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In this qualitative study, we explore how lesbian recipients view and experience the selection of their anonymous sperm donor. The study was conducted in Belgium, where fertility centres follow a legal protocol that severely restricts personal choice in donor selection. While previous studies have shown that recipients want greater control and input in the selection of their sperm donor, this was not a main concern for most women in the present study. They generally acknowledged their lack of control on the selection outcome and accepted this as part and parcel of an anonymous donation policy that provides an opportunity to have a child. They actively and passively downplayed initial concerns about the donor selection procedure and felt they did not have or need a right to further control over the donor selection. In adopting this ‘subordinate’ position, they felt they should trust the hospital, which they hoped would fulfil rather high screening standards. Those who did want more choice were nuanced and careful about their motivations: they focused on selecting traits that would facilitate normal child development or increase family coherence. The findings shed light on how these patients perceive their position in this third-party reproduction setting.

Keywords: assisted reproduction; counselling; ethics; gamete donation; Belgium

Introduction

In this study, we explore Belgian lesbian couples’ views about and experiences of the selection of their anonymous sperm donor. Whereas in the past the use of clinical donor conception treatment was restricted to heterosexual couples, over the years there has been greater willingness to consider access by lesbian couples. This has been accompanied by evidence that lesbian donor conceived families do not fare worse than heterosexual families in terms of quality of family functioning and child development (Brewaeyts et al. 1997; Brewaeyeys 2001; Baetens and Brewaeyts 2001; Vanfraussen, Ponjaert-Kristoffersen, and Brewaeyeys 2003; Bos, van Balen, and van den Boom 2005). Relatively little attention has been paid to the ways in which lesbian couples negotiate kinship and the meanings of genetic parenthood (for a review, see Nordqvist 2012) and particularly to how lesbian (aspiring) parents deal with the third party involved in the reproduction process. It is often assumed that the involvement of a donor causes fewer problems for lesbian than for heterosexual couples, since lesbian couples know from the start that they will need donor sperm to conceive a child and since there is no social father who could feel threatened by
the male procreator (Wyverkens et al. 2014). Along the same lines, there is little research thus far into how lesbian recipients deal with the clinic’s selection of their donor.

**Restricted versus consumer-directed donor selection**

Due to ethical, socio-cultural and religious differences, there is substantial diversity worldwide concerning all aspects of gamete donation. This is also the case for the sperm donor selection programmes in fertility centres. Even within nations, criteria for donor acceptance can differ significantly between centres (Thijssen et al. 2014). In general, however, we can differentiate between two extremes: on the one hand, regulations where candidate recipients have very restricted input in the centre’s donor selection procedure, as is the case in Belgium, and, on the other hand, the ‘consumer-directed models’ of donor selection that are prevalent, for example, in the USA. In restricted donor selection procedures, the focus of donor screening is on assessing semen quality and cryosurvival and on avoiding the most frequent and severe infectious and genetic diseases. It is part of established practice that staff then select a donor (sometimes in dialogue with the recipients) that best matches basic phenotypic traits of the birth mother or the non-genetic partner. This matching aims to reduce the risk of apparent differences from naturally conceived families (and thus to allow secrecy about the donor conception). Other traits, such as personality, intelligence, interests, capacities and social background, are generally not included in the selection procedure because of ethical concerns, particularly the concern that this would lead to commercialisation of gamete donation (Pennings 2000). In consumer-directed models, by contrast, fertility centres let their clients choose their donor of preference from a catalogue that provides information about the donor’s medical (family) history, physical characteristics, achievements, personality, interests, hobbies, religion and so on. Various commercial sperm banks have been founded that offer similar donor choices. These sperm banks often provide online services to both clinics and private customers. Cryos International and its daughter company in New York are perhaps the best known examples of such enterprises. On their websites, clients can choose the level of information they want about the donors. ‘Basic profiles’ include basic phenotypic characteristics and occupation/education. Clients interested in ‘extended profiles’ are granted access to detailed information about the donors’ medical history, baby photos, personality, interests, education and staff assessments. For both profile types, one can choose between anonymous or open-identity donors.

**Concern over the donor**

Given these conflicting models of donor selection procedures, it is worth reflecting on how the recipients of clinical donor conception experience restrictions in their choice of donor. This question seems all the more pressing given evidence that recipients of donor gametes want greater control and input in the donor selection (Heinemann-Kuschinksy et al. 1995; Adair and Purdie 1996; Lindheim and Sauer 1998; Ross, Steele, and Epstein 2006). The main concerns of patients appear to be the need for reassurance about the quality of the donated gametes and health of the donor, as well as an interest in the cultural and psychological background of the donors (Lindheim and Sauer 1998; Garrido et al. 2002). Various studies have shown that the potential donor’s appearance, intelligence and personality are important to heterosexual candidate recipients (Lindheim and Sauer 1998; Baetens et al. 2000; Becker, Butler, and Nachtigall 2005). To be informed about these aspects is considered a great advantage of known donation. The intelligence of the donor is, after health, the most important donor characteristic reported by donor parents (Klock...
and Greenfeld 2004; Sawyer et al. 2013). Lesbian couples have described feeling frustrated about the choice of donors available to them in the clinic, either because they want a larger donor pool from which to select (Ross, Steele, and Epstein 2006) or because they desire a better physical match between the donor and the mothers (Nordqvist 2011).

The Belgian context
In Belgium, clinical donor conception was first provided to lesbian couples in the Centre for Reproductive Medicine of the Brussels Free University in 1981 (Baetens, Camus, and Devroey 2003). Both anonymous and known donors (relatives/friends) can be used. In conformance with Belgian Law on Medically Assisted Reproduction and the Disposition of Supernumerary Embryos and Gametes (2007), the selection of anonymous sperm donors is based on medical criteria and basic phenotypic matching. From this pool of medically screened donors, candidate recipients are allowed only to state a preference for basic phenotypic traits: hair colour, eye colour, height and weight. Out of fear for eugenic practices, it is not permissible to select donors on the basis of other non-pathological criteria, such as other physical features, intelligence and psychosocial aspects. In fact, these criteria are not generally part of the selection procedure at all (although candidate donors will be rejected if they show signs of behavioural abnormality or below average mental capacities).

The present study
In this study, we focused on how (candidate) recipients of clinical donor conception treatment in a Belgian fertility clinic experienced the restricted selection of their donor. For all participants, the phenotypic preferences were discussed during a counselling session, which – according to the law – must be offered to all patients seeking donor conception treatment. The session took place at the start of their treatment, which means that they did not yet know whether or not they were eligible for treatment. During this meeting, different topics were discussed, including (the context of) their wish to have a child and the conditions and limitations of the anonymous donor conception procedure. The topic of donor selection was introduced by the counsellor at the end of the session through a phenotype card that lists the various options. The couples were asked if they had a certain preference. If a couple had difficulties choosing, they were advised to use their own phenotypic traits as a basis for filling in the card.

Methods
Participants
A total of 20 lesbian couples (40 participants) were recruited via the Department of Reproductive Medicine of Ghent University Hospital: 10 couples had at least one child conceived after successful donor conception treatment in this department and 10 couples were in treatment at the time of data collection. Throughout the paper, we refer to these groups as the ‘recipients’ and ‘candidate recipients’ of donor conception treatment. For both groups of participants, the approval of the Ethics Committee of the Ghent University Hospital was obtained. Participants provided written informed consent at the time of the interview.

Recruitment was carried out by a counsellor who had met each couple during a counselling session before they commenced treatment. The ‘recipient group’ was recruited in October 2012, based on a list of lesbian couples who had been accepted for treatment
with anonymous donor sperm at the Department between 2002 and 2004. These couples had given birth for the first time between 2002 and 2005, which means that the oldest child was between 7 and 10 years old at the time of recruitment. Recruitment for the ‘candidate recipient group’ started in January 2013 and was based on a list of lesbian couples who wanted treatment for a first child and had recently (between November 2012 and February 2013) had an insemination or ICSI treatment with anonymous donor sperm at the department.

The inclusion criteria were: lesbian couples using anonymous sperm donors (no intra-partner oocyte donation), Belgian citizenship, being Dutch-speaking and being currently in treatment or post-treatment. For both groups, recruitment was completed when 10 couples agreed to participate.

**Interviews**

Couple interviews were conducted (in Dutch) by two psychologist members of the research team at a location of the couples’ preference: Ghent University Hospital’s Department of Reproductive Medicine or their own home. The interviews were semi-structured and part of a larger study with multiple focuses related to the participants’ thoughts on and experiences of different aspects of (parenthood after) donor conception treatment. The interviews lasted approximately 90 to 120 minutes and were audio-taped and transcribed with participants’ consent. Transcripts were checked for accuracy (first by a team member and then by the interviewer) and the relevant segments were translated. Pseudonyms were given in order to protect the anonymity of the participants.

**Analysis**

Within the data corpus, a particular data set was analysed in which couples referred to the selection of their donor, the role of the hospital in donor screening and selection, and certain wishes or considerations in terms of the donor’s physical/mental characteristics or motivations. Step-by-step inductive thematic analysis was performed (as presented by Braun and Clarke 2006) using the qualitative data analysis software MAXQDA and resulting in themes that are grounded in the data. Transcripts were constantly reviewed in light of new themes. All phases of the analysis were followed by team discussion and auditing by the co-authors.

**Findings**

**Basic phenotypic matching**

An unexpected twist

In recalling the counselling session at the start of their treatment, many participants mentioned that donor selection and phenotypic matching was not their main concern at that time. Of the group currently in treatment, for whom the meeting with the counsellor was easier to recall, five couples explained that they had not given the donor selection any thought beforehand. At the time of counselling, they had not expected to be asked about phenotypic matching. They described their surprise when they were asked about it:

Marilyn: That was a bit funny, really. All of a sudden, we were presented with a situation in which we had to choose ...  

Kelly: And we didn’t really know that, did we?
Some of these candidate recipients mentioned that they had not expected to have any input in the selection of their donor at all. Clara and Bo, for instance, felt that being asked about their preferences ‘right after the counselling’ was ‘confusing’ and ‘a bit overwhelming’. In describing their surprise, the notion of the counselling session as a form of ‘gatekeeping’ arose. A few participants mentioned that the meeting was not as expected. Central to their recollection was a feeling of relief. These participants had expected that they were the ones who were going to be screened, rather than the donor. One couple explicitly said they regarded the counselling session as a test, a ‘cross-examination’, to see whether or not they would be allowed treatment.

While some of the participants had not expected any questions about the donor selection at all, a recurring theme nonetheless was their appreciation for having been allowed to make (rather limited) choices pertaining to phenotypic matching. Ten participants explicitly mentioned that this was valuable in terms of greater involvement and recognition of the social parent. Emily, a candidate recipient, explained that it was important for her to create confusion about which of the partners was in fact the biological mother:

You know, so that people would say, that they would wonder ‘Hmm, which one is the mother?’ Like, ‘Which one carried the child?’ (…) Then you’d really feel like ‘It’s our child’. I’d like that, yeah.

Two couples, however, did mention that the selection of traits to match the social mother was irrelevant – or even hypocritical – given the fact that they were a lesbian couple. Beth and Christine, for instance, mentioned that ‘It’s obvious that it [future child] is not ours’, so one shouldn’t pretend it has to look like the social mother.

An unfamiliar domain

When asked if, hypothetically, they would have liked to choose other and/or more donor traits, the participants typically said they found this idea ‘strange’, ‘weird’, ‘funny’ or even ‘scary’:

Frances: Don’t you think it’s scary that you can determine everything? I find that very scary.

Clara: It’s not as if you can say: ‘I want a baby with those traits’, ‘cause that would be a bit weird’.

Five participants even described the current selection of phenotypic traits in those terms. For instance, Martha said she found the matching with her eye and hair colour ‘weird’ because that gave her the feeling that they were picking a donor:

... as if you have to decide: ‘Oh, pick that one!’ ... I found that quite funny actually, as if you could choose what you, you know, sort of wanted.

The question as to whether they would have liked to choose more donor characteristics was seen as out of the ordinary. Many couples struggled to put into words why they felt uncomfortable. They did not have a suitable script to talk or think about it and sought analogies with other situations in which one can choose certain options. Evie and Grace compared the situation of choosing a donor to ‘shopping’ from donor ‘catalogues’, which they felt would be ‘unethical’. Tamara thought of the selection of donor characteristics in terms of ‘assembling’ a child. For Ada and Frances, it was like taking extra options when you buy a car.

Only one couple drew a comparison in support of their view that they should in fact have had more input in the selection of their donor. Kelly and Marilyn compared the situation of donor selection to buying a house: you set up certain criteria and look for the
house that is the best match, without expecting the perfect house. The others came up with analogies to ridicule the idea of choosing donors. The mocking tone of the descriptions suggests that they found the idea of selecting a donor bizarre. Martha, for instance, mockingly imagined choosing a donor from a ‘line-up’:

You mean like a line-up, like in the . . . [laughs] like behind a window? ‘Would that one please turn around?’ ‘Hmm, nice bottom.’

In both groups, humour was used throughout the interviews to express their unease about donor selection, either to emphasise the irrelevance of such selection or to describe their concerns or uncertainties about the selection outcome.

**Being a recipient: taking a ‘one-down’ position**

In general, the participants described their experiences and views from a rather accommodating attitude. This seemed to arise from the fact that they were on the receiving end and depended on others and the hospital to become parents. A persistent theme throughout the data was that the (candidate) recipients – the ‘receivers’ – spoke in terms of the expectation that they should be grateful for what they had been offered: a chance to have a child. As Sara put it: ‘I think we should be quite happy that this is possible, that we got to have children.’ Complaints or wishes concerning the donor selection procedure were often balanced against that sense of gratitude. Abigail, for instance, felt that ‘It’s nice that you can choose [phenotypic characteristics], that it has come so far’, given that it ‘used to be just an anonymous donor, nothing else.’ Five participants noted that there were limits to what you can ask or expect, and the selection of donor characteristics was one of those limits. They should not ‘push it’ or be too ‘difficult’:

Kelly: No, eyes – we said that it really doesn’t matter, huh? . . . I mean, we didn’t want to . . . we felt a bit embarrassed about pushing it so far.

Martha: You’re thinner than me [laughs], so we said: pick someone somewhat like her. We weren’t difficult about it.

The participants adopted this accommodating attitude both passively and actively: through withdrawal from involvement in informed decision-making and by actively downplaying initial wishes or concerns related to donor selection.

**Relinquishing involvement in informed decision-making**

In a passive sense, they showed few signs of initiative to question or control their input in the donor selection procedure. In having chosen for anonymous donation, it seems, they relinquished all active involvement in decision-making about the donor.

**An unquestioned belief**

A first example of this derives from the fact that many participants appeared ill-informed about the donor selection protocol. For instance, nine participants shared the unquestioned assumption that donor anonymity precludes donor selection; that by choosing any other donor characteristics, you necessarily end up knowing the donor:

Sandy: No, no, because then you would have to choose.

Kate: Yeah, then there’s the fact once again that it’s not anonymous.

These participants did not consider that some form of donor selection was possible without undercutting donor anonymity: for instance, through selection from a list of non-identifying traits.
Also, nine people explicitly mentioned that they did not know how donor selection occurred and said they received very little information about this. Bo, for instance, who was in the middle of the treatment process, said she and her partner, Clara, lacked information about the criteria and values underlying the donor screening:

‘How do they screen at the hospital? Which traits or, uhm, values did they assess?’ I have no idea. Maybe it’s dealt with in a brochure or something, but it wasn’t really explained to us, or ... yeah.

Throughout the interviews, participants described very different recollections of whether and to what extent they were informed about the donor selection. Importantly, a few explicitly stated that they regretted lack of information or feedback, but did not mention having asked questions or requesting information themselves. This lack of initiative was even apparent when participants expressed quite significant doubts or concerns:

Marilyn: We didn’t get any feedback, huh? For instance, I would have really liked it if I could have – before Kelly received the vial – taken a look through the microscope. At the sperm. To see if it moves, for instance. ... It might as well have been water.

A matter of good faith

Participants seemed to put their fate in the hands of the hospital and staff, stressing that, to some extent, the outcome of the screening and donor selection was a matter of trust. The need to trust the goodwill of the donor also arose when they considered that not everything can be tested, or that the donor may sometimes be untruthful during the screening:

Beth: Sometimes I think: ‘Oh, I really hope it’s not too easy to lie about certain things.’ Because a screening, well, it’s partly a matter of trust, isn’t it?

They were not always completely comfortable with having to rely on ‘trust’. Still, there was an underlying assumption that they could not control the situation; they seemed to feel they could not or should not even ask questions. Also, in speaking about their expectations of the donor screening procedures, they did not try to validate whether that trust was justified. They talked about the clinic’s donor screening procedure in terms of what they ‘assumed’, ‘would expect’ and ‘hoped’:

Kim: Well, I assume that they, well, that the medical histo-, you know ... That they don’t have a genetic disease, I mean, I assume that’s what happens.

Some assumptions about the hospital’s role in the screening and selection of donors included rather high expectations. A common expectation was that the medical screening was stringent. For some participants, this screening was thought to be even more elaborate than merely selecting physically healthy donors. Lauren, for instance, had heard from others that the screening is so comprehensive that the donor ‘can’t even wear glasses or anything’. For Molly and Abigail, it was important that the donors were screened for genetic diseases and drug and alcohol addiction, but the donor should also look ‘decent’. Martha stated some concern over the fact that her son had dyslexia, while she had chosen this hospital because acquaintances ‘had led her to believe’ that it conducted the best check-ups of donors’ medical backgrounds.

Actively downplaying wishes and concerns

The participants also adopted this accommodating attitude in a more active manner. Of the 10 couples who were in the process of treatment, 6 explicitly mentioned that initially they had serious doubts about using an anonymous donor, out of fear of the ‘unknown’ and of
passing on undesired/unknown/unrecognisable genetic traits to the child. They would have liked more choice or information to be able to at least better picture their future child. However, they actively downplayed these expectations, doubts and uncertainties to conform to the clinic’s policy. This ‘downplaying’ involved different strategies.

**Putting genes in perspective**

Some downplayed their initial doubts by referring to uncertainties inherent to nature and genetics. Evie and Grace emphasised that, while you cannot imagine what your child will eventually be like if you do not know what the donor looks like, ‘it can always turn out completely different’ anyway. For Ruby, one had to let go and wait until the child is born: ‘eventually, nine months later, you’ll know anyhow.’ Others emphasised the remedying or compensating impact that their upbringing and parenting skills may have. Christine, for instance, mentioned that initially she wanted control over the genetic origin of the child, but ‘started to put things into perspective’ as she realised that the child is shaped by a combination of genetics and environment.

**Avoiding difficult choices**

Another recurring theme throughout the data was the idea that having more input in the donor selection would make it more difficult to make good decisions. Participants commonly downplayed their (initial) wishes for more input by pointing out that donor selection was not ‘right’, that it was unethical. For instance, April said that intelligence was important to her and that she worried people living in the margins of society donate for easy money, but she immediately noted that that’s quite prejudiced of her. Others commonly referred to the risk that donor selection would be detrimental for the donor pool. Twelve participants stated the concern that it would favour an ideal, standard type of donor and would stir up wishes for ‘assembling’ the perfect children. As Mia explained, ‘it would always be the same donors that get chosen. An ugly one will never get chosen then.’

Another sense in which donor selection was thought to impede good decision making was the idea that the more options one is given, the more difficult it becomes to choose between them. Nearly all the participants mentioned that they would have a hard time deciding which criteria to choose. In the end, many felt that the choice was too subjective. Grace explained that, while it would be nice to choose from ‘a photo catalogue’, you would tend to choose merely what you thought was attractive. Sandy felt ‘safer’ with the current selection procedure because she thought the hospital staff made ‘the best choice’. This way, the choice was more objective and less subject to discussion.

Other participants felt it was impossible to decide what to choose and where to draw the line. Kelly explained that ‘the more you can choose and influence, the more you will want to do so’ and she did not see how you could stop people once they were allowed some level of control. Frances explicitly stated that she hoped the system would not change, after realising that she too would want to choose too much if given the option.

In general, there was great willingness to hand over the perceived responsibilities related to donor selection. As they wondered how to select and rank the most important donor criteria, eight participants considered it easier and more reassuring to let the hospital or policy decide. This willingness to pass on the responsibility of choosing to others not only related to the perceived burden of making donor choices; two couples also felt that choosing their own donor would make them responsible for any adverse effects on the child. It was deemed best to leave these matters to ‘fate’, rather than to play an active part in the outcome themselves:
Christine: What played a role for us was the idea that if we make the wrong choice – that sounds silly of course, but anyway – if something were to be seriously wrong with your child, then I think you blame yourself. Even though it could happen to anyone. But now it’s a bit like fate, and we liked that idea better than having to make an active choice.

Repeatedly, the idea arose that the selection of other donor traits was not a priority. As mentioned above, in the end, what mattered was that one got the opportunity to have a child. As long as the child was happy and healthy, the rest did not matter. Having stated a few donor preferences, Sara and Lisa immediately downplayed the importance of their wishes by adding that selection of those traits was not necessary and would only be considered if they were given the ‘luxury’ of choice.

**The functions of choosing**

Of those who expressed some (initial) wish for more input in the donor selection procedure, all but one couple stressed that it was not about what ‘they’ themselves wanted. Specific functions were attributed to the donor selection: the selected traits would either be in the interest of the family or a way of ensuring normal child wellbeing.

*For the benefit of the family: a match with the couple*

As mentioned above, 10 participants explicitly mentioned that phenotypic matching was valuable in terms of greater involvement and recognition of the social parent. Some of these participants mentioned a wish for extra traits that would further enhance the future child-social parent resemblance. For example, Ada and Frances specifically wanted the counsellor to add ‘curly hair’ to their phenotypic preferences, because they wanted to have a child with hair similar to that of the social mother. Interestingly, in this case as well as for Lola and April, it was the biological mother who felt particularly strongly about this.

Two couples expressed a wish for such ‘extended’ matching with the social mother involving traits other than those related to outward appearance, particularly character traits. For instance, Molly, an educator, would have liked a match with someone who also had a ‘caring’ personality. Patricia regarded herself as ‘highly sociable’, ‘enthusiastic’ and ‘motivated’ and she and her partner said they would have liked to see these characteristics passed on to their future child.

For others, the main point of extended matching was to have a child that ‘fits’ in well with the family, matching the characteristics of the couple. Monica stated that she wouldn’t really consider the unique characteristics of the donor, but would choose in function of her and her partner’s respective characteristics in terms of personality or at least appearance. Similarly, two couples said they would prefer a donor with interests and talents matching their own. Lisa and Sara mentioned that an interest in sports was important to them. Lola and April were both creative (artistic/musical) and admitted that they would have liked to choose someone whose interests were along the same lines.

Three recipients explained the importance of a good match with the donor in terms of wanting a rapport with the donor, comparable to what you experience when you make a new friend or fall in love with someone:

*Sandy:* I mean, you don’t choose just anyone to be friends with, right? Why’s that? Because there has to be a spark. Then you have certain things in common to talk about . . . It’s a better match . . .

That ‘spark’ would reassure them that they had things in common with the donor that they found important. But it would also mean that they liked the person: it would be a ‘match’ for the two of them as a couple, a match of traits they admired in each other.
For the sake of the child

Twelve participants expressed a very nuanced and conditional wish to choose certain traits for the sake of the traits themselves, rather than to create a better match with the couple. However, all participants justified their wishes by referring to the child’s wellbeing. For most of these participants, it was not about preferences or characteristics that would help create a better, smarter, cuter child. Rather, the focus was on eliminating ‘problematic’ traits – such as medical risks, low intelligence, learning difficulties, problematic social backgrounds – or choosing traits that compensated for undesirable characteristics of the parents. Anni, for instance, would have liked to choose a donor who was ‘reasonably intelligent’, for the sake of her child:

Life can be easier when you’re a bit smart. … If you see that some kids have trouble keeping up at school, that’s such a pity for them, that really isn’t easy.

She and her partner also noted that some form of matching in terms of cultural background and skin colour is needed to reduce additional differences with ‘normal’ families. They contemplated that the child will already be different because it will be raised by a lesbian couple. Any other apparent ‘deviations’, such as a different skin colour, would make matters even more complicated for the child.

Four participants admitted that, if given the option, they would choose in terms of attractiveness, such as ‘someone a bit tanned’ (Ruby and Emily), but they did not find that important. Only one participant – Marilyn, an aspiring social mother – said she would like to choose certain traits to create the best chances for her future child; a positive choice, as you might call it. These traits included good looks (an ‘Adonis’, with ‘blue eyes, brown hair, tanned complexion’), a good job, communicative skills and a feel for languages. She acknowledged that there are problems related to choosing certain traits, but these were of a practical rather than ethical nature. Together with her partner, Kelly, she had long considered known donation, but they eventually decided against it out of fear for having a ‘father figure’ and ‘intruder’ in their family. Marilyn would nonetheless be happy to change the current policy, allowing for greater choice on the part of the recipients, but she felt that society was not ready for that yet.

Discussion

There are some limitations to this study that need to be borne in mind when interpreting the results. Given that we report on a small-scale qualitative study of lesbian (candidate) donor sperm recipients at one Belgian fertility clinic, our results are not representative for lesbian parents in general. Rather, we tried to understand a relatively unexplored aspect of lesbian family building through clinical donor conception within a specific context. The in-depth interviews provided a unique opportunity for participants to express their views about and experiences with a debated donor selection policy. One of the strengths of this study is that the recruitment did not occur via donor-conceived family networks, which generally attract respondents with a very outspoken view on the topic of donor conception. Thereby, a possible bias of self-selection was prevented. However, our participants were questioned after they had applied for treatment at the department. As such, the question of whether they would have liked greater input in the selection of their donor involves a hypothetical scenario and risks hindsight rationalisation biased by current commitment to the procedure. We have attempted to reduce this risk by including participants who only recently started donor conception treatment at the clinic (the ‘candidate recipients’) and who can, therefore, vividly recall their decision to use an anonymous donor instead of a
known donation. Another risk is that participants may have produced socially desirable responses. While we cannot rule out this possibility, the interviewers did emphasise their neutrality and the fact that they were not involved in (decisions to allow) treatment at the clinic.

Having said that, two clear observations emerge from our data. The first is that, contrary to other studies, many participants appeared somewhat resigned when discussing the lack of input in the donor selection procedure and did not express a desire for more choice. A second is that even those who did, merely expressed a wish to facilitate normal child development or to increase family coherence, rather than to try to assemble the perfect child.

As for the first observation, it appears that the (candidate) recipients did not behave as if they were the main characters in the selection process: they did not adopt an active, inquisitive attitude but, rather, placed themselves at the side-line. They seemed to feel they did not have (or need) a right to any level of donor selection or control over the procedure. Important decisions, initiatives and responsibilities were left to the hospital (staff). This is noteworthy given that the main intention of anonymous donation policies is to suppress the role of the donor so that the wishes and rights of the recipients prevail. In our view, two possible interpretations can help make sense of this finding. One interpretation may simply be that it functions as a means of coping. The (candidate) recipients of this study had to have ‘blind faith’ in the donor selection, because the policy provided no opportunity for seeing the donor or knowing more about him. Even if they did know more, they would still have no control over the outcome. Trusting that both the doctor and the donor respected high screening and selection standards may therefore be a way to assuage their fears. To a large extent, also, they did not want to see the donor, because they feared this would disrupt their family life. Other authors have also observed that not only heterosexual (e.g., Kirkman 2004) but also lesbian couples may regard the donor as a threat to their parenting status and family integrity (Donovan and Wilson 2008; Nordqvist 2012; Wyverkens et al. 2014). Different strategies are used to minimise the donor’s role in the family building process and to reinforce the initiative and loving basis of the couple relationship. Given that participants had chosen to use an anonymous donor provided by the clinic, rather than present a known donor or conceive in a self-arranged way, it is reasonable to assume that they wanted to keep the donor out of their family as well.

A second possible interpretation of the participants’ ‘one-down position’ relates to their perception of their position in this third-party reproduction setting. As is inherent in all patient-physician interactions, patients are in a subordinate position to the physician, who acts as an expert and authority and whom the patients trust to direct them during treatment. In comparison to the consumer-directed model, restricted donor selection fits within the traditional medical model, where the doctor acts in the role of the sole decision-maker, choosing what is best for the patient. The patients are passive participants in the donor-conceived family building (Braverman 2010); all phases of donor recruitment and selection are undertaken by clinical staff. Nordqvist (2011) interviewed recipients of both clinical and self-arranged donor conception and found that the logic and experiences of both processes are very different. Interestingly – and in contrast to our findings – she found that women in clinics conceptualised the donor selection through a discourse of ‘choice’, whereas women who self-arranged their donor conception referred to a cautious development of trust relationships.

The fact that the couples we interviewed were lesbian and would not have been allowed access to clinical donor conception in the fairly recent past, may also be relevant. Many of the quotes suggest that the participants felt they should be thankful foremost that
they were allowed treatment in the first place, and should not ‘complain’ about the policy. This notion of gatekeeping also arose in a study conducted by Donovan and Wilson (2008), where participants described ways in which they sought to increase the hope of acceptance. They prepared themselves in advance for the clinic’s questioning and its possible heterosexist assumptions of family-building and parenting. This could help explain why our participants primarily supported donor selection for the benefit of normal child wellbeing and family coherence. As we saw, some participants felt that certain donor characteristics could benefit the child in the sense that it would ensure a ‘normalised’ situation. They feared that the child would already feel ‘different’ by having two mothers and that inheriting certain problematic characteristics from the donor – such as low intelligence and obvious differences in appearance with the mothers – would bode for more trouble during his or her upbringing. As such, the couples appeared to anticipate confrontations with hetero-normative assumptions. Their common appreciation of the current ability to match certain phenotypic traits to the social mother and some participants’ wish to facilitate further matching is also illustrative of such sensitivity. A desire for family resemblances and donor matching is perhaps surprising, given that – unlike heterosexual families – lesbian donor conceived families cannot hide the donor involvement. As they are clearly distinct from naturally conceived families, they are often typified as alternative families or ‘families of choice’ (Gabb 2005). However, similar to results presented by Nordqvist (2010), our results show that matching does bear great meaning for some (though not all) couples. Nordqvist (2010) has argued that, in lesbian couple donor conception, family resemblances are sought both to create distance (e.g., from the donor) as well as connectedness. They signal a (socially observable) continuity of family relations and identity and thereby confirm the child’s place in the family. In our study, some participants also wanted to match in terms of the social mothers’ interests and character traits, which, following Becker, Butler and Nachtigall (2005), are viewed as expressions of the biogenetic connection as well. According to Nordqvist (2010), matching is an instrumental way for lesbian couples to counteract the social stigma they fear and experience. They normalise their family to legitimise their family form. Almack (2006) found that lesbian respondents to her study were very aware of and concerned about potential negative stereotypes and prejudices that circulate about their ‘fitness to parent’.

The social acceptance of gays and lesbians in Belgium is amongst the highest compared to other European nations, and Belgium was the second European country to introduce same-sex marriage (Szalma and Takács 2013). Recently, Belgian law also granted the non-genetic parent in lesbian couples the same parenting rights as the genetic parent, thereby circumventing the prior adoption procedure. Both our participants and participants from another Belgian study on lesbian donor conceived families (Baetens, Camus, and Devroey 2003) described the overall social and clinical environment as supportive of their family project. However, the data suggests that our participants are still concerned about securing their joint parenting status and avoiding additional (outward) differences with conventional family models. The fact that our participants were preoccupied with not being accepted for treatment and regarded as a legitimate family could also explain why many participants showed little interest in more advanced donor choices.

Both observations – the participants’ accommodating attitude on the one hand, and the apparent need to protect their family form from stigma on the other– bring to light opportunities for enhancing informed consent and facilitating patient empowerment. It is possible that candidate recipients do not fully understand their role in the donor conception treatment and are fearful of being too critical. An increasing numbers of lesbians choose to
access donor conception treatment, while the service is still primarily targeted toward the needs and wishes of heterosexual patients. In clinics that officially accept lesbian women, access to services can be negatively influenced by implicit signals of a heterosexual nature (Johnson 2012). Even if hospital staff explicitly welcome fertility interventions for lesbian couples, as was the case for our participants, they still need to be reassured about the legitimacy of their wish (Baetens and Brewaeys 2001). As suggested by Ross, Steele and Epstein (2006), offering infertility support that is specific to lesbians as well as (visual) cues that the service is favourable to lesbians may be helpful in this regard.

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References


Dans cette étude qualitative, nous examinons comment les lesbiennes réceptrices de dons de sperme perçoivent et expérimentent la sélection du donneur anonyme. L’étude a été conduite en Belgique, pays dans lequel les centres de fertilité appliquent un protocole légal qui restreint fortement la sélection personnelle du donneur. Alors que de précédentes études ont montré que les réceptrices veulent exercer plus de contrôle sur la sélection du donneur de sperme, cette caractéristique n’émerge pas de la présente étude en tant que préoccupation majeure chez la plupart des participantes. D’une manière générale, celles-ci reconnaissent leur manque de contrôle sur l’issue de la sélection et l’acceptent en tant que partie intégrante de la politique de dons anonymes qui leur offre la possibilité d’avoir un enfant. Elles minimisent, activement et passivement, les préoccupations initiales concernant le processus de sélection du donneur et considèrent qu’elles n’ont pas — ou n’espèrent pas avoir — le droit d’exercer plus de contrôle sur la sélection du donneur. En adoptant cette position de « subordonnées », elles considèrent qu’elles doivent faire confiance à l’hôpital, dont elles espèrent qu’il applique des normes de sélection de niveau élevé. Celles qui souhaitent vraiment plus d’options sont nuancées et prudentes concernant leurs motivations: elles se
concentrent sur la sélection des caractéristiques pouvant faciliter le développement normal d’un enfant ou renforcer la cohésion familiale. Les résultats apportent un éclairage sur la manière selon laquelle ces patientes perçoivent leur positionnement dans ce contexte reproductif tripartite.

**Resumen**

En el presente estudio cualitativo, los autores examinan las opiniones y las vivencias experimentadas por participantes lesbianas en torno a la selección de su donante de esperma anónimo. El estudio fue realizado en Bélgica, donde los centros de fertilidad acatan un protocolo legal que limita estrictamente las preferencias personales respecto a la selección del donante. Si bien estudios anteriores concluyeron que las receptoras de esperma quieren ejercer mayor control y tener más participación en la selección del donante de esperma, en el presente estudio este deseo no figuró entre las principales preocupaciones de las participantes. En general, reconocieron no tener control sobre el resultado de la selección, aceptando tal situación como parte de una política de donación, en la que prevalece el anonimato, que brinda la oportunidad de tener un bebé. Asimismo, en forma activa o pasiva las participantes menospreciaron sus preocupaciones iniciales en torno al procedimiento efectuado para seleccionar al donante, señalando que no tenían, o no requerían, el derecho a ejercer mayor control en ese sentido. Al adoptar esta posición “subordinada”, las participantes dijeron que debían confiar en el hospital, esperando que cumpliera con los altos estándares predominantes en la selección. Quienes querían ejercer más control expresaron sus motivos de una forma matizada y cuidadosa, centrándose en querer seleccionar aquellos rasgos que facilitaran el desarrollo normal de sus bebés o que contribuyeran a una mayor coherencia familiar. Estos hallazgos arrojan luz sobre cómo las pacientes perciben su situación en un ambiente reproductivo en cuyo proceso intervienen terceros.