

Gay men choosing parenthood through assisted reproduction: medical and psychosocial considerations

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Objective: To medically and psychologically assess gay men seeking parenthood through assisted reproduction and to provide guidelines for the assessment.

Design: Qualitative observational study.

Setting: Academic medical center.

Patient(s): Thirty gay males (15 couples) presenting for assisted reproduction using an oocyte donor and a gestational carrier.

Intervention(s): Semistructured interview and medical evaluation.

Main Outcome Measure(s): Determination of psychological and medical eligibility for treatment.

Result(s): The average age of men was 38.4 years. All couples were in a committed relationship and had been together for an average 6.4 years. All met medical and psychological criteria for acceptance.

Conclusion(s): Gay men increasingly choose fatherhood through assisted reproduction. Counseling these couples on the medical and emotional demands of in vitro fertilization with a gestational carrier and an oocyte donor is a vital component of pretreatment preparation. (*Fertil Steril*® 2011;95:225–9. ©2011 by American Society for Reproductive Medicine.)

Key Words: Fatherhood, gay men, gestational surrogacy, homosexuality, in vitro fertilization, oocyte donation, psychological assessment

In the past 30 years, the gay rights movement has increasingly encouraged gay men and women to be open about their homosexuality, open about their relationships, and, more recently, to be open about choosing to have children within the context of those relationships (1, 2). This phenomenon has resulted in rising numbers of gay persons seeking parenthood through assisted reproductive technology (ART). Lesbians are routinely treated in fertility centers, and there is an emergent literature on the medical and psychological demands of their experience (3–6) as well as on the developmental and psychological well-being of their children conceived through donor insemination (7–10). Unfortunately, the same is not true for gay men. Although gay men increasingly seek parenthood through assisted reproduction using an oocyte donor and a gestational carrier (11, 12), they are not always welcomed by fertility centers (13) despite the call for nondiscrimination of gay persons by the American Society for Reproductive Medicine (14). So far, the literature is lacking in reports describing the medical and psychological aspects of treatment unique to gay men and studies on the developmental and psychological well-being of their children conceived through assisted reproduction. We describe the medical and psychological experience of a cohort of gay men who

presented for treatment in a university-based ART program and describe a protocol for medical and psychological assessment of gay men choosing to become fathers through assisted reproduction.

MATERIALS AND METHODS

Patients participating in the study were recruited from Yale Fertility Center, New Haven, Connecticut. All gay male couples seeking gestational surrogacy and oocyte donation between January 2006 and February 2009 (n = 15 couples) have been included in the study. Institutional review board approval was obtained.

All patients were medically and psychologically screened. The purpose of the psychological interview is both educational and evaluative. It gives the couple a thorough overview of the program and the essential medical and psychological implications of ART with gestational surrogacy and oocyte donation. Psychological criteria for patient acceptance or rejection are the same as those for heterosexual couples. These include the ability to understand and tolerate the stress of the treatment, the ability to give consent, the quality and stability of the relationship, and the absence of severe or disabling psychopathology.

Each couple met with the program's mental health counselor for a 60-minute interview. During that meeting, the process was explained, and a semi-structured interview was completed. This interview was specifically developed for patients entering fertility treatment (15). Additional questions addressed issues pertinent to gay male couples using an oocyte donor and a gestational carrier. These included how the couple came to the decision about who would provide the sperm; their understanding of the female reproductive system and pregnancy; their "coming out" history and how it may have impacted family and social relationships; and whether family and friends supported their decision to have children. The interview also included

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TABLE 1

Medical evaluation of male same-sex couples undergoing assisted reproduction treatment using donor oocyte(s) and a gestational carrier.

Medical evaluation of the sperm donor(s)	Medical evaluation of the partner who does not provide sperm
Health history and physical evaluation	Health history and physical evaluation
Semen analysis	
Laboratory testing for transmissible diseases (required by the FDA as of January 1, 2010)	Laboratory testing for transmissible diseases (not required by the FDA as of January 1, 2010)
Hepatitis B surface antigen	Hepatitis B surface antigen
Hepatitis B core antibody	Hepatitis B core antibody
Hepatitis C antibody	Hepatitis C antibody
HIV I/II	HIV I/II
RPR with reflex syphilis IgG	RPR with reflex syphilis IgG
Gonorrhea and chlamydia urine cultures	HTLV I/II
CMV antibody	

Note: Based on U.S. Food and Drug Administration (FDA) regulations, a donor eligibility determination must be made for male member(s) of the gay couple providing sperm (24), but the use of reproductive cells or tissue from an ineligible directed donor is not prohibited (24). Similarly, neither quarantine of the directed donor semen nor re-testing of the directed donor is required (24). CMV = cytomegalovirus; HIV = human immunodeficiency virus; HTLV = human T-lymphotropic virus; IgG = immunoglobulin G.

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questions about the couple's decision to use a known or anonymous oocyte donor, donor characteristics, their relationship with their gestational carrier, and their plans for disclosure to offspring about the nature of their conception.

Medical screening included a meeting with the primary physician, who obtained the medical history of both partners and provided an explanation of the procedures involved in ART using oocyte donation and gestational surrogacy. Medical screening also included the U.S. Food and Drug Administration (FDA) mandated communicable disease testing for the partner or partners providing sperm, who also underwent a semen analysis. A description of the medical screening is presented in Table 1.

RESULTS

The average age of the men in this study was 38.4 years. Twenty-seven men (90%) were Caucasian, three were Hispanic. Twelve couples from the United States, two couples from Europe, and one couple from Canada came specifically for this treatment.

All couples lived together, were in a committed relationship, and had been together for an average of 6.4 years. However, their histories and specific circumstances varied considerably (cases illustrating some of these differences are included in Table 2). Six couples (40%) had been joined in a civil union, which was recognized in the states of Connecticut, New Hampshire, New Jersey, and Vermont (16). Two couples had been married in countries where same-sex marriage is legal (in this case the Netherlands and Canada), and one other couple was in the process of being married in the state of Connecticut, which has recently legalized same-sex marriage

TABLE 2

Examples of male same-sex couples seeking parenthood through assisted reproduction.

Case 1: A and L

The couple has been in a committed relationship for 6 years. They live together with A's two teenage children from a previous heterosexual relationship. L has no children but "always wanted to be a father." The couple worked with a private agency to recruit the carrier and used an anonymous oocyte donor through our program. The couple chose to have L's sperm fertilize the oocytes because he had never biologically fathered a child. They requested that the donor's physical characteristic match those of the nonbiological father. The carrier gave birth to a baby girl. Two years later, the couple came back with the same carrier and had a frozen embryo transfer resulting in the birth of a baby boy.

Case 2: B and K

The couple has been in a committed relationship for 5 years. B says that he "dreamed of being a father his whole life" and that when he and K became a couple having children together was their goal. The couple reports that they both come from large, supportive families who have encouraged them to become parents. They pursued adoption only to learn that gay men are "at the bottom of the heap" in the adoption process. Subsequently, they were encouraged by gay friends who became parents through assisted reproduction. They were matched to a carrier and an anonymous oocyte donor through a private agency. They decided that B would provide the sperm because he is older and the one "who always had the dream." Their carrier gave birth to twin girls. They hope to have more children in the future using K's sperm.

Case 3: G and J

The Hispanic couple has been together for 10 years. In the course of their relationship they have been foster parents to eight children and have two adopted sons, ages 8 and 9. When a 2-year-old they had fostered from birth and hoped to adopt was returned to his biological mother, the couple decided to pursue parenthood through assisted reproduction. A family member agreed to carry the pregnancy, and they used an anonymous oocyte donor from our program. After the medical consultation, the couple elected to have half of the oocytes fertilized with G's sperm and half with J's sperm with the understanding that the two best embryos would be transferred regardless of inseminator. The couple explained that they would both like a "chance" at being the biological father and would disclose true paternity to the offspring. As it turned out, two embryos were transferred, one from each partner, and the carrier gave birth to twins, a boy and a girl.

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(17). In the United States, laws regarding same-sex marriage are currently in flux, but as of this writing, gay marriage is legal in Connecticut, Iowa, Massachusetts, New Hampshire, Vermont, and the District of Columbia (18).

All the men met the medical and psychological criteria for acceptance. One individual had bipolar disorder, which was controlled by medication and in remission for many years. He chose not to be the sperm donor for that reason. Another man had a history of panic attacks during adolescence. Five men had sought psychological

TABLE 3**Treatment considerations and questions specific for gay men who are using an egg donor and a gestational carrier.**

Treatment considerations	Specific issues to be addressed
Relationship	Assess couple's relationship to determine stability and their commitment to becoming parents through assisted reproduction.
Treatment education	Ensure participants' understanding of the medical, legal, financial, and emotional demands of ART with a gestational carrier and an oocyte donor.
Familial and social support	Explore whether there is a network of family and/or friends who support their intention to become parents.
Sperm decisions	Typically, couples have made this decision before entering treatment, but it is a subject that warrants careful medical and psychological counseling.
Shared sperm cycle	Discuss the importance of embryo quality in making this decision. Discuss the fact that such a cycle may result in twins who are biological half-siblings.
FDA regulations	Inform the couple that the sperm provider needs to be retested within 7 days of the transfer.
Legal contract	Counsel couples about the importance of a legal contract and that state laws vary regarding surrogacy and adoption. These include the laws of their home state, the laws of the carrier's home state, and if different, the laws of the state in which the carrier delivers (16).
Oocyte donor	Discuss decision-making process regarding an anonymous or nonanonymous oocyte donor. If nonanonymous, determine whether there will be future contact between donor and offspring.
Gestational carrier	Explore the couple's relationship with the gestational carrier, particularly whether they have a trusting and open relationship with her and what her future relationship (if any) will be with their children.
Disclosure to offspring	Discuss their plans for talking to children about the nature of their conception and the circumstances of their birth.

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counseling as young men regarding “coming out” about their sexual orientation. All denied current psychiatric symptoms. The men appeared to have a good understanding of the demands of assisted reproduction using a gestational carrier and an oocyte donor.

In terms of family support, one individual reported that his family had “disowned” him when he came out at age 21 and that he has not had a relationship with them since. His partner and all other participants in this study reported that their families supported them when they came out, supported their same-sex relationships, and supported their decision to have children through assisted reproduction.

Twelve couples (80%) chose one of the partners to provide the sperm and inseminate the oocytes. This was a clear choice on their part, and how they came to the decision fell into the following categories: six couples agreed that the older partner should donate (the average age of the inseminating partner was 40.3 years, and the noninseminating partner 36.3 years); two couples had a partner who had children from a previous heterosexual relationship, and they agreed that the other partner should have a chance to father a child; two couples chose the partner who had the greater desire for biological fatherhood; and two couples felt that the partner with “better genes” should donate. The remaining three couples, who had equal desires for biological fatherhood, chose to inseminate equal numbers of oocytes to transfer an embryo from each partner. In all cases, implications of transferring more than one embryo, including the risks associated with multiple pregnancy, were discussed in detail with the couples. Special emphasis was given to the morbidity and mortality associated with preterm birth in ART-related multiple pregnancies. A maximum of two embryos were transferred per cycle.

Most of the participants, 12 couples (80%), worked with an agency to find a gestational carrier; two couples had a friend who offered to carry the pregnancy; and one couple had a carrier who was a family member. Twelve couples chose an anonymous oocyte donor, two chose a friend as donor, and one other couple asked the sister of the noninseminating partner to donate. Donor character-

istics most commonly requested were that the donor be tall, attractive, educated, and bear resemblance to the noninseminating partner.

Treatment outcome thus far is as follows: after the initial psychological consultation, two couples chose not to proceed for financial reasons and were not medically screened, one couple dropped out of treatment when their gestational carrier (a friend) decided she was not comfortable proceeding, and three couples are waiting to be matched to a gestational carrier. Nine couples completed treatment, and all successfully achieved pregnancy. Babies have been born to seven couples: four sets of twins and three singletons. Two couples have carriers with ongoing pregnancies, one with a singleton pregnancy and the other with a twin pregnancy. Of the three couples who chose to have each partner inseminate half of the oocytes and transfer an embryo from both, one couple has 3-year-old twins (who are in fact half-siblings), one couple has a singleton, and the third couple's carrier is currently pregnant with twins (who will be half-siblings).

DISCUSSION

Common issues emerge from these cases that are instructive for clinicians counseling gay men planning to become fathers through ART. In our experience, participants are in a committed relationship and have given the idea of becoming fathers and having a family together a great deal of thought. They are equally attentive to the decision as to who will provide the sperm. It may be that one is older, and both agree that he should be first; it may be that one feels more strongly than his partner about being biologically related to the offspring; it may be that both agree that one has “better genes”; and/or it may be that one has children from a previous heterosexual relationship and feels that his partner should have a chance to father a child. For those couples who choose to have half the oocytes fertilized by one partner and half by the other, counseling should include considerations of treatment outcome. For example, does the

couple have a clear understanding that though an embryo from each partner is being transferred, a singleton pregnancy may result, meaning that one partner is the biological father? Conversely, a discussion of such a transfer should include the possibility of having twins who share the same maternal genetics but have different paternal genetics (11).

For the most part, gay men in our program came from families who were supportive when they came out, supportive of their gay relationship, and supportive when they announced their plans for having children. However, this is often not the case. Gay men and women often face family dissolution, social stigmatization, and even violence (19). Because potential gay fathers may not always have encouragement or support from their families of origin, an assessment of the couples' social support and any "alternative family structures" is important (19).

In our experience, gay male couples using an oocyte donor and a gestational carrier require more education and counseling about the female reproductive system than heterosexual couples participating in the same program. The latter often come to us with a history of infertility and are sophisticated about its treatment (11). For gay men the process is usually entirely new and unfamiliar. Because they will ultimately become very closely involved with the process of ART with donor oocyte and gestational surrogacy, and ultimately if all goes well, will be closely involved in the carrier's pregnancy, it is crucial that they have a clear understanding of the demands of treatment and pregnancy.

Within the duration of the study, we have observed that gay male couples who have successfully conceived in our program have a close relationship with their gestational carriers, one that is often ongoing after the birth of the children. They appear to appreciate the carrier's input, defer to her on aspects of the pregnancy, and value her female presence.

All participants are required to have a legal contract, and, depending on what state they come from and what state the carrier delivers in, they may or may not be able to have the names of both partners on the birth certificate. The study was conducted in Connecticut, which is one of nine states in the United States that has a statute allowing for two-parent adoptions. Therefore, in Connecticut, both fathers can be listed on the birth certificate. At the other end of the spectrum are the states of Arkansas and Florida, where adoption by gay persons is prohibited (16). Gay male couples need to be very clear about the surrogacy laws of their home state and the laws of the gestational carrier's home state, and should they be different, the laws of the state in which she delivers. Because surrogacy is prohibited in Florida, Indiana, Louisiana, Michigan, Nebraska, Nevada, New York, North Dakota, Texas, Utah, and the District of Columbia (16), and because these laws are always changing, this information is crucial.

Fertility programs offering ART to gay men need to be respectful of same-sex relationships and to demonstrate an appreciation of the challenges unique to gay men seeking parenthood through ART (20). In addition to general American Society for Reproductive Medicine guidelines for intended parents using oocyte donation and gestational surrogacy (21, 22), we follow guidelines issued by the American Psychological Association for counseling same-sex couples (23), and we recommend the treatment considerations unique to the assessment of gay men seeking parenthood through ART summarized in Table 3.

In addition to the psychological assessment, the medical evaluation and its documentation are a key component of ART treatment for male gay couples. It is noteworthy that the medical assessment of gay men is essentially the same as the medical assessment of heterosexual men attempting parenthood through oocyte donation and gestational surrogacy. In the United States, gamete donation and gestational surrogacy are regulated by the FDA, which requires sperm and oocyte donors to be thoroughly tested. When an anonymous donor (sperm or oocyte donor who is not known to the gestational carrier or recipient intended parent) is found to be positive for an FDA-mandated infectious disease test, he or she becomes ineligible to donate and an alternate donor must be found. However, if a gestational carrier is involved in an ART cycle (with or without an oocyte donor), the male partner (whether he is gay or heterosexual) providing the sperm is considered a "directed donor," as he is known to the gestational carrier (24). Based on FDA regulations, a donor eligibility determination must be made for male member(s) of the gay couple providing sperm (24), but the use of reproductive cells or tissue from an ineligible directed donor is not prohibited (24). Similarly, neither quarantine of the directed donor semen nor retesting of the directed donor is required (24). Therefore, although a number of tests are required by the FDA from gay men who desire to provide sperm in an ART cycle, those who are found to be positive for one or more transmissible diseases are not prohibited from undergoing ART treatment. Therefore, positive results for FDA-mandated infectious disease tests need to be carefully evaluated by the physician and discussed in detail with all parties involved. In addition, the overall health of gay men who intend to be parents needs to be carefully evaluated, similar to the evaluation performed for heterosexual intended parents seeking parenthood through oocyte donation and gestational surrogacy.

CONCLUSION

Gay men increasingly choose fatherhood through assisted reproduction. Counseling these couples on the medical and emotional demands of ART with a gestational carrier and oocyte donor is a vital component of pretreatment preparation.

REFERENCES

1. Tasker F. Lesbian mothers, gay fathers and their children: a review. *J Dev Behav Pediatr* 2005;26:224-40.
2. Johnson SM, O'Connor E. The gay baby boom: the psychology of gay parenthood. New York: New York University Press, 2002.
3. Golombok S, Tasker F. Donor insemination for single heterosexual and lesbian women: issues concerning the welfare of the child. *Hum Reprod* 1994;9:1972-6.
4. Leiblum SR, Palmer MG, Spector IP. Non-traditional mothers: single heterosexual/lesbian woman and lesbian couples electing motherhood via donor insemination. *J Psychosom Obstet Gynaecol* 1995;16:11-20.
5. Gartrell N, Hamilton J, Banks A, Mosbacher D, Reed N, Sparks CH, Bishop H. The national lesbian family study: 1. Interviews with prospective mothers. *Am J Orthopsychiatry* 1996;66:272-81.
6. Jacob MC, Klock SC, Maier D. Lesbian couples as therapeutic donor insemination recipients: do they differ from other patients? *J Psychosom Obstet Gynaecol* 1999;20:203-15.
7. Baetens P, Brewaeys A. Lesbian couples requesting donor insemination: an update of the knowledge with regard to lesbian mother families. *J Hum Reprod* 2001;7:512-9.
8. Braeways A, Ponjaert I, Van Hall E, Golombok S. Donor insemination: child and family development in lesbian-mother families with children of 4 to 8 years old. *Hum Reprod* 1997;12:1349-59.
9. Golombok S, Tasker F, Murray C. Children raised in fatherless families from infancy: family relationships and the socioemotional development of children of lesbian and heterosexual mothers. *J Child Psychol Psychiatry* 1997;38:783-91.
10. Chan R, Raboy B, Patterson CJ. Psychosocial adjustment among children conceived via donor insemination by lesbian and heterosexual mothers. *Child Dev* 1998;69:443-57.
11. Hanafin H. Surrogacy and gestational carrier participants. In: Covington SN, Burns LH, eds.

- Infertility counseling: a comprehensive handbook for clinicians. 2nd ed. New York: Cambridge University Press, 2006:370–86.
12. Greenfeld DA. Gay male couples and assisted reproduction: should we assist? *Fertil Steril* 2007;88:18–20.
 13. Gumankind AD, Caplan AL, Braverman AM. Screening practices and beliefs of assisted reproductive technology programs. *Fertil Steril* 2005;83:61–7.
 14. Ethics Committee of the American Society for Reproductive Medicine. Access to fertility treatment by gays, lesbians, and unmarried persons. *Fertil Steril* 2006;86:1333–5.
 15. Burns LH, Greenfeld DA, for the Mental Health Professional Group. CPHI: Comprehensive Psychosocial History of Infertility. Birmingham, AL: American Society for Reproductive Medicine, 1990.
 16. Wald DH. The parentage puzzle. In: Assisted reproduction for gay men and lesbians: social, psychological and legal aspects. Postgraduate course sponsored by the American Society for Reproductive Medicine, 2008.
 17. Levenson M, Ryan A. Connecticut Supreme Court legalizes same-sex marriage. *Boston Globe*, October 10, 2008. Available at www.boston.com/news/local/breaking_news/2008/10/connecticut_sup.html. Accessed June 14, 2010.
 18. Zernike K. Amid small wins, advocates lose marquee battles. *New York Times*, December 2, 2009. Available at www.nytimes.com/2009/12/03/nyregion/03analysis.html. Accessed June 14, 2010.
 19. Esterberg K. Gay cultures, gay communities: the social organization of lesbians, gay men, and bisexuals. In: Savin-Williams R, Cohen K, eds. *The lives of lesbians, gay, and bisexual: children to adults*. New York: Oxford University Press, 1996:337–92.
 20. Bergman KE. Counseling issues for gay men and lesbians seeking assisted reproductive technologies. In: Assisted reproduction for gay men and lesbians: social, psychological and legal aspects. Postgraduate course sponsored by the American Society for Reproductive Medicine, 2008.
 21. American Society for Reproductive Medicine. Guidelines for oocyte donation. *Fert Steril* 2002;77(Suppl 5):S6–8.
 22. American Society for Reproductive Medicine. Psychological assessment of gamete donors and recipients. *Fertil Steril* 2002;77(Suppl 5):S11–2.
 23. Division 44/Committee on Lesbian, Gay, and Bisexual Concerns Joint Task Force on Guidelines for Psychotherapy with Lesbian, Gay, and Bisexual Clients. Guidelines for psychotherapy with lesbian, gay and bisexual clients. *Am Psychol* 2000;55:1440–51.
 24. U.S. Department of Health and Human Services, Food and Drug Administration, 21 CFR Parts 210, 211, 820, and 1271 [Docket No. 1997N–0484S]. Eligibility Determination for Donors of Human Cells, Tissues, and Cellular and Tissue-Based Products, 2005.