems, he is unable to father his own children." This sentence was changed to, "After some medical tests, he is diagnosed as infertile and is therefore unable to impregnate his wife."

Second, Case 3 on fetal reduction; Case 4 on fertilized embryos; and Case 5 on gestational surrogacy for convenience, from the original survey, were not included in this survey. Instead, new vignettes were developed. Case 3 outlines some of the issues surrounding pre-conception agreements. Case 4 considers a few of the issues surrounding adoption.

Third, a number of the questions in the original survey were changed so that the gender of the survey participant and her/his relationship to the potential donor was made clearer. For example, the original survey read, "Would you donate, or if you are a woman encourage a family member (e.g., your husband, another brother) to donate, sperm for this purpose IF THIS INFERTILE MAN WAS YOUR BROTHER?" This

question was changed to read, "**Male:** If I were the infertile man I would want a member of my family to donate sperm. **Female:** If the infertile man was my husband I would want a member of my husband's family to donate sperm."

Fourth, this survey, unlike the original survey, did not include the questions that asked whether a sperm or egg donor should have any legal rights or responsibilities for the resulting child, or whether there should be laws preventing a procedure from being done for people who choose to participate.

Fifth, new questions were developed for each case which asked whether the respondent would consider using the procedure in question and at what age (if ever) would the child be old enough to be informed about her/his biological origin.

Sixth, in order to compare participant responses, the same questions were asked for each vignettes. There were a few exceptions. In Case 3 the question "The surrogate mother should have the right to change her mind" was added.[15] In Case 4 the questions "A child conceived in this way should have a right to know how he/she was conceived,"

---

[15] Since the writing and administration of this survey I have reconsidered the appropriateness of the use of the term surrogate mother. After further reading, I believe that the term "contractual pregnancy" more effectively conveys the dynamics of this arrangement without being judgemental or degrading to the women who has agreed to carry the child to term. At the same time, "surrogate mother" appears in the survey. Therefore, this term will be used throughout this discussion section in order to maintain consistency and avoid confusion. In section III. Findings the term contractual pregnancy is used.

and "If I had a child using this procedure I would tell my child how she/he was conceived" were not included.[16]

Finally, the questions that measure attitudes towards living child free were developed specifically for this survey.

2. Psychosocial Issues

Section 2 of the *Reproductive Alternatives Attitude Survey* assessed a number of the psychosocial aspects of experiencing infertility. The questions asked in this section included: Do you feel pressure to have children?, if yes please describe; Which reproductive alternatives have you considered pursuing?; What was the outcome?; Who have you told you are considering a reproductive alternative?; Who have you received support from while going through this process?; How do you feel about living child free?; and, Is there a point at which you would feel you have done enough to bring a child into your life?

[16] This oversight is discussed in greater detail in section IV Discussion: Limitations of the Study.

3. Demographic Information

Section 3 of the *Reproductive Alternatives Attitude Survey* requested demographic information from the respondent.