CHAPTER 6

Alternative Pathways
Becoming a Parent through Reproductive Donation or Adoption

While procreation is a biological function, parenthood is a social construct (Leon, 2002). In Western and non-Western cultures, parenting, inheritance, and traditional definitions of the family are grounded in 'bloodlines' and there is a strong drive toward biogenetic parenthood – having a child of one's own (Freeman, 2014). There is growing diversity, however, in those seeking to become parents and the ways in which they can do so (Golombok, 2020; Patterson, 2019). Adoption and medical treatments for infertility have provided alternative pathways to becoming a parent for those unable or disinclined to have children through heterosexual sex (Guzzo & Hayford, 2020). More liberal social attitudes accompanied by legal reforms in many Western countries have enabled same-sex couples to marry, to adopt or foster children, and to participate in medically assisted conception (using donated sperm, eggs, embryos, and in some cases, surrogate gestational mothers). Nonetheless, social acceptance of these pathways to parenthood remains patchy (Dempsey et al., 2021). Becoming a parent is more complex when there are donors involved – conceptually, legally, and biologically. Extensive planning and negotiation are required including some or all of the following: potential donors themselves, sperm and egg banks, ART clinics, surrogacy brokers, adoption agencies. There may be extensive screening protocols (both medical and psychosocial) and there are generally high financial costs. No-one embarks lightly on these pathways to parenthood.

This chapter examines the process of becoming a parent when one or both parents are not genetically related to the child. We begin by reviewing the developmental processes of adapting to pregnancy discussed in earlier chapters on becoming a mother (Chapter 3), becoming a father (Chapter 4), and conception through ART (Chapter 5), in order to explore the additional challenges when reproductive donation is involved.

To recap briefly: theories propose that the first 'developmental challenge' in becoming a parent is to come to terms with the biological reality

of the pregnancy, or, as discussed in this chapter, the implications of *not* being genetically (and in some cases gestationally) related to the expected child; the second is the psychological challenge of taking on an identity as a parent and developing a relationship with the anticipated child. Third, expectant parents need to renegotiate their partner relationship and restructure their broader social networks in preparation for parenthood. Pathways to parenthood involving reproductive donation or adoption often follow infertility and prior experiences of reproductive loss, although this is not always the case. Uncertainty regarding the likelihood of achieving the goal of parenthood can add a further layer of complexity.

The chapter then examines research evidence on the transition to parenthood for heterosexual couples who conceive with donated eggs, sperm, or embryos, and the pathways to parenthood for lesbian and gay couples. Finally becoming a parent through adoption is considered.

Biological Connections: Genetics and Gestation

Couples who decide to embark on parenthood when one or both will not be genetically related to the child assign different meanings to the importance of genetic, gestational, and social connectedness, depending on their own context (Almeling, 2015).

Genetic Relatedness: Meanings and Alternatives

Genetics has long been reified as the essence of identity and family relationships; a prerequisite for 'natural' love between offspring and progenitors (Freeman, 2014; Kirkman, 2008). Adults seek to recreate themselves by passing on genes to their offspring, and heterosexual couples seek to consolidate their relationship by bringing their sperm and eggs together. A belief that it is best for children to live with their biological parents is both implicit and explicit in contemporary adoption and fostering systems and underpins policies and practices that aim to reunite children with biological parents or kin.

If medical advice suggests it is even remotely possible, most couples will leave no stone unturned, in their efforts to conceive a child who is genetically related to at least one of them, often at great personal and financial cost. The fact that the woman can experience pregnancy and childbirth is seen as an added benefit (Inhorn, 2020). Non-genetic

parenthood is often viewed as a last resort (Leon, 2002). The infertile couple may undergo a period of mourning the inability to conceive a genetically related child with a loved life partner before considering the involvement of a donor. There may also be insecurity about the third party involved, and envy about the gestational experience in the case of surrogacy (Glazer, 2014).

Despite significant advances in ART, discussed in detail in Chapter 2, some heterosexual couples are unable to conceive with sex cells from both parents; if the male partner has a very low sperm count or poor sperm motility, if the woman has stopped producing eggs, or her eggs are not able to be fertilised (generally due to older maternal age), or when the cause of the infertility is not known. When two men or two women are in a relationship, the child conceived can be genetically related to only one of them. There are various combinations in relation to genetic and gestational connectedness: a heterosexual couple can conceive with donated sperm, a donated egg, or a donated embryo. Single women can conceive using donated sperm. A gay male couple can conceive with the sperm of one male and a donated egg (the embryo is transferred to a surrogate). A lesbian couple can conceive using donated sperm; the woman whose egg is fertilised may carry the pregnancy, or the fertilised egg may be transferred to her female partner. When couples conceive with a donated embryo, neither is genetically related to the child, but the woman is gestationally related – she carries the foetus from the time of implantation, and she gives birth to the child. In some cases, heterosexual couples may require a surrogate to 'carry' the pregnancy for medical reasons that preclude the woman being pregnant (prior hysterectomy, uterine problems, recurrent miscarriages). In these cases, both parents are genetically related to the child, but the woman is not gestationally related.

The significance of genetic and gestational relatedness can be downplayed or emphasised. Even when downplayed, for many intending parents selection of phenotypic characteristics in the donor is a conscious and carefully planned process. Following a long-established tradition in domestic adoption, couples conceiving with donated sperm or eggs frequently try to select donors who share characteristics with the parent who will not be genetically related to the child (Murphy, 2013; Wojnar & Katzenmeyer, 2014). Commercial egg and sperm banks advertise for donors based on their phenotypic characteristics, and some even adjust payment rates for characteristics perceived as desirable in a particular culture (for example, height, hair colour, skin colour, ethnicity).

Gestational Relatedness

Recent scientific advances in understanding the neurological and hormonal underpinnings of caregiving draw attention to the biological underpinnings of the caregiving system, emphasised by advocates of natural childbirth, early contact with the infant, and breastfeeding. When conception is achieved with the use of donated sperm, eggs, or embryos, the woman (gestational mother) is able to experience pregnancy, give birth, and breastfeed the child. During pregnancy she experiences changes to her body shape, breasts, sleep patterns, energy, and feels the baby's movements in the womb, discussed in detail in Chapter 3. Hormonal changes driven by the placenta (surges in oxytocin, oestrogen, progestogen) will influence her emotional state and activate her caregiving system. Her partner will have the opportunity to observe the pregnancy at close range, to attend the birth, and perhaps cut the umbilical cord. When heterosexual couples engage a surrogate, they may both be genetically related to the child, but the commissioning mother does not experience the hormonal and physical changes of pregnancy, childbirth, and lactation. In the case of lesbian couples, only one of the women has these biological experiences. For gay couples, one of the men is likely to be the genetic father of the baby, and there is generally an egg donor and a surrogate (discussed later in this chapter).

Adoptive parents do not experience pregnancy, childbirth, or breastfeeding. They may not see their child as a young infant, and the infant is likely to have had prior experiences with different caregivers. Adoptive parents may or may not have access to information about the birth mother's identity, her health and circumstances during pregnancy and childbirth, paternity, and the baby's health and development in early infancy.

Psychological Challenges: Integrating a Parental Identity

It is more challenging for parents who are not genetically or gestationally related to their infant to reconfigure their sense of self, and some struggle to feel like a 'real' parent, doubting their entitlement to parent a genetically unrelated child (Kirkman, 2008; Sandelowski et al., 1993). Assuming a parental identity is grounded in intellectual and emotional work, rather than tangible biological experiences (Hill, 1991). The bureaucratic (often intrusive) screening procedures that have to be negotiated in order to adopt or foster, and, in some settings, to commission a surrogate, require an explicit articulation of motivations. Intending parents

are repeatedly asked to demonstrate their capacity to provide a loving nurturing environment for a child, in a way that naturally conceiving parents never have to. Requirements regarding psychological screening and counselling vary for those conceiving with donated gametes, but even in unregulated 'direct contact' environments, intending parents will need to convince potential donors that they have what it takes to provide a positive parenting environment for any child conceived (Jacob, 2017), a process that has been likened to online dating (Golombok, 2020). This is likely to provoke reflection about the meaning of parenthood, the emotional needs of infants and young children, and one's capacity to meet them. Memories of early childhood experiences in the family of origin may surface. Non-heteronormative individuals may revisit memories of coming out, including rejection from parents and extended family, in some cases. Developmental struggles with gender identity may have limited early fantasies about making families and imagining a future as a parent (Glazer, 2014; Murphy, 2013; Wojnar & Katzenmeyer, 2014).

In the case of lesbian couples, only the gestational mother will have the gestational experiences that elicit public validation of impending parenthood. For those conceiving through surrogacy or adopting a child, external validation of their new life roles is delayed. If the baby is from a different racial background, even strangers may publicly and frequently question their parental status.

Developing a Relationship with the Expected Child

The process of forming an attachment may be more complicated when the child is not genetically related, and even more so if the child is from a different cultural or racial background. For gestational mothers, the experience of pregnancy (including quickening, ultrasound images, hearing the baby's heartbeat, diurnal rhythms in the baby's activity levels) is likely to help them accept the viability and individuality of the expected child, and to activate protective feelings and a commitment to caregiving. Those becoming a parent through surrogacy or adoption do not experience these tangible physical confirmations of the baby's development. Foetal attachment, discussed in detail in Chapters 3 and 5, is largely a projection of maternal and paternal fantasies, however (Raphael-Leff, 2005), and one that is enhanced by 'nesting' activities: planning a nursery, selecting a name for the baby. It is not necessary to be genetically related or to experience pregnancy to engage in fantasies and prepare a nest for the baby, as discussed later in this chapter.

Social Challenges

Social constructions of parenthood and families are being challenged by contemporary parents. Mothers are resisting the pressure of gendered and idealised expectations of selfless devotion to infant care, and fathers complain that a tendency to marginalise or exclude them from the process reveals a dismissively low regard for their capacity for nurturing. Those taking alternative pathways to parenthood face additional social challenges.

Judgement and Stigma

There is debate about the universality and legitimacy of the 'right' to parent. Frame (2008) asserts that the right of a child to know, and be genetically related to, its parents is fundamental, and he opposes the deliberate creation of a child involving an egg or sperm donor, or a surrogate, who will be intentionally alienated. Agnes Bowlby (2013) points to the large numbers of children in need of care, and she suggests that the child's need to be cared for should be placed ahead of the adult's need to become a genetic parent.

Same-sex couples, having already grappled with discrimination and a lack of social affirmation of their sexuality, are likely to face additional scrutiny and stigma from extended family and the broader community when they announce their intention to have a child (Glazer, 2014). Stigma is more notable when surrogacy is involved due to opposition from those espousing traditional family values, and from some feminists who argue that surrogacy is inherently exploitative of women, based on the widespread perception that women who agree to be surrogates are poverty stricken, socially disadvantaged, and/or vulnerable (Golombok, 2020).

Secrecy and Disclosure

While there has always been diversity in family forms, for most of the twentieth century, only heterosexual couples could become parents through adoption and with the assistance of ART clinics offering treatment involving donated sperm and eggs. The process was shrouded in secrecy to shield both intending parents and donors from stigma, retribution, and accountability. Over the last two decades, changes to legislation and more tolerant social values in most high-income countries have made it possible for non-married and non-heterosexual couples and single women to adopt and to access donated sperm, eggs, and embryos. At the same time, in response

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to decades of vehement advocacy from donor offspring, legal reforms in many jurisdictions have enshrined the child's right to know the identity of genetic parents. Nonetheless, non-disclosure remains widespread among heterosexual couples conceiving using donated sperm, eggs, or embryos (Daniels, 2020). Same-sex couples are generally unable to hide the use of donated sperm or eggs, but disclosure of the identity of genetic parents remains optional, at least until the child is eighteen years old. While disclosure is becoming more commonplace (Lampic et al., 2021), when families are formed through non-regulated commercial and informal arrangements, it is at the discretion of participants (Dempsey et al., 2021). The complexities of trans-national surrogacy may make it difficult or impossible for the child conceived through these arrangements to explore their genetic and gestational heritage. Adults intending to become parents with the involvement of third parties will need to grapple with these issues from the outset, and plan for how they will be managed in the longer term.

Couple Relationships and Third-Party Donors and Surrogates

Creating a safe and accepting 'social' space for the baby is a key task of pregnancy. Complex arrangements with outside parties (potentially involving birth mothers, donors, surrogates, and their own families) can be disruptive and threatening. The infertile partner in a heterosexual couple may struggle with feelings of blame and shame, as he or she confronts the fact that the fertile partner could conceive a child with someone else (Burns, 2007). The decision to use donated gametes requires agreement about how the relationship with the donor (if they are known), and disclosure to the child will be managed. These discussions may activate sensitivities that can destabilise the couple dynamic: the non-genetic parent may fear that disclosure will disrupt their relationship with the child, and may envy the child's resemblance to the genetic parent (Dempsey et al., 2021; Imrie et al., 2020).

There is also asymmetry for couples in same-sex relationships. Only one can be genetically related to the baby; and in the case of lesbian couples, only one can be gestationally related. The couple will need to agree about how the sperm or egg donor, or surrogate (if known) is integrated into the family system, and about the extent of involvement of the donor with the child. Like all couples becoming parents, it is challenging to re-orient as two become three, with inevitable changes in attention, emotional availability, and the sexual relationship, which can leave the partner less involved in primary caregiving feeling excluded (Wojmar & Katzenmeyer, 2014).

Relationships with Extended Family

Grandparents are key stakeholders in their children's reproductive choices. Pregnancies are generally proudly shared with grandparents and extended families, particularly in collectivist cultures. The process of conception is private, however. Some heterosexual couples may choose to keep the use of donated gametes secret, due to family, religious, or cultural beliefs. This can lead to conflicting and competing needs for privacy and family support, as the intending parents navigate invasive and emotionally taxing screening and medical procedures (Nordqvist & Smart, 2014). Same-sex couples face additional challenges as they explain their plans to have a baby, and the complex procedures required. They may encounter disapproval and worry that their child will be rejected by extended family and experience stigma in the future (Golombok et al., 2004).

Relationships with Donors, Surrogates, Birth Parents

How is the prospective donor or surrogate to be selected? Should there be contact prior to the birth? After the birth? What form will the relationship take? Sometimes the egg or embryo donor or surrogate is a family member, sometimes a close friend. A new (or different) relationship will need to be negotiated. In cases of open adoption or fostering, the adoptive parents will need to work with the birth mother and the agency to arrive at a level of social connection that is comfortable for all of them.

The above discussion has reviewed the psycho-social adaptations common to all prospective parents during the transition to parenthood. Some of the additional challenges faced by those who take alternative pathways have been outlined in broad terms. In the next section, we turn to the research on adjustment during the transition to parenthood for those becoming a parent using donated sperm, egg, or embryo, or through surrogacy. The chapter concludes with stories of complex alternative pathways to parenthood: two women who adopt and two men who become parents with the assistance of ART and surrogacy.

Conception using Donated Sperm, Eggs, or Embryos

Conception through sperm donation can be arranged with or without medical involvement. The process for the donor (ejaculation through intercourse or masturbation) is straightforward. Freezing and storage of sperm has been a widespread medical practice since the middle of the twentieth

century, and there are numerous commercial sperm banks, as well as those attached to ART clinics. Egg storage and donation is more medically complicated. The age-related decline in female fertility is primarily related to ovarian function, due to progressive loss from a finite pool of primordial egg follicles, ultimately culminating in menopause (Stoop et al., 2014). Egg donors are required to undergo hormonal stimulation to increase egg production on any given cycle, and surgical retrieval of eggs is performed under sedation. Recent advances in capacity to successfully freeze and thaw eggs have enabled egg banks (Golombok, 2020). Embryo donation is made possible by the common practice during ART treatment of creating more embryos than individual couples wish to use, and then freezing the surplus embryos.

In recent decades the profile of recipients and donors has changed; advances in treatment of male infertility have meant that fewer heterosexual couples use donated sperm to conceive, while social and legal reforms have opened this pathway to parenting to single women and lesbian couples (Patterson, 2019). A well-established trend to postpone childbearing in high-income countries has led to increased demand for donated eggs and embryos (Human Fertilisation and Embryology Authority, (HFEA, 2020). The desire of single women and gay couples to 'have their own child' with genetic or 'blood ties' and to have a child through means that appear conventional or 'natural' has expanded the clientele engaged with the ART industry and commercial markets for donated gametes (Graham, 2014). There has been a parallel trend for intending parents to make their arrangements directly with potential donors, either through within-family arrangements or through advertisements on contact websites and social media. These unregulated arrangements can lead to medical and legal risks and result in less clear boundaries between donors and recipients (Jacob, 2017).

The most substantial body of research on parenting after conception involving third party donation has come from the UK Longitudinal Study of Children Conceived through ART, led by Susan Golombok in Cambridge, in the United Kingdom. Parent wellbeing, adjustment to parenting, and child developmental outcomes have been examined in samples of parents conceiving through egg, sperm, embryo donation, conventional IVF, surrogacy, and adoption. Mixed methods (quantitative methodologies, in-depth narrative interviews, observations of parent–child relationships, teacher reports, reports from offspring) have offset the influence of socially desirable responding. Results indicate overall positive functioning for parents and their children throughout childhood, irrespective of

mode of conception and genetic relatedness (see Golombok, 2019, for a comprehensive review). The researchers acknowledge various limitations of this body of research: relatively low response rates, the use of convenience samples possibly biased towards those experiencing positive adjustment, the possibility of socially desirable responding in those likely to be sensitive to scrutiny and stigma (although study instruments [described earlier] are robust to this), and unanswered questions related to the impact of secrecy and disclosure, particularly for families conceiving through egg and embryo donation (Golombok et al., 2017; MacCallum & Golombok, 2007). Studies typically focus on childhood and adolescence, with very little research on adjustment during the transition to parenthood.

Becoming a Parent through Donor Insemination (DI)

When conception through sperm donation is managed in an ART clinic, medical screening of sperm is mandatory. Many ART clinics collaborate with overseas sperm banks, and require that the legislative requirements in the recipient's home country be met before they accept exported sperm. Women can, however, independently purchase sperm online from commercial sperm banks (often in a different country, with the United States a major supplier), and use 'direct insemination' at home. Conceiving with donated sperm is part of a mercantile process: there are detailed catalogues (displaying photographs, hobbies, religion, academic achievements of donors). The sperm from the selected donor is mailed, frozen in a cannister, to the purchaser. Sperm donation has always provoked social anxiety, with images of adultery and incest and worry about bloodlines, and inheritance. Psychotherapist Joan Raphael-Leff (2005) describes intra-psychic challenges a woman may experience when pregnant with donated sperm; the sense of a 'foreign body' (p. 97) within her, anxiety about who the baby will look like, and fantasies about the donor.

Heterosexual Couples

Donor insemination has been available to heterosexual couples through ART clinics for many decades. Concerns have focused on the potential psychological impact on the parent–child relationship and the family dynamic when one parent (the person the child knows as father) is not genetically related, and the impact on the child of disclosure of that information. Golombok (2019) summarises results from studies across childhood. Findings indicate that heterosexual couples who have conceived through DI generally show effective parenting and positive parent–child

relationships, irrespective of genetic relatedness and disclosure. One study found evidence of higher emotional distress in middle childhood for those mothers who kept mode of conception secret (Golombok et al., 2011). While causal links between disclosure and more positive functioning have not been established, there is a broad consensus among social scientists that disclosure in the preschool years is likely to be optimal for the wellbeing of offspring (Golombok, 2020).

Single Mothers by Choice

As legislation has enabled equitable access to ART Clinics, there has been a growing trend for single women to become parents through donor insemination (Golombok, 2020; Guzzo &Hayford, 2020). Nonetheless, they remain vulnerable to stigma and criticism. Media representations reflect disapproval of intentionally creating a child who will not have a father, a view that conception using donor sperm is unnatural, that it represents a concerning consumerist attitude to parenthood, and one that can make men redundant (Zadeh & Foster, 2016). In Chapter 3, discussion about becoming a single mother focused on the challenges for young women who become parents on their own, after unintended pregnancies, often in socio-economically deprived circumstances. In contrast, women who make an active choice to be a single parent through sperm donation, tend to be older, well educated, and financially independent. They have typically spent many years thinking about becoming a parent, and DI is rarely their first choice; rather it is often a decision based on concern about age-related declines in fertility (Golombok et al., 2005; Golombok., 2020).

Playwright Alexandra Collier (2020) describes her decision in her late thirties to take this path to parenthood when her romantic life was out of synchrony with her 'baby hunger' and her reproductive timeline. It was not an easy decision; she worried about judgement from her family and friends (the word 'selfish' was frequently used); she worried it would imply she had failed at finding a partner, and she worried about how she would cope with raising a child alone. The conception was organised through an ART Clinic. She had rejected the option of using a friend's sperm, concerned that it would feel like a pseudo-marriage with complex legal and emotional consequences. The autonomy afforded by using donor sperm seemed preferable. Collier was fortunate; after deliberating for several months about which donor to choose from a database, and injecting herself with hormones to promote ovulation, she conceived with the first insemination procedure; chose a professional support person (doula) to support her during the birth, and subsequently gave birth to a healthy son.

Her parents, initially wary about her decision, became enthusiastic and supportive once the baby was born, and her brother and her father have become important men in her child's life.

There is limited empirical research on adjustment during pregnancy and early parenthood for single women who conceive through DI; most is based on in-depth interviews with socially advantaged samples. The cohort of single women in the United Kingdom longitudinal study have shown positive psychological adjustment during infancy with comparable warmth, joy, and bonding with the infant, and psychological wellbeing, when compared with naturally conceiving couples and heterosexual couples conceiving through DI. The single difference identified was that the single mothers reported less interaction with their young infants and showed less sensitivity during observed interaction, perhaps due to not having a partner to assist during the exhausting early months of parenthood (Murray & Golombok, 2005a). A follow-up at two years, showed, however, that compared with the married mothers, the single mothers reported greater joy and less anger towards their children (Murray & Golombok, 2005b), and these positive findings were sustained when the children were pre-schoolers (Golombok et al., 2016) and in middle childhood (Golombok, 2020). A growing body of research on child and family outcomes in planned lesbian families where women conceive using DI reports similarly positive findings, discussed later in this chapter.

Becoming a Parent through Egg Donation

When a couple conceives using egg donation, the father may be genetically related, but the mother is not. As discussed earlier, the expectant mother experiences pregnancy, birth, and breastfeeding and all the hormonal and neurological changes that go along with that. There is limited empirical evidence on adjustment during the transition to parenthood, with some studies retrospectively exploring the experience of pregnancy.

Golombok and colleagues (2004) found no differences in mood or relationship satisfaction comparing fifty-one parents conceiving through egg donation with eighty naturally conceiving parents when their infants were aged between nine and twelve months, however there was some concern about potential stigma in the egg-donation group. More recently, Imrie and colleagues (2019) explored psychological health and the couple relationship during early parenthood (infants aged between six and eighteen months) in fifty-seven heterosexual couples conceiving through egg donation compared with fifty-six couples conceiving through IVF,

where both parents were genetically related to the child. There were more similarities than differences on questionnaire measures of mood, relationship satisfaction, and parenting stress. Scores were generally within the normal range, with some increased vulnerability related to older parental age. Older mothers conceiving through egg donation reported less social support from family, but adequate support from friendship groups and older fathers whose partner had conceived through egg donation reported poorer psychological health.

Developing a Maternal Identity and Relationship with the Unborn Baby

In retrospective surveys, women conceiving through egg donation have indicated that while they thought about not being genetically related to the foetus during pregnancy, most felt this did not influence their developing relationship with the child (Hertz & Nelson, 2016). Conceiving through egg donation may make the process of adapting during the transition to parenthood more complex, however. Maggie Kirkman (2008) conducted in-depth interviews with twenty-one women who had conceived through egg donation. They downplayed the role of genetics and emphasised the importance of gestation, pointing out that they had fed the baby through the umbilical cord for nine months. Nonetheless, the lack of a genetic connection was experienced as a meaningful absence for some of them, who described feeling 'inauthentic' and like an 'imposter' during pregnancy and early parenthood. Future disclosure was also on their minds, as some of the respondents were worried that the child might reject them, or that disclosure would expose that they were not the 'real' mother. Some women worried that inability to conceive with their own eggs, might also compromise their capacity to give birth normally or breastfeed.

Imrie and colleagues (2020) have confirmed with a larger sample that the process of establishing a maternal identity and a relationship with the baby is complex and individualised after conception through egg donation. Their study is the most methodologically sophisticated to date, using an attachment theory informed narrative interview to access unconscious caregiving representations in ninety-nine women conceiving through egg donation. Most did not know the identity of the donor. Thematic analysis of interview transcripts showed that the lack of genetic relatedness raised concerns about bonding with the baby and about who the baby would look like. New mothers described a variety of cognitive strategies to make the baby feel like their own. These included downplaying the donor's contribution, for example likening egg donation to blood or tissue donation, and also emphasising the importance of gestation and

their physical contribution through a shared blood supply to the baby's growth and development, also noted in Kirkman's study, discussed earlier. Experiencing pregnancy was important. Some women described how having the baby inside them (feeling movements and kicking) enabled them to develop a representation of the baby as a person. After birth, experiences developing a relationship with the baby varied: some expressed sadness that the baby did not look like them, while others felt the baby was their own from the very beginning. Most highlighted the contribution of consistent, responsive, parenting behaviour, rather than genetics, in shaping the baby's personality, and felt secure and confident as a mother by the end of the first postnatal year. A minority were still struggling at that stage to feel that the baby was really theirs. Clearly many new mothers have struggles of this kind, however the women conceiving through egg donation were inclined to attribute their difficulties integrating a maternal identity to the fact that they were not genetically related to the child.

Becoming a Parent through Embryo Donation

Embryo donation is like adoption in that neither parent is genetically related to the child. There are marked differences, however. The rigorous screening protocols that are typically prerequisites for adoption generally don't apply. Embryo recipients, like donor egg recipients, see the gestational connection during pregnancy and childbirth as significant for developing an attachment relationship to the unborn baby and they value the opportunity to exercise control over the antenatal environment (Goedeke & Daniels, 2017). As is the case for egg and sperm donation, recipient parents need to accept the lack of a genetic link with their child, and consider if, when, and how, they will tell the child of its origins. MacCallum and Keeley (2012) found that many couples conceiving through 'closed' embryo donation do not intend to tell the child, and even when they do have such plans, they often don't enact them. Recent practice changes that support early and ongoing contact between donors and recipients have reduced the potential for secrecy in Australia (Jacob, 2017) and in the United Kingdom (Golombok, 2020), with implications for how communication and contact with the donor couple and their children will be managed.

Becoming a Parent through Surrogacy

Secrecy is not an option for parents having a baby with the assistance of a surrogate. They will need to explain to everyone how they became parents,

and they are likely to experience disapproval and stigma (Golombok, 2020). When surrogates are known, the intending parents will need to negotiate with them regarding the degree of contact and their own involvement in the pregnancy and birth. When they are unknown, intending parents may feel excluded or remote from the gestational process, with potential concerns about the surrogate's feelings about relinquishing the child, and the potential for commercial exploitation, discussed in more detail later in this chapter.

Despite the complexity and controversy associated with this path to parenthood, available research suggests positive parenting outcomes. Heterosexual couples conceiving with the involvement of a surrogate who participated in the UK longitudinal study have been compared with parents conceiving through egg donation, and with naturally conceiving parents across childhood, from one year after birth through to adolescence. Estimated to represent about 60 per cent of the eligible families, 70 per cent of the study participants had used an unknown surrogate. Results indicated that those becoming parents with the involvement of a surrogate reported more positively than the naturally conceiving parents on most study measures (parenting stress, depression, enjoyment of parenting, warmth, and attachment behaviours directed to the child) at each of the early study follow-ups (Golombok et al., 2004, 2006). Outcomes were not related to whether the surrogate parents were genetically related to the child, however parent adjustment was more positive in cases where the surrogate was a relative or friend (Golombok et al., 2004). The small numbers and significant attrition limit generalisability, and there is a clear need for more research. There is no published evidence to date on adjustment during pregnancy; a time when managing the relationship with the surrogate may be particularly challenging. There is, however, emerging research on relations between intending gay fathers and surrogates (perhaps the largest group becoming parents via surrogacy) discussed later in this chapter.

Donor/Recipient Relationships: Indebtedness and the 'Gift Dynamic'

Demand for donated sperm, eggs, and embryos greatly exceeds supply, and this has the potential to contribute to a complex 'gift dynamic' whereby recipients feel profoundly indebted to donors (Kirkman, 2008). One approach to boosting the number of donors has been the practice of conditional donation, which allows donors to specify who will receive their embryos (or eggs) (McMahon & Saunders, 2009). This can lead to

discriminatory decisions, however. For example, donors may choose to exclude single women or lesbian couples, or couples from specific religious, cultural, or ethnic groups (MacCallum & Keeley, 2012). Despite altruistic motives, complicated and ambivalent power relationships can emerge, particularly when there is direct negotiation between donors and potential recipients on 'contact websites'. In a small Australian study, one embryo donor explained how she arrived at her decision about who would receive her embryos: it was based on her perception of the 'worthiness' of potential recipients: 'I chose her, she didn't choose me. I feel really comfortable; in that I know how hard they've tried, so I know they will be appreciative of the donation' (Jacob, 2017, p. 31).

Study participants reported a range of views regarding contact. Some donors wanted detailed progress reports at every stage of the pregnancy, while others felt a tension between their desire for contact and the need to respect recipient privacy and freedom from scrutiny: 'We want to know, but we also don't want to know … we would only keep in contact for the children, because they're full-blooded siblings' (Jacob, 2017, p. 33). Another donor was wary, and preferred minimal contact: ' if you know too much you can start to get concerned' (p. 34). There are different views on the appropriateness of an 'open adoption' model for embryo donation. Millbank and colleagues (2017) recommend flexible, elective approaches that reflect different donor and recipient preferences and needs. Currently, there is no clear evidence regarding which practices are in the best interests of donors, recipients, and offspring, but there is consensus that early disclosure is generally best for children and families (Golombok, 2020).

Increasingly, sperm, egg, and embryo donation arrangements are organised by potential donors and recipients through online communities via social media. It can be challenging for couples to manage early and regular contact in a fully open environment without professional support and oversight (Goedeke & Daniels, 2017; Jacob, 2017; van den Akker, 2017). While Millbank and colleagues (2017) argue that mandatory counselling can be an obstacle to donation, Jacob takes the view that counselling is a duty of care for clinics as part of their contribution to the conception of the child. Open donation is increasingly the preferred practice, however there is very little evidence regarding how couples manage the process, which can be particularly complex when it is other family members who donate.

In a more open environment, there is the potential for difficult relational dynamics with sperm donors as well. In one landmark legal case in

Australia, a sperm donor who was a close friend of the mother (a woman in a lesbian relationship), was involved in the life of the baby from the outset. He was present for the pregnancy scans; he cut the cord at the birth; he regularly visited the family afterwards; and often did childcare, preschool, and school pick-ups. When the two mothers decided to relocate to New Zealand, he objected, took his fight for paternity rights through the court system, ultimately to the High Court, and won the case, setting a legal precedent (Callaghan, 2019).

The gift dynamic is most complex in the case of surrogacy. The surrogate's contribution is more substantial, intimate, and personal, as she carries and gives birth to the infant (Golombok, 2020). Reviews to date suggest surrogates generally adjust well to relinquishing the baby and that they are able to maintain satisfying ongoing relations with intending parents and offspring (Söderström-Anttila et al., 2016; van den Akker, 2007, 2017), however there are few studies, and they have significant limitations, most notably in the representativeness of samples (Söderström-Anttila et al., 2016). Van den Akker (2007, 2017) points out that both surrogate and intending mothers (and fathers) use cognitive restructuring to reconcile their unusual path to parenthood. For example, surrogate mothers are trained and encouraged to view the foetus as 'not theirs', and to view themselves as not the 'real mother'. One surrogate mother interviewed by Golombok and colleagues (2006) describes how she intentionally avoided activities that might promote attachment to the foetus. She refrained from speculating about what the baby would look like, buying clothes, and preparing a nursery, arguing that these were the prerogative of the intending parents. Many surrogates report moderate short-term distress after birth, and that they particularly miss the close and regular contact with intending parents during pregnancy (Golombok, 2020; van den Akker, 2017).

When the surrogacy process is highly regulated, there are few reports of emotional distress. There are more concerns about surrogate wellbeing when arrangements are trans-national, as there can be marked socio-economic inequities between intending parents and surrogates, and different cultural expectations and legal guidelines around contact and procedures (Golombok, 2020; van den Akker, 2007). A study of 50 Indian surrogates recruited between 2015 and 2017 found that the surrogates had more depressed mood than a comparison group of pregnant Indian women during pregnancy and postnatally, that most were unable to meet with intending parents, and many were not allowed to see the baby or even keep a photograph, leading to considerable distress after birth (Lamba et al., 2018). More positive relationships between intending parents and

surrogates have been reported for Italian gay fathers whose surrogates were pregnant and gave birth in North America (Carone et al., 2017), discussed in more detail later in this chapter.

LGBTQ Parents

There are several pathways to parenthood for gender diverse adults. While some same-sex, transgender, and gender non-binary couples may have become parents with prior heterosexual partners, the next section focuses on a growing body of research evidence regarding the processes of adaptation when lesbian or gay couples choose to embark on parenthood together, using donated sperm, eggs, or surrogates (and ART), or adopting a child. The section concludes with an overview of emerging research on options for bisexual, queer, transgender, and gender non-binary adults who want to become parents.

Two Mothers: Becoming Parents as a Lesbian Couple

While women have raised children together over many generations, families initiated by openly identified lesbian couples deciding to become parents together are a relatively recent phenomenon. There is limited research on the decision-making process, and their experience of pregnancy and the transition to parenthood. Some lesbian couples will choose to foster or adopt a child (discussed later in this chapter). The choice to conceive using insemination with donor sperm (DI) is increasingly the preferred pathway (Patterson, 2019). In common with all women becoming pregnant through DI, there are practical decisions to be made regarding the method of conception (home or clinic), and the involvement of the sperm donor in the child's life. There may be additional challenges: reconciling a maternal with a lesbian identity, confronting the potentially divisive relational dynamics of choosing which of the women will become pregnant and be genetically related to the child, and, in some cases, hostility and opposition from extended family (Wojnar & Katzenmeyer, 2014).

Birth Mothers and Co-Mothers: Complexities of Maternal Identity

Which of the women will become pregnant? There are practical considerations: age, health, individual differences in the desire to be pregnant, and in capacity to conceive. Some couples plan more than one child and

intend to alternate (Wojnar & Katzenmeyer, 2014); some opt for a more complex approach, whereby one woman will donate her egg, while the other will be the gestational mother; after embryo transfer, she will carry the pregnancy and give birth. This approach requires ART (Golombok, 2019; Patterson, 2019). Hayman and colleagues (2015) interviewed 30 Australian lesbian women (15 couples) about the decision-making process. The decision related to a 'butch–femme' dynamic (Rosario et al., 2009) where the 'femme-identified' woman was considered the obvious choice for childbearing in some cases. Couples who did not identify butch–femme roles based their decision on age and health, generally choosing the younger partner. If more than one child was planned, the older partner was chosen for the first pregnancy, in case her time for childbearing was limited.

The 'Co-Mother'. Navigating the transition to co-parenthood can be challenging. First, the terminology can be confusing and problematic. The woman who does not give birth is generally referred to as the co-mother (or non-birth mother). In some cases, as noted earlier, the co-mother is the genetic mother of the child. The perspective of the non-birth (non-gestational) co-mother has been largely absent in research. Two studies (McKelvey, 2014; Wojnar & Katzenmeyer, 2014) have conducted in-depth interviews to explore the experiences of the transition to parenthood of co-mothers who do not give birth . Feeling like an outsider was a pervasive theme in both, accompanied by a sense of unreality about the pregnancy in the absence of physical symptoms (although this was mitigated by seeing ultrasound images of the baby moving). Non-birth mothers reported taking on a protective role towards their partner and the baby during the pregnancy, doing most of the physical housework and preparing healthy meals (McKelvey, 2014). In both studies, non-birth mothers reported feeling jealous and excluded, at least some of the time, when they were confronted with the intimate connection between their partner and the infant, particularly in relation to breastfeeding. Like most new parents in the early weeks and months, they struggled with changes to their relationship, whereby they received far less attention from their partner, and they felt guilty about feeling this way (Wojnar & Katzenmeyer, 2014). Similar feelings are frequently reported by fathers in heterosexual couples (Chapter 4).

In terms of relations with the baby, non-birth mothers were conscious of the potential role of biology in attachment and caregiving. Several

feared that the baby would not bond with them, and that they would never achieve the deep connection to the infant that their partner had, even if they took on the role of primary caregiver. As one woman explains:

> I was the one who stayed behind and changed the diapers and fed him. But when she came home from work, he would instantly squeal in joy. Sometimes I felt there were just the two of them in the entire universe. He loves me too, there's no question about it, but when it comes to choosing between the two of us, he knows who his real mother is. I guess the biology always prevails when it comes to mothers and babies. (Wojnar & Katzenmeyer, 2014, p. 57)

Choices regarding sperm donors and method of conception are often aimed at ensuring the non-birth mother feels included (Hayman et al., 2015; Wojnar & Katzenmeyer, 2014). Some couples explained that they had chosen an anonymous donor to protect the parenting status of the non-birth mother, as it avoids a complex dynamic where the sperm donor (biological father) may want an active parenting role and/or feels that he could stake a claim to the child. In both studies, women reported trying to match physical characteristics of the non-birth mother with those of the sperm donor. When a known donor was chosen, the goal was to facilitate the child's ease of contact with their genetic father, whilst ensuring that the non-birth mother didn't feel marginalised. Some chose a brother of the non-birth mother, so they could achieve a genetic link, and several gave the infant the last name of the non-birth mother to formalise and legitimise her connection.

A lack of external recognition and validation as a mother was also challenging and distressing. In the hospital, non-birth mothers reported feeling ignored, misunderstood, or judged by nursing staff. Defined by 'who I am not', they felt they had to repeatedly come out as a lesbian and explain themselves and their family to relative strangers (McKelvey, 2014, p. 108). While some of these feelings (being ignored, treated as marginal), have been described by heterosexual fathers in healthcare settings, the experience was further compounded due to a lack of legal and semantic recognition of non-birth mothers as parents, leaving them to feel that their very legitimacy was questioned.

There is some evidence that non-birth co-mothers are more involved in childcare than is typical for fathers (Patterson et al., 2014), and that they may be more vulnerable to post-partum depression than the birth mother (Wojnar & Katzenmeyer, 2014). This may be due to stigma, and to the absence of scripts, role models, and guidance, as parenting literature is targeted almost exclusively at birthmothers (McKelvey, 2014).

Psychological and Social Adjustment

The national longitudinal lesbian family study in the United States is one of the most comprehensive sources of research data (see Gartrell 2020; Patterson, 2019 for reviews). The study commenced before birth and continued across childhood into adolescence with exceptional retention of participants. Experiences of lesbian mothers were compared with US normative data. Findings to date indicate overall positive outcomes; a greater likelihood of two actively engaged parents, and equitable sharing of childcare and housework achieved through mutual agreement. There are many similarities with the well-documented experiences of heterosexual couples during the transition to parenthood: concerns about the decline in available time and energy for partners, more relationship conflict, and less sexual engagement. Lesbian women generally reported enhanced relationships with their families of origin, including a more explicit acceptance of their own couple relationship, and changes in their social network, with declines in socialising with childless lesbian friends.

Two Fathers: Becoming Parents as a Gay Couple

The numbers of gay men expressing a desire to become parents together is growing (Guzzo & Hayford, 2020). It is not an easy path, however, as the gap between desire and intention to parent is larger for gay men than for lesbian women (Patterson, 2019). Social barriers are similar: there may be a lack of support from the family of origin for some, as well as social stigma and a questioning of entitlement to parent (Murphy, 2013). These barriers can be even more daunting for men, as they need to engage with complex and costly arrangements involving Assisted Reproductive Technology (including surrogacy), or adoption (Patterson, 2019). The pathway chosen is likely to be influenced by financial, medical, and legal considerations (see Josh's story at the end of this chapter).

Taking on a Paternal Identity

Like lesbian mothers, gay fathers may struggle to reconcile seemingly contradictory identities as members of the gay community and parents (Bergman et al., 2010). The decision to become a parent runs counter to both heteronormative definitions of masculinity and paternity, and the dominant gender and sexual norms of gay culture. Many gay men have assumed that coming out as gay means that parenthood is not an option for them (Berkowitz & Marsiglio, 2007; Murphy, 2013). Earlier developmental conflicts and social stigma about gender identity can be reactivated

when gay men contemplate parenthood (Glazer, 2014). For some, coming out as gay activates and intensifies their procreation and caregiving desires (Berkowitz & Marsiglio, 2007). There are also social motivations. Gay men participating in a study by Blake and colleagues (2017) described the importance of intergenerational transmission of the family line and the family name (Blake et al., 2017). Dean Murphy (2013) interviewed thirty Australian gay men who became parents through surrogacy (arranged in the United States). Several described a powerful, innate desire to reproduce, to the extent that they had prioritised finding a partner interested in having children, and they had raised the issue early in the relationship. More liberal social attitudes and public discourse were also influential – the growing representation of gay parents in the media, and web-based promotional materials published by commercial surrogacy agencies. Men in this study were well informed about the practical challenges and the costs and benefits of surrogacy (not legal in Australia) compared with adoption. The opportunity to have genetically related children (at least for one member of the couple), was a powerful motivator:

> I guess a lot of parents probably would probably deny this, but I think that for a lot of people there's a biological imperative to reproduce and I don't know if it's to do with ego or what, but to almost … see themselves in children … I think with an adoptive child, maybe, of course you'd love them, but maybe there's not that actual, it's an animal kind of thing, that animal connectedness with them. (Murphy, 2013; Andrew, p. 1116)

Becoming Gay Fathers through Surrogacy

Surrogacy is the most controversial application of ART; it is not legal in many jurisdictions, frequently involves international arrangements and brokers, and is extremely costly, with estimates of a minimum of US$100,000 in the United States (Golombok, 2020). Golombok points out that gay father families formed through surrogacy are a minority group, even among other non-traditional family forms. They defy both personal and social conventions and deviate most from the traditional nuclear family, as there are two fathers and two mothers, a genetic (egg donor) and gestational mother, but no mother in the family home.

Available evidence about the quality of parenting, wellbeing of the children, and life satisfaction for the men concerned is generally positive (see Carneiro et al., 2017 for a systematic review). This may be due, in part, to the fact that men who achieve parenthood through ART and surrogacy are a highly selected and well-resourced group. Maturity, resolute motivation, and financial security are required to negotiate the daunting social,

structural, legal, and institutional barriers. Gay couples are required to meet stringent mental health criteria for acceptance into some, but not all, surrogacy programs (Greenfeld & Seli, 2011). There is currently scant research focusing on the transition to parenthood for gay fathers, however a few qualitative studies have explored the decision-making processes, the desire for children, and relations with the surrogate.

Compared with adoption, surrogacy allows gay parents to have knowledge of both progenitors and provides the opportunity to acquire the baby very soon after birth, so the child will not have had previous separation or abandonment experiences. Genetic relatedness is not important to all gay fathers (Blake et al., 2017; Goldberg et al., 2012; Murphy, 2013). Those who assign less importance, are more likely to adopt, discussed later.

Which Father will be Genetically Related? Gay couples face similar dilemmas to those described above for lesbian mothers. Men in Murphy's (2013) study described several strategies to address the fact that the baby could only be genetically related to one of them. Some planned two children, preferably using eggs from the same donor, fertilised with sperm from each father, either consecutively (taking turns to provide sperm) or with the goal of a twin pregnancy. Others sought to achieve a similar phenotype to the father who was not genetically related, through their choice of egg donor. For example, one couple used sperm from one of the men and an egg donated by his partner's sister; for one mixed race couple, it was important to choose a Eurasian egg donor, to ensure the baby looked similar to the father whose sperm were not involved. Still others went to considerable lengths to obscure the genetic connection, mixing sperm for 'intentional unknowing' (which has implications for the child, later); others were committed to secrecy, and chose not to tell others which father was the biological parent: 'So we don't want people thinking "oh right, your're the real father, and no, you're not". We're both equal fathers, we want to be recognized that way ….' (Murphy, 2013, p. 1118).

Contact with the Surrogate. During pregnancy, physical distance from the surrogate mother and the foetus growing inside her can be a source of anxiety for gay intending fathers, leading to a sense of alienation and detachment from the pregnancy (Ziv & Freund-Eschar, 2015). This is particularly the case for international arrangements. One Israeli father whose surrogate was brokered and managed through an agency in India described his experience as follows:

> … pregnancy is this folder … my pregnancy is fed on emails, reports and Excel tables. This binder is full of formal documents but has no emotionality … You do not see anything or know anything … You travel to India and you come back with a child in your hands. (Roy, p. 161)

Six of the eight men interviewed in this study described their experience of pregnancy as unreal, 'theoretical'. While all men are one step removed from the biological experience of pregnancy, these gay fathers regretted that they couldn't accompany the woman for scans, see her growing belly, and feel and observe the baby's movements. They struggled to imagine the foetus and described feelings of powerlessness – that they had no capacity to protect the wellbeing of the surrogate or the future child. In contrast, the fathers in the study who had a surrogate in the United States or Canada (a significantly more costly arrangement), had regular contact in an open arrangement with the surrogate, including the option to visit her in her home, observe her way of life, and talk with her about her interactions with the developing foetus.

Fathers in an Italian study (also involving international surrogacy arrangements) emphasised the importance of the surrogate helping them to feel emotionally connected with the developing child, however they were keen to clarify that her role was temporary:

> I could trust her, for me the pregnancy meant only that something which was mine was growing somewhere else, in someone else's house … she was amazing in involving us … she wrote down every aspect of the pregnancy. (Carone et al., 2017; p. 185)

Another highlighted the importance of the surrogate's language: 'She always said "your child". In doing so, all was defined … we were the parents, she was the surrogate' (p. 185). Most were profoundly grateful to the surrogate and determined she would always be a part of their child's life as an 'auntie' or 'tummy-mummy'.

Enthusiastically embracing practical preparations (the complexities of surrogacy-related travel, taking legal steps to formalise parental status, reading parenting books, preparing a nursery) provided compensation when there was physical distance. Nonetheless, all men interviewed were acutely conscious of a missing an emotional layer during pregnancy and hoped this would be overcome once they had a physical connection with the child.

Psychological and Social Adjustment

Bergman and colleagues (2010) conducted an in-depth study of the transition to parenthood for forty gay American fathers who became parents

through surrogacy. Interviews indicated very similar experiences to those described for heterosexual couples and lesbian women: marked changes to lifestyle and work patterns, and declines in romance, personal intimacy, and sexual relations, alongside an improved self-esteem and sense of meaning in life. While changes to social networks are typical during the transition to parenthood, the gay men reported a notable shift, socialising more with heterosexual parents, with whom they had more in common, and many found they had less contact with their gay childless friends. In this study, all but two of the forty participants were pleasantly surprised by the support from grandparents and extended family, which led to more frequent contact and explicit endorsement of their relationship with their partner and their new family unit, also noted by lesbian mothers (as discussed earlier). The complexity and the costs of the surrogacy pathway to parenthood are prohibitive, and this pathway to parenthood is not an option for many gay men, who may need to explore options to become parents through adoption, discussed later in this chapter (Goldberg et al., 2012).

Transgender and Gender Non-Binary Parents

Sex and gender are in alignment for some individuals and not for others. A growing number of adolescents and adults are identifying as transgender or gender non-binary (TGNB) (Tornello et al., 2019). Research is only beginning to emerge on their pathways to parenthood, their experiences of pregnancy and early parenthood, and family wellbeing. In the most substantial study to date, Tornello and colleagues reviewed pathways to parenthood for 311 TGNB parents from diverse geographical locations in the United States. Most became parents through biological means rather than adoption or fostering. Those with a partner assigned a different sex at birth generally did so through sexual intercourse, and those whose partner was assigned the same sex at birth conceived using an egg or sperm donor, generally with ART). Transgender women (assigned male at birth) were likely to become parents before their gender transition, while transgender men (assigned female at birth) and gender nonbinary adults were more likely to become parents after gender transition. Tornello and colleagues point out that this can present significant emotional and biological challenges due to the need to stop hormone therapy and deal with the physical changes of pregnancy. The younger participants in this large study were more likely to become parents *after* their gender transition, likely due to changing social norms, however many reported difficulties finding health providers who would work with them in culturally sensitive ways tailored to their individual needs.

Similar challenges were reported in a smaller British Study, where researchers interviewed eleven transgender parents about their experiences. Respondents found the transition to parenthood to be a very stressful time, as they negotiated non-supportive and judgmental attitudes in IVF and adoption services (Bower-Brown & Zadeh, 2021). Riggs and Bartholomaeus (2020) discuss the need for trans-inclusive fertility education that allows adolescents who intend transition to make informed decisions regarding fertility preservation options at the time when decisions are being made about puberty suppression, so that the option of biological parenthood remains open in the future. Riggs and Bartholomaeus caution that education programs need to ensure informed choice, whilst avoiding pronatalist pressure. We return to these issues in Chapter 9.

An exploratory study by Imrie and colleagues (2020) examined family functioning and parent–child relationships in thirty-five families with transgender parents, using the multi-informant, multi-method approach employed in the UK longitudinal study of non-traditional families. Results indicated generally good quality relationships and positive child adjustment (compared with normative British data) during middle childhood, however the researchers acknowledged the small sample size, which is problematic given the heterogeneity of the sample – there were diverse family structures, a broad age range of children and parents, and many different methods of achieving parenthood. Child wellbeing was related to relationships within the family, and to parent stress, depression, and social support, rather than parent sexuality, gender identity, or family type.

The Transition to Parenthood for Adoptive Parents

Much of the above discussion has focused on genetic and gestational relatedness. Adoptive parents have neither. The adoption process is bureaucratically onerous, costly, and lengthy. It can take anything from nine months to nine years (Skandrani et al., 2019). Widespread access to contraception and termination of pregnancy has led to a situation where there are dramatically fewer healthy newborns available for adoption in Western countries, compared to the middle and latter decades of the twentieth century. There was a surge in intercountry adoptions during the 1990s, due to global health problems, political instability, and Government policies in China that mandated one child families. These numbers have also significantly declined in recent decades, due to changes in China's population policy, concerns about child trafficking

and commodification, debate about cross-ethnic and cross-racial adoptions, cross-cultural sensitivities, and increased regulation of intercountry adoption (Guzzo & Hayford, 2020).

The children available through intercountry adoption tend to be older, and come from countries struggling with internal conflict, poverty, and war. There are many challenges establishing a relationship with an older child who may be from a different racial, language, and cultural background. The child's pre-adoption history is likely to be complex; there may be pre-existing health, developmental, or emotional problems related to a history of trauma or abuse, and multiple separation experiences. Information may not be available about birth parents and early health history. When adoption processes are open, adopting parents will need to support the adopted child's contact with birth parents, on a regular basis (Skandrani et al., 2019).

Skandrani and colleagues note that on a day-to-day basis, parents adopting older children may be faced with a child who has under-developed or disrupted attachment capacity, unresolved grief, organic learning or behaviour problems, and cultural disorientation. The parents will need to manage naïve, sometimes idealised expectations about the extent to which parental love and good intentions can heal past trauma. Parents adopting older children need professional support to relinquish idealised expectations, develop the skills required to support a child with complex needs, and embrace and accept the long-term nature of the process they have embarked upon.

In some Western countries, there is a growing trend to facilitate early adoption of children removed from their birth families and placed in temporary foster care in the child protection system (e.g., Australian Institute of Health and Welfare, 2021b). These children, who have experienced several separations, are likely to present similar challenges to those adopted through intercountry arrangements discussed above. The goal is to provide a safe-haven and secure base for the child by avoiding the trauma and instability of multiple placements and separation experiences when the preferred option of reunification with birth parents is not possible. Meg and Kym describe their experiences of adopting a daughter through the welfare system later in this chapter.

Adoptive parents face many challenges. Well-meaning friends tell stories of adoptions gone wrong, and adoptive parents and children may experience stigma and discrimination. There is an extensive literature on developmental outcomes for adopted children and family dynamics in adopted families, and a broad consensus that adoption is a social intervention that

generally leads to long-term positive outcomes for the child (Palacios & Brodzinsky, 2010). There has been scant research, however, regarding the experience of the transition to parenthood for adopting parents.

Who Adopts?

The profile of adopting parents is changing. More lesbian, gay, trans and gender non-binary couples, and professional single women are now able to adopt as social attitudes have become more inclusive and liberal (Guzzo & Hayford, 2020). The capacity of adoptive parents to adapt to the stress of the transition to parenthood is influenced by characteristics of the adoptive context (the child's age, trauma, and placement history, whether the adoption is intercountry or domestic, whether it is an open or closed adoption), and their own psycho-social resources and vulnerabilities (Belsky, 1984). Adoptive parents are generally older, well educated, financially well-resourced, and have been in a couple relationship for some time (Palacios & Brodzinsky, 2010). Perhaps due to extensive screening and scrutiny of their suitability, they are typically high-functioning adults with excellent potential and high motivation to parent. Research shows that both heterosexual (Calvo et al., 2015) and gay adoptive parents (Goldberg et al., 2012) are likely to have positive recall of their own parents, secure attachment styles, positive relationships with partners, and healthy psychological functioning. They are, therefore, well placed to negotiate stressful life transitions and to provide the corrective attachment experiences that children need after trauma, abandonment, and institutionalised care.

The two partners are more equal travellers during the transition to parenthood than is the case for heterosexual couples conceiving spontaneously, or for same-sex couples conceiving through sperm and egg donation (as discussed previously). The lengthy screening process and intensive planning also make it more likely that any differences in expectations and potential conflicts will be identified and dealt with before the child arrives.

The Process of Becoming a Parent through Adoption: Women's Experiences

In their quantitative study with a large, randomly selected, and nationally representative US population sample, Ceballo and colleagues (2004) found more similarities than differences during the transition to parenthood for adoptive compared with biological parents. Where there were differences, they were in the direction of more favourable adjustment for

the adoptive parents, who reported less marital strain and higher satisfaction with becoming a parent. The researchers acknowledged that the children in this study were adopted during infancy, did not have special needs, and that the study relied only on self-report data.

Two in-depth qualitative studies shed some light on how adoptive mothers adapt as they prepare for their child and cope with the challenges of early encounters. Sandelowski and colleagues (1993) interviewed thirty-five infertile American women waiting to adopt domestically. Almost ten years later, Solchany (2000) interviewed twenty-one American women after they had adopted a child from China. Women in both studies described a lengthy period of 'hoping to be parents' with no clear starting point, no guaranteed due date, no pregnancy landmarks, no public signs to show others they were expecting a child, and no cultural rituals or scripts. Several used the term 'disembodied', describing an acute sense that there was a child somewhere, out there, but not inside. Nonetheless, it was a rich period of anticipation: 'a dynamic interlude in which they actively worked to … transform disadvantage into advantage' (Sandelowski et al., 1993; p. 482). Like women pregnant after egg or embryo donation, adoptive parents downplayed the importance of genetics, pointing out that there was no guarantee that a genetically related child would be a good temperamental fit for parents, and that love was not contingent on a biological connection, as evident in their love for their partners.

The parents-in-waiting constructed fantasies about the child, the birth, and the birth parents. Sometimes a photograph offered a material reality. The pregnancy was experienced cautiously – in the earlier study, all participants had prior experiences of reproductive loss, and they were careful to limit their emotional investment: As one woman put it, 'I put a shield up over my heart' (Sandelowski et al., 1993; p. 473). There was a poignant awareness that their gain represented a loss for the relinquishing mother. In cases where there were 'matching criteria', some of the women invoked fate, and magical thinking. They felt it was worth waiting for the *right child*: 'when all the elements come together at the proper time, when we get her, we'll be able to say, "She's the one".' (p. 477). There were dilemmas, too, about the difficult choices adoptive parents are asked to make. One of the women, who had indicated that she would not accept a handicapped child, felt uncomfortable and guilty about the 'commodification' implicit in setting criteria that were acceptable to her (p. 479).

In Solchany's (2000) study of international adoption, intending mothers were troubled by the ethics of taking a child from one country to another. When they finally met the baby, many didn't feel entitled to call

her their own. Conscious of the intimate pre-birth connections the baby had experienced with another woman, they worried that they would be rejected. Several described the challenge of having their first contact with the child in a public setting, dealing with the 'curt' business-like manner of the officials, and feeling like they were on trial or probation. One mother, who was suddenly presented with an older baby in a crowded waiting room in a foreign country, was unable to settle her, no matter what she tried:

> So her caretakers gave her to me. She … cried and cried and I cried, and she kicked, and she screamed, she tried to fight herself out of my arms … She looked up at me and sobbed big huge tears … Oh it was just awful, it was awful. It was awful. And I worried that they would take her away from me … nothing I did would comfort her. I just felt badly for her. Really overwhelming. (p. 49)

Adoptive parents need to reconcile the actual baby with the imagined baby, as all parents must do. This can be complicated by the need to come to terms with the child's history. When the baby's history was not available, imagined histories and birth mothers often loomed large for adoptive parents. They created elaborate reconstructions of the background to the adoption, attributing altruistic motives to the birth mother regarding the child's abandonment or relinquishment, but this in turn made them feel more guilt and empathy for her loss.

Adoptive mothers work through the challenges of forming a relationship with their baby in their own way, in their own time, and in the context of their own attachment history (Sandelowski et al., 1993; Solchany, 2000). Like all new parents, the baby's behaviour can be baffling at first, but gradually rendered understandable through observation, and ascribing meaning to the child's cues and signals. New parents may seek to 'normalise' challenging behaviour, for example interpreting crying and unsettled behaviour as evidence that the child had been securely attached prior to adoption. Some cope by minimising the significance of the child's pre-adoption trauma, and try to avoid thinking about it (Skandrani et al., 2019). Others may positively reframe, believing that due to their complex history, adopted babies have a deeper understanding of the world – a deeper awareness, attunement to joy, and capacity for happiness. (Solchany, 2000). As noted earlier, these idealised expectations may make it more difficult for adoptive parents to acknowledge and accept the protracted timeframe for establishing a relationship with the child and the inevitable hurdles they are likely to face.

Same-Sex Parents Adopting: Adoptive Fathers' Perspectives

There has been very little research attention directed to fathers' experiences of adoption, and most of the existing work focuses on gay fathers. Same-sex couples are more likely than heterosexual couples to adopt children (Gates, 2015) and gay men are more likely to pursue adoption than are lesbian women (Golombok, 2020). The willingness to adopt may be related to a greater valuing of relational than genetic ties in sexual minorities (Goldberg et al., 2012) and the fact that biological parenthood via surrogacy is so complex and inaccessible to many, due to extremely high costs. Goldberg and colleagues studied motivations for parenthood among seventy men (thirty-five gay male couples) who were planning to adopt, and they found a high concordance with the motivations described for heterosexual couples: they were strongly influenced by their partner's desire for a child and expressed altruistic motives to share their considerable financial resources and give a child in need a better chance in life.

The limited empirical research has studied fathers from middle- to upper-middle class backgrounds, typical of those who adopt. Few studies have included comparison groups of heterosexual fathers or lesbian mothers (Carneiro et al., 2017). Some have suggested that men in same-sex couples may experience a more stressful pathway through adoptive parenthood than do heterosexual and lesbian couples due to stigma, discriminatory attitudes, and questioning of their entitlement to parent (Golombok et al., 2014). The few available studies, however, report comparable parenting stress to heterosexual fathers and other adoptive parents (Farr, 2016; Golombok et al., 2014) and comparable warmth and sensitivity as a basis for secure attachment with their children (Carneiro et al., 2017). One study with a francophone Canadian sample of ninety-two gay adoptive fathers (forty-six couples) reported a more egalitarian division of tasks and high levels of involvement in childcare compared with community normative data (Feugé et al., 2019).

Summary Comments

The desire to have children is innate and universal, and one that crosses the lines of gender and sexual orientation (Goldberg et al., 2012). Research evidence challenges assumptions that genetic parents have instinctive advantages or that coping with infertility or social obstacles to parenting impedes parenting capacity. Adoptive parents (Palacios & Brodzinsky, 2010), and those who become parents through sperm, egg, or embryo donation are

generally competent and loving parents, irrespective of gender or sexual orientation (Golombok et al., 2014) supporting the axiom that family processes, rather than family structure determines child wellbeing (Goldberg et al., 2012; Golombok, 2019; Lamb, 2012).

Psychological motivations to parent inform normative adult life-course decision making for heterosexual and same-sex couples, alike. Nonetheless, sexual minority status and genetic relatedness are likely to shape representations and experiences. By the time they overcome all the hurdles, couples opting for alternative, non-traditional pathways to parenthood tend to be cognitively comfortable with their unusual method of forming a family (van den Akker, 2007). This chapter concludes with two accounts of the transition to parenthood: Meg and Kym, a lesbian couple who adopted their daughter through the welfare system and Josh and Sean, a gay couple who became parents of twins with the assistance of a surrogate.

Meg and Kym's Story: Adopting a Baby Girl

Meg,* a mental health professional, had been with her partner Kym,* who worked in the creative arts, for twenty years. As a lesbian couple, they had always assumed they wouldn't have children; it simply would not be part of their lives. Their lives changed completely, however, when Tina* came into their home – initially as a foster baby, and they began proceedings to adopt her two years later. From the outset, it was clear to Meg that becoming a parent didn't need to involve a genetic child:

> Well, I … didn't want children for a long, long time. I'd had a very difficult childhood and I felt that having children would be incredibly stressful. So I didn't have a craving. I just never felt a need to have my own child. And I say that because I know that a lot of people do … I just never had that need, that, it had to come from me.

In their late thirties, Meg and Kym both started to question their longstanding assumption that they wouldn't have a child. For most of her adult life, Meg had assumed that she wouldn't cope well with the stress of mothering: and then at some point it dawned on her that she *could* care for a child; what's more, she wanted to do it. She was about to embark on a Masters' degree, and she and Kym were both working full-time, so the timing was not ideal, but they were aware that if they were to become parents, time was running out.

Significant policy and practice reforms that facilitated earlier placement of children in the child protection system provided the impetus. Meg, who had worked for many years with foster parents, felt the system was changing for the better, and that both children and their carers would benefit. She had always felt strongly that 'she didn't want to add more children to the planet' and the idea of fostering suddenly felt right to her: 'The first hurdle was me thinking, can I do it? And the answer was yes, of course I can. And then it seemed to be the most amazing and wonderful idea, and it's been amazing ever since.'

The process was lengthy and thorough: assessments, panel interviews, home visits, training courses. Meg didn't find it intrusive. In her view, it was just as it should be: 'It's what kids like Tina deserve. It's their job to get it right. It was exciting for me to do the training and I went into it wholeheartedly. I wasn't going in as a professional. I was going in as a parent to be.'

The first proposed placement didn't eventuate, but some months later, Meg and Kym were invited to meet a baby girl. Tina had been removed from her mother's care at birth, and placed with foster-carer, Jane. Meg's eyes fill with tears and her voice is choked with emotion as she describes their first encounter with Tina. It was filled with wonder and joy, but tempered by sadness and empathy for Jane, her foster mother:

> Oh, I remember it so clearly. We had to go down to a dingy office. We walked down these stairs, we kept walking down and down, and there was a big meeting

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> table in the office. There was a woman at one end of the table. It was Jane, the foster mum, and she had a little baby sitting on the table – she was just sitting there. She was a very chubby little girl, and she had her hair up in this topknot, and these amazing blue eyes. She was extraordinarily beautiful, just so beautiful. But I could also tell quickly that Jane [foster mother] was upset. Then, about half-way through the meeting, they asked If we wanted to hold her, and she came and sat on Kym's lap. After a while, it was my turn. I was trying not to cuddle her, because I felt, well poor Jane; this was a very serious thing to be handing over a child, but I was completely overcome with emotion. I thought she was just the most beautiful baby. It was astonishing!

Over the next month there was a gradual transition to Meg and Kym's care: brief visits to Jane, the foster mother's home, short outings, a day visit to their home for a nap. Meg reflects on those early days:

> There are so many kids in need. And you've got the chance to love one; just one! You simply need to love that one child and love her completely. It's her mum's loss, which is terrible. But for us, it was amazing. Soon the little thumper was part of our lives, forever. I was tired. It was all consuming, but in a really good way.

Like all new parents, Meg and Kim had to adjust to huge changes in their relationship and lifestyle. They didn't designate a primary caregiver, juggling Tina's care and household tasks based on their different skill sets and diurnal rhythms. Meg felt fortunate to have a supportive network of gay couples; women they had been friends with over many years who also now had young children of their own, mostly through IVF and sperm donation. She reflected on the highly positive social change that had made this possible:

> When I came out, I was nineteen, and that was really, really hard. There weren't same-sex parents. There just weren't any … as gay people we never expected to have this in our life, and nor did our friends. It's no mistake we're all in our forties before becoming parents. It's more culturally available now. The changing social influences have enabled it to happen. It's been a dramatic and welcome change.

*Names have been changed.

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Josh and Sean: Two Fathers, Two Babies

Broadcaster Josh Szeps and his partner, Sean, had been together for seven years (married for three) when they became parents. Before the twins, life had felt like one long honeymoon: footloose, and fancy-free, with all the excitement and opportunities New York City had to offer. They had no commitments, no mortgage, no obligations. During his twenties, Josh had engaged in an ongoing debate with himself, weighing up the pros and cons of becoming a parent. There was no sense of urgency, and certainly no pressing visceral longing for a newborn infant:

> To be honest, I never felt drawn to having kids on a raw emotional level. I don't like babies. I like children who can talk and play with you, but I feel no affection towards the little lizard creatures, who are covered in goo and poo and wail all the time.

Ultimately, his motivation was intellectual and philosophical: 'If I died never having been a father, I might feel l had missed out on something fundamental to the human experience.' Sometimes Josh wanted kids, and Sean didn't; then Sean did, and Josh didn't. When their respective desires to become parents finally synchronised, there were two pathways open to them as a gay couple. Both were complicated: adoption and surrogacy.

They considered adoption, but 'the adoption process seemed fraught with delays, uncertainty, and risk. Surrogacy offered more confidence about the outcome, provided you had the large amounts of money required for legal and medical (IVF) fees.' Josh and Sean sought a premium quality agency – one that would take every care to minimise exploitation of the women working as surrogates. The agency they chose accepted only married women who already had at least one child, and positive experiences of pregnancy and childbirth. Sara, the surrogate had three children of her own. There was mutual and amicable agreement about the desirability of close contact during the pregnancy and ongoing contact after the birth. The egg donor had altruistic motives for donating. The extended family were enthusiastic, excited, and supportive. Everything was in place.

Sara lived in the mid-west and the IVF procedure took place in California, so there were a lot of cross-country flights and skype calls during the pregnancy. Josh and Sean had hoped to be present for the birth, but as things turned out, they narrowly missed it. When they heard that Sara was about to go into labour, earlier than expected, they jumped on a plane, landing in the middle of the night. It felt like a scene from a movie – they were speeding in their rental car from the airport to the hospital when they received the call. The babies had been born. As he pressed the after-hours buzzer, Josh found himself uncharacteristically lost for words: 'Baby, baby, we're having a baby', he mumbled. The security guard buzzed them in, and they dashed up a flight of stairs. They were able to see the babies within half an hour of birth. Josh describes this first contact as 'terrifying, surreal, and extraordinary. I didn't

know what to make of it. I was full of emotion, but also fear. What to do with these helpless, slimy little things?'

And two of them! They had decided that two embryos would be implanted, hoping to maximise the likelihood of a pregnancy. Twins were always a possibility, and while not explicitly planned, seemed like a good option. Josh had no illusions about becoming a parent. He knew that having kids was going to be hard – he was aware that he might not love it. So, the idea of having a complete family and not having to repeat the costly processes of IVF and surrogacy, and the exhaustion of parenting a young infant was appealing. Despite these longer-term advantages, early parenting is extremely arduous with twins. Initially, the strain was cushioned by generous and sensitive support from Sean's mother. Never overbearing, she allowed them to make their own mistakes, and was always there for them. This got them through the first two months.

When the babies were eight weeks old, the family flew to Australia where Josh was starting a new job. It was a formidable undertaking. They both had to be full on parents, all the time. Josh describes this two-month window before his own parents (who were overseas) were available to help: 'It was a mayhem of mutual depression, antagonism, sleeplessness, and anxiety. It was really, really hard; by far the most emotionally gruelling thing either of us had ever lived through.'

He found himself temperamentally quite unsuited to the parenting role, at least when it came to very young infants:

> One misconception that I had; I knew it was going to be stressful, but I'm good at handling stressful situations. I'm a good ring-master and a multi-tasker. I thought – I'll be able to keep tap-dancing, whilst keeping all those balls in the air. What I didn't realise is that while multi-tasking skills might be useful when the kids are about five years old, when they're just a few months old, it's not complicated at all, and being a multi-tasking tap-dancer is completely useless. You need to be resilient, enormously patient, and not easily bored. It is relentless: the drudgery of sleep, feed, change, cry, sleep, feed, change nappy. I did not love it, at all.

From time to time, Josh found himself wondering if the process of becoming a parent might be easier for women. Perhaps the gradual nine-month period of discomfort, during which a woman can gradually adjust to disturbed sleep and physiological changes in her body eases the transition:

> For us, a switch was flicked, and we went from normal life to suddenly having a baby. So I do think perhaps nature has a clever way of gradually acclimatising you, over the course of a pregnancy, and we missed out on that.

Relationships change when adults become parents. Both Josh and Sean found themselves much more forgiving of their own parents' shortcomings. Josh delighted in watching his own parents as they stepped into the roles of grandparents 'with enormous grace, tenderness, and joy'. As for their own

relationship with each other, it became more about coping than celebrating life. Both felt warmly supported by extended family and close friends. Many gay parents report stigma, but it wasn't a big issue for Josh. Like many gay fathers, he was subject to frequent assumptions that there must be a mother in the picture, and 'Where's Mummy?' questions when out on his own with the babies. He took the pragmatic view that those asking were just playing the statistical odds, and nothing untoward was intended:

> I think generally the culture has done a great job of moving very quickly to accept something that was really, really, weird, until very recently. I'm impressed that everyone's doing a bang-up job of trying to be OK with it.

Nonetheless, he appreciates some progress towards inclusiveness, for example, official forms that now say 'Parent 1 and Parent 2' rather than mother and father. Asked whether he'd recommend parenthood to other couples, Josh is disarmingly frank:

> Not necessarily. In the long arc of my life, I'm delighted that I did it, but there are huge opportunity costs. As long as you're cool with that, then do it. But I don't think people should be cajoled into having kids, or shamed for not having them.

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