
A Good Surrogate: The Experiences of Women Who Are Gestational Surrogates in Canada Une bonne mère porteuse : les expériences de femmes agissant comme mères de substitution au Canada

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ABSTRACT

This narrative study focused on eight gestational surrogates' overall experiences of engaging in third-party reproduction. In-depth interviews were conducted in order to understand the various ways that these women narrated the diverse challenges they encountered. The findings suggest women may benefit from more support to deal with several issues post-delivery. Counsellors have a role to play in supporting women through this identity shift before, during, and after the gestational surrogate pregnancy by being aware of various discourses that impinge on the experience. Future research in the areas of gestational surrogacy counselling practices, contract issues, and clinic procedures is needed.

RÉSUMÉ

Cette étude narrative est centrée sur les expériences globales vécues par huit mères porteuses qui s'engagent dans la procréation par l'entremise d'un tiers. On a mené des entrevues approfondies afin de bien comprendre les diverses façons dont ces femmes racontent les différents défis qu'elles ont dû relever. Les résultats semblent indiquer que les femmes auraient avantage à recevoir plus d'appui pour gérer les divers problèmes qui surviennent après l'accouchement. Les conseillers doivent jouer un rôle d'appui auprès de ces femmes qui vivent un changement d'identité avant, pendant, et après la grossesse de substitution, notamment en étant conscients des divers discours qui peuvent affecter l'expérience. Il y a lieu de pousser les recherches à venir dans les domaines des pratiques de counseling auprès des mères porteuses, des problèmes contractuels, et des procédures cliniques.

Given the current increase in gestational surrogacy practices worldwide, little is known about the personal experiences and psychological health of women who are gestational surrogates. As such, women who have carried a genetically unrelated embryo to term by way of in vitro fertilization (IVF) for intended parents are the focus of this article. This study delves into the stories of gestational surrogates in Canada and some of the challenges experienced. These women are assigned a variety of names related to their role, including but not limited to gestational carrier, surrogate mother, host mother (Goldfarb et al., 2000), and birth other (Ehrenshaft, 2007). In this article, the term *gestational surrogate* will be used to identify women who undergo reproductive technologies to help

friends, family, and, in some cases, strangers who wish to parent a genetically related child (Twine, 2011).

HISTORICAL AND CONTEMPORARY CONTEXT

In 1987, the first baby was born by gestational surrogacy in the United States through IVF embryo transfer (Hanafin, 2006). Ciccarelli and Beckman (2005) report, “from 1991 through 1999 there were 1,600 babies ... who were born as a result of IVF surrogacy in America” (p. 23). In the 21st century, Brakman and Scholz (2006, p. 59) report that “about 1,000 births result from [gestational] surrogacy” in the United States each year. Gestational surrogacy in its most simplistic description is a means of reproduction.

Family matters, illness, infertility challenges, and aging populations in Western societies precede the decision to choose gestational surrogacy and account for its rise as a family-building option (Hanafin, 2006). Griswold (2006) states, “the trend for women to wait until later in life to have children has perhaps contributed to the number of those seeking fertility treatment today” (p. 46). Daniluk (2011) adds, “by 2003, the percentage of Canadian women who were 30 years or older at the time they had their first child had jumped to 48% from 14% in 1983” (p. 40). Ehrenshaft (2005) points out that gay families, single parents, and infertile adults are some of those who choose surrogacy. Gay couples choosing to become parents contribute to the increase in gestational surrogacy, and primary and secondary infertility of both men and women is also a contributory factor. “The World Health Organization (WHO) estimates that, globally, about 8–10% of couples experience infertility in their reproductive lives” (Widge, 2005, p. 226). In Canada, 11.5% to 15.7% of couples who try to become pregnant experience infertility (Bushnik, Cook, Yuppe, Tough, & Collins, 2012).

Family composition and medical issues such as infertility are the two main factors involved in choosing the process of surrogacy. However, Nakash and Herdman (2007, p. 246) add, “other factors like age, health, or even poor adoption odds” play a part in surrogacy as an option for parenthood. Many women are deciding to delay childbearing to acquire increased financial stability or for career advancements, and this family planning postponement increases the chances of infertility and other health problems, which may result in families choosing gestational surrogacy.

As well, gestational surrogacy is often chosen because adoption is no longer as viable an option for many intended parents, and maintaining family lineage is significant. According to Hanafin (2006), “most couples choose surrogacy out of a desire to be connected genetically, to participate in the pregnancy, and to know the child’s birthmother” (p. 381). Edelmann (2004) explains further: “a number of studies have noted the expressed desire of infertile couples to have a biological connection between the child and one of the prospective parents rather than to adopt an unrelated child” (p. 128). Furthermore, van Den Akker (2007) states that, in the UK, “adoption tends to be seen as the last resort option, or second best

choice” (p. 55). Thus, the desire for some people to have a genetic connection is often important and prompts the decision of gestational surrogacy.

In Canada, the 2009 Canadian Assisted Reproductive Technologies Register (CARTR) indicated that 272 gestational surrogates underwent embryo cycle transfers, also known as in vitro fertilization (IVF) that year, and 29.4% resulted in live births (Gunby, 2009). Gunby notes there is approximately a 5% yearly increase in IVF treatments with gestational surrogates in Canada, as reported by CARTR. Canadian statistics, however, are misleading due to the fact that a number of intended parents from Canada go to the United States or overseas for gestational surrogacy procedures. In these cases, statistical data are not collected, thus underestimating the number of gestational surrogacy families living in Canada (Gunby).

Research on surrogacy has primarily focused on technological advances, the emotional and psychological stability of the gestational surrogate, cross-cultural differences, ethics, and policies. What has been missing is an exploration of the experience of surrogacy from the women’s perspective. This gap in the literature may be partly due to the legalities of gestational surrogacy. For instance, in Canada *altruistic surrogacy* transpires when a surrogate is unpaid. Accepting financial compensation—*commercial surrogacy*—is illegal. But there are grey areas when it comes to real situations. For example, some women may receive indirect compensation from the intended parents. This can result in subversive practices such as paying for a surrogate’s time, providing fiscal compensation for various unplanned medical procedures and recovery, and gifting women with family trips, jewellery, and education funds, to name a few. As a result, surrogate mothers may not be willing to share their stories for fear of the intended parents being criminalized (Kashmeri, 2008). In addition, some surrogacy contracts actually have a clause restricting a surrogate from talking about her situation (Kashmeri, 2008; Teman, 2010). Given the rapidly increasing prevalence of gestational surrogacy, there is much to consider.

Currently, there appears to be a great deal of mystery and secrecy for both intended parents and the surrogate herself. For several reasons, a focus in the literature on the medical aspects tends to be much more prevalent. But this narrow focus means that we know little about the experience for the surrogate mother. What will her relationship to the new baby be once she has given birth? How will she learn to reposition herself and also redefine herself once the experience is over? These are the questions that this study addressed in order to understand how various helping professionals such as nurses, social workers, and child and youth care practitioners, counsellors, and psychologists can be better prepared to address the needs of women who have engaged in surrogacy.

EXPLORING SURROGACY EXPERIENCES

The overall purpose of the study was to conduct in-depth interviews with gestational surrogates focused on the question: What is the meaning and experience of gestational surrogacy for women who birth a child or children for intended

parents? The University of Victoria Ethics Board approved this research, participants signed consent forms, and pseudonyms were used as requested. Given the relatively small community of third-party reproduction in Canada, a discussion about confidentiality and anonymity was held with each participant, and all other names were changed, including those of doctors, clinics, agencies, intended parents, and family members, unless approval was obtained. Interviews covered a range of topics including family, medicine, attachment, legislation, pre- and post-surrogacy birth experiences, pregnancy management, ethics, and identity.

Narrative methodology and content analysis was used. The researcher did not specifically go into this study with a feminist approach, but a gendered analysis was drawn on when appropriate. Particular attention was paid to how the stories were told (Churchill, 2000) and how the stories were situated within certain cultural discourses on mothering and reproductive technologies, as well as legal and ethical discourses surrounding surrogacy in Canada. Canadian cultural discourses about mothering experiences are imbued with notions of naturally attaching and bonding with infants, selflessness in familial relationships, worthiness through body image and performance (Goslinga-Roy, 2000; Reddy & Butler, 2004), and female identity formation that impinges on fertility and becoming a mother (Teman, 2010), to name a few. These mothering discourses intersect, shape, and underpin the “good surrogate” discourse, as illustrated within the narratives of the gestational surrogates and reflected on further in the discussion section of this article. Surrogates mainly narrated their experiences using chronological stories and a language of experience that implicitly described the discourse of the *good surrogate*, thus a more discursive narrative methodological approach was adopted. The good surrogate discourse finding outlines the concealed, non-negotiable rules and behaviour expectations for surrogates, as discussed below.

METHOD

This section describes the method used by the researcher to locate participants, the criteria to be met to become a participant, and a discussion about researcher transparency. Procedures of the study, such as data collection, relationship building, and insider knowledge, are outlined. The narrative thematic theoretical orientation employed as part of the method is further articulated.

Participants

Eight gestational surrogates voluntarily participated in this study. Snowball sampling helped in the recruitment stage of the research. After one gestational surrogate was interviewed, she posted her participation in the study on a private Facebook group page for surrogates, thus prompting other women to inquire and participate. Surrogacy can be a close community and it has an online network of women making recruitment possible. Despite some of the constraints mentioned above, eight women agreed to participate. Inclusion criteria required that all participants experienced gestational surrogacy once in the past three years (one woman

was a surrogate twice). Surrogates were between the legal ages of 21 and 50, as mandated by the Assisted Human Reproductive Act of Canada, and no participant was rejected from participation. One gestational surrogate was pregnant with twins, one of whom died in utero, although all participant pregnancies resulted in either a healthy singleton or twin babies. The first author conducted this research and was a gestational surrogate as well. Her surrogate pregnancy resulted in the birth of a healthy baby girl. Her experience was helpful in co-creating knowledge and relationship building with participants prior to and during the interviews, but she is not a participant in this study. Rules of the good surrogate discourse emerged out of the synthesis of all eight surrogate participant stories.

Procedure

Relationship building was key in the study design and recruitment process of this research because participants were being asked highly personal and emotionally laden questions. Following Newbury and Hoskins (2010), a relational inquiry evokes active listening and empathy skills of “an effective researcher ... in order to better connect with and join participants in the experience of the research” (p. 232). A relational approach, according to Bochner (2000), also suggests that “research is about generating new ways of comprehending subjective experiences, not documenting results” (p. 185). According to Weiss (1994), “most of the significant events of people’s lives can become known to others only through interview,” as interviewing opens a window to the past and “rescues events that would otherwise be lost” (p. 2).

The semi-structured dialogical interviews ranged in length from one to two hours and were recorded and transcribed. Interviews began with the open-ended request: Tell me about your gestational surrogacy experience. Interviews were more like conversations in that roles were often reversed and participants often asked questions. Sometimes a participant asked a question about the interviewer’s experience, which in turn created deeper conversations and more opportunities for meaning making. This dialogical process fostered a spirit of collaboration as both interviewer and participant were deeply invested in the phenomenon. Interviews also yielded rich data because of the skill, knowledge, and surrogacy experience of the primary interviewer. Insider knowledge established credibility and authenticity while building relationships and constructing collaborative dialogue with participants (Bensimon, Polkinghorne, Bauman, & Vallejo, 2004).

From a constructionist perspective, language does not represent reality; rather it sheds light on how discourses shape individual and collective interpretations of experience (Gergen & Gergen, 2004; Hoskins, 2002; Thompson, 2005). Discourses are also discursive. In this research, surrogate mothers both shaped their interpretations and, at the same time, were shaped by cultural norms and practices. Further, discourses of surrogacy are historical and contextually embedded in gender, identities, mothering, and legal and medical discourses. With these theoretical lenses in mind, the transcribed interviews were examined about how surrogates made meaning of the birthing experience, their relationship with the

intended parents, their own immediate and extended families, and their unique changes in their identities.

All transcripts were read at least six times, and points of convergence and divergence were highlighted using traditional methods of clustering and organizing dominant and subjugated themes (Polkinghorne, 1988, 2005). This was done to familiarize the researcher with the data as well as to think narratively about the stories of experience. In addition, themes were interpreted by focusing closely on language in each of the stories while using a temporal lens (Frank, 2010; Reissman, 1993). This meant following and exploring themes in chronological order from the start to the end of a story. Consistent with Winter and Daniluk (2004), themes were identified for each personal narrative and then tracked for the plot, storyline, and chronological order of events.

In an effort to bring the narratives to life while also staying true to the participants' descriptions of experiences, direct quotes are woven throughout the analysis. What emerged within and between all of the narratives was the strong belief that there is one best way to be a surrogate. During a supervisory meeting with the research committee, the theme of the good surrogate became a useful metaphor to explore in more depth. For this article, we discuss in greater detail how such a discourse shapes what can and cannot be acknowledged. In particular, what soon became apparent were that the rules for surrogacy do not make room for acknowledging the multiple layers of loss and grieving that occur post-delivery.

FINDINGS: NARRATIVES RELATED TO HOW TO BE A "GOOD SURROGATE"

Due to space limitations, only three participant narratives are highlighted in this article. All three women used their first names, although use of a pseudonym was discussed and offered. These participant narratives were chosen because they present difference among the stories shared and provide a diverse sample with rich descriptions regarding the themes, scripts, images, and metaphors related to being a good surrogate. Core themes that inform the rules of the good surrogate include mothering, attachment/detachment, parenting, gender, identity, politics, relationships, physicality, embodiment, and altruism, to name a few. All eight participants spoke of these rules in various ways. What is significant is the influence these discourses have on the telling of a particular narrative at this particular time in Canadian society.

Helen's Narrative

Helen is a 28-year-old single mother with a 4-year-old daughter who lives in Ontario, Canada. Helen shared that she delivered a four-pound-one-ounce surrogate baby boy on March 4, 2011, for a gay couple who used an egg donor and arranged the birth through an agency. Helen expressed a multitude of mixed feelings she experienced after her gestational surrogacy process and did not share whether she maintained contact with the intended fathers and child post-delivery.

Some of the mixed emotions Helen discussed are in relation to the unexpected early delivery and birth of the baby boy that did not go according to plan:

It was so happy. It was, I felt really guilty almost that he had come early, even though the logical part of my brain says, "That wasn't my fault. There wasn't anything I could do about it." I still felt like it was my job to keep him in there and it was my job to make that happen so I felt really guilty that he had come early and they were going to have to stay and they weren't going home with this chubby little baby the next day. Other than that, I felt so happy. Seeing their crying faces when they came in. I didn't get to see them with him until the next day but it was really overwhelming how good I felt. They walked in and they were crying and I started crying. I have said to people that I have a lot of mixed emotions, but the mixed emotions aren't around him and aren't around him going home with them. The mixed emotions are around everything that went wrong. Feeling like there should have been something I could do.

In this one interview excerpt alone, Helen mentioned a wide range of emotions about events she says went wrong, such as the premature birth, during her gestational surrogacy experience.

Helen recounts that the IVF procedure resulted in her carrying a fraternal twin pregnancy for the intended fathers. She shared that one of the twins, a little girl, tragically died in utero between 24 and 31 weeks gestation. Helen refers to this twin as Baby A. She acknowledged her sadness and helplessness for the loss of Baby A and sadness for the intended parents, as the membership of their family was altered early by death.

It was hard because for me I feel like I did a really good job of keeping separate from them and as unattached as you can be from them. But watching their dads go through this, and it wasn't like "Oh, she could die" and she did die right away. We had seven weeks of this dragging on, of it could happen, it might not happen, and they were emotional wrecks the whole time. It was really hard to watch the picture of their family falling apart. And to be able to do nothing, I felt so helpless about it. The doctor said, "There's nothing you can do."

Helen clearly feels guilt and disappointment about not carrying both babies to term, although she believes there was nothing she could have done about it. She recalls that it was simply out of her control. She affirmed that her sadness was more for the intended fathers as she tried to distance herself from grief for the loss of the twin.

It just felt like, "They're in my body, I should be able to do something about it." But as far as emotionally around her death, I mean it was really sad but it was more, I felt sad for them. Of course I felt sad she had died, but it wasn't my sadness you know.

Helen also noted her grief for the loss of her "ideal gestational surrogacy journey," which she illustrated as a full-term pregnancy, with a big pregnant belly, and

growing a chubby baby for the intended parents to take home. Helen explained it best herself:

And the feelings of disappointment where I didn't get the [crying] journey—they call it—that I expected. I had all those weeks of stressfulness where I didn't really get to enjoy the pregnancy, which was part of the reason why I did it. And I didn't get that last couple of months of pregnancy of feeling him move and getting that huge belly that most people hate that I actually really liked. So my own disappointment for—calling it a loss isn't right—but my own stuff that I did not experience because of what happened.

Helen clearly differentiates between herself and the surrogate babies. Thompson (2005) argues that the notion of the separation of a pregnant woman from her embryo is a result of the abortion debate and assisted reproductive technologies. Women have rights around making choices about their own bodies, which may be in the form of abortion and/or reproduction. Thus, both women's rights and embryo rights emerge from this argument, contributing to the idea of two separate entities rather than one until the baby is born. This is an important concept pertaining to gestational surrogacy because the surrogate and embryo can be considered as separate.

Meredith's Narrative

Meredith is a 33-year-old single mother of two, an 11-year-old boy and a 4-year-old girl, living on Vancouver Island. Meredith said she first thought of becoming a gestational surrogate when she was 15 years old and stated, "Then it went away." Meredith said that after she had her own babies the idea of gestational surrogacy came back. Meredith claimed, "I wasn't done being pregnant but done having my family." Although she was finished having children of her own, she was still young and healthy enough to be pregnant again. Plus, Meredith exclaimed, "I love being pregnant!" As a result, she explained that she began to look into gestational surrogacy online and found a Canadian fertility agency to work with. Meredith's surrogacy experience resulted in the birth of a healthy baby girl for intended parents living in Ontario.

Meredith describes divergence between pregnancy with her own children and with what she refers to as her "journey." Specifically, Meredith said she recognized the growth of the surrogate baby but not in the same way as with her own children. Meredith added, "I tried to do different things during pregnancy than with my own children." She described using a midwife, birth coach, and doula for her journey and attending a prenatal class with her birth coach, which she claimed was different than her children's pregnancies. A doula is a non-medical support person for pregnant women. Meredith mentioned that she liked that the intended parents, a heterosexual couple, who lived in Ontario while she lived in British Columbia. She stated, "I didn't want to be an auntie or anything for the baby like other gestational surrogates I know." Post pregnancy, Meredith shared that she cried on day eight while doing a load of laundry of her pregnan-

cy clothes, and “nothing else.” Lastly, according to Meredith, she identified the intended parents as acquaintances and they maintain minimal e-mail contact post-delivery.

Meredith described the use of social media such as Facebook as a beneficial support network for her gestational surrogacy “journey.” Surrogates from across Canada write on Facebook every day to support each other’s journey. Discussions are held about needle injections, IVF procedures, issues with intended parents, and emotions within the confines of the script of the good surrogate.

Angele’s Narrative

Angele is a married woman and mother of two children living in Eastern Canada. She is a social worker by profession. According to Angele, the idea of gestational surrogacy entered her consciousness as she and her husband completed their own family planning. Up until that point, she was uncertain if surrogacy even happened outside of the movies or specifically in Canada. Angele said she began searching online for information about surrogacy in Canada and immediately found the intended father, with whom she embarked on her surrogacy journey through a Canadian agency. An egg donor was used in Angele’s gestational surrogacy arrangement and the outcome was the birth of a healthy baby girl. Angele maintains in-person, e-mail, and phone contact with the father and baby post-delivery.

Bonding and attachment of the intended parent(s) to their baby was of significant importance to gestational surrogates, since they were supposed to be the ones who needed to detach from the baby (Teman, 2010). From her perspective, Angele supported her intended father’s attachment to his child through rituals from a distance since they lived at least a four-hour drive away from each other. For example, Angele recalled that she recorded the sound of the baby’s heartbeat at the doctor’s appointments the father could not attend and sent them to him. In addition, Angele claimed she encouraged her intended father to record himself talking reading bedtime stories and nursery rhymes so that she could play it nightly to her growing belly. Here is what occurred in Angele’s words:

Every time I would go to the doctor I would tape the heartbeat on my Blackberry and then just send it to him. I had had the idea of him reading bedtime stories or nursery rhymes or whatever and put it on a USB key, and he mailed me that. So every night after the 12-week mark, I just put the headphones to the belly and played his talkings.

According to Angele, she ensured and fostered attachment between the intended father and the baby during the delivery by constructing a delivery plan with the nursing staff in which the father held and spoke to the baby first. Angele illustrated:

Anyway so we pushed, she came out, and right away I remember my hands going up over my chest, and I remember our birth plan was that I was not going to be the one to put my hands on her and I wanted the room to be quiet and

him to be the first one to say something to her. I wanted the closest connection he could have to her right from the get go. So sure enough, everything followed suit that way. I didn't touch her [till] she was cleaned off. The doctor she was fantastic—she just held her there for my intended father. He just looked at her and said “Hi” and he said her name, and then she looked right up at him and we all started crying, doctor included, were sobbing. It was just THE most amazing thing!

After the delivery, in the hospital Angele excitedly met and held her surrogate baby with the father's approval. She recounted:

I didn't hold her until I think it was 6 hours till after she was born. It didn't even cross my mind. It was really really weird, 'cause then my intended father came up to me and whispered, “Do you even want to hold her?” I'm like, “Oh my god, yeah! Of course.” But it never crossed my mind to say, “Hey, can I hold your child?” 'Cause I couldn't imagine someone asking me “can I hold your baby?” the minute I had my own. After everybody was cleaned up and everything was good, that's when I finally met her. And it was SO surreal. I was holding her going, “I don't want to hurt her. I don't want to drop her.” But with my own children, I stripped them down naked and checked them out and inspected them. I had to see. And with her it was “Oh I don't want to hurt you. I'll give you back to your dad.” It was really surreal. In my head I was like “I'm totally okay with this.” I was right all along that I would be okay. It really just is surreal.

Based on her experience, Angele also described her confirmation and discernment that she was able to sufficiently detach from and part with the baby in acceptance of the gestational surrogacy arrangement, once the baby was born. Ragone (1994) substantiated that a key psychological determinant of the surrogate's well-being was her ability to separate from the baby post-delivery.

Language was another important aspect of detachment for the gestational surrogate, as depicted in Helen's story above. Angele stated, “I would have never entered a surrogacy had I thought I'd have any feelings of this is MY pregnancy. I never even called it 'my pregnancy'—it was always 'his pregnancy.' I think that sort of detachment is healthy.” The choice of words and language that Angele used consciously constructed a boundary that fostered detachment from the surrogate baby, thus making space for the intended father to attach. These creative pregnancy and birthing rituals, behaviour strategies, and language selections displayed above support the bonding of the intended father to his child, and the distancing of the gestational surrogate from the baby. Ragone (1994) reported professionals and fertility clinics in the United States encouraged surrogates to focus on their relationship with the intended parents rather than on a relationship with the baby. Hanafin (2006) noted that the clinical pre-screening interview with the potential surrogate should include issues such as “expectations about relationship with the intended parents; [and] expectations about relationship with the potential child”

(p. 378). Implicit in the research arguments above was the expectation of detachment by the surrogate that Angele referred to her in her dialogue.

From her perspective, Angele described her relationship with the intended father as more significant than her embodied relationship with the baby. The expression *embodied relationship* refers to the physical, emotional, and psychological relationship that emerges during pregnancy between a mother and baby. This embodied relationship is often seen as highly important in forming attachment, although Angele suggested that her relationship with the intended father was more valuable. After the gestational surrogate baby was born, Angele shared her fear of losing the close relationship she felt she had and hoped for in the future with the intended father. The baby's birth posed a threat to the relationship between the gestational surrogate and the intended parent(s), which Angele illustrated:

My brain was like, he's not going to message you every day. He has a newborn. You know how big that is. But my heart was also, how come he's not messaging me? And then my hormones would go into overdrive, he forgot about me. He's not going to talk to me anymore. So it was a real battle the first three weeks between brain and heart. Subconsciously I knew how I was feeling irrational and it was just hormones, but I still had to live through the emotions of it all. I remember it was a week before he had messaged me and I went, that's it, I'm not friends with him anymore. We're not going to talk again. It was just so completely irrational.

Angele articulated her sense of loss for the relationship with her intended father after the gestational surrogacy experience was over. In keeping with the dominant discourse on relationships in surrogacy, this shift in relationship dynamics was to be expected, as Angele acknowledged; however, it did not make the change any easier for her. Wanting to be the good surrogate, she added, "It was just a matter of accepting our new relationship."

On the same note, the relational change between Angele and the intended father was also connected to a shift in identity for Angele post-delivery based on her experience. More specifically, Angele described

getting back into the groove that I have two kids and a husband and a home to take care of. I no longer have that pat on the back any longer, "Hey good for you. You're a surrogate." Just to come back down to normal life. I had a bout where it was like, "Now what? What's my point now? What do I do now? What's the point of me being here?" kind of thing. I was a surrogate before. What am I now?

According to Angele, as her pregnancy ended, she questioned her life purpose and identity. Angele refocused her attention on her family after many months of commitment and concentration on creating a family for someone else. In conversations, Angele referred to her surrogate baby as a cousin to her children. She further described her gestational surrogacy journey: "Fate brought us together as friends but surrogacy brought us together as family." From Angele's perspective,

the strong connection of kinship that resulted from her gestational surrogacy experience with her intended father is often a theme in Canadian, American, and Israeli surrogate narratives (Ragone, 1994; Teman, 2010).

DISCUSSION

As I analyzed and explored the participant narratives, the dominant theme of the good surrogate emerged and permeated all of the narratives. Even during the interviews, all of the participants told their stories in a positive way, at least on the surface. In fact, some felt that their narratives needed to be told in this particular way because the media tends to sensationalize all that can go wrong. None of the participants in this study wanted to tell their gestational surrogacy experiences along tragedy plotlines. Their desire to provide positive accounts of surrogacy presented a challenge to the researcher. In addition to their explicit descriptions, what was left unsaid also became the focus of the analysis. Consideration of the spoken and unspoken rules for how to “do” surrogacy at this particular time and in this location (i.e., in Canada) became central to the analysis phase.

Looking at discourses that position gestational surrogates and the telling of their experience is consistent with certain narrative methodologies (see, for example, Frank, 2010; Polkinghorne, 1988). Frank (2010) suggests that the analysis of narratives shifts from “how stories work—what they consist of—to how stories do their work for people and on people” (p. 28). In Canada, the privileged single story of the good surrogate was related to cultural expectations and societal beliefs in which discourses of motherhood, gender, attachment, power, family, and gestational surrogacy all intersect. Discourses of mothering and reproduction are prevalent in our society and are tangled in the good surrogate discourse as well. This good surrogate discourse was apparent in all eight stories as the women navigated their way through gestational surrogate experiences.

In Thompson’s book *Making Parents: The Ontological Choreography of Reproductive Technologies* (2005), one chapter is specifically about different variations of surrogacy from the context of an American fertility clinic, in which she references the common medical role of the “good patient.” In exploring the good patient role, Thompson describes the surrogate as “subordinate to those whose procreative intent they were working to realize” (2005, p. 158). The dominant script that arose when analyzing the data reveals several rigid and unspoken rules embedded within surrogacy experiences. It privileges only one script for how gestational surrogates *should* act. Below I list the main rules to which a surrogate must adhere that are implicitly shaped by social practices such as e-mail, Facebook, media, surrogate information-sharing about detaching, medical protocols, and legal contracts that participants of this study openly discussed. Gestational surrogate participants mentioned professionals in the field of third-party reproduction—including doctors, nurses, counselors, agency personal, and lawyers—who, in addition to surrogates and intended parents, also shape the good surrogate discourse.

It is important to note that the implicit and explicit rules embedded in surrogacy have been learned through various avenues. Online communities have a particular way of promoting surrogacy and have several “posts” that serve a mentoring role for those considering surrogacy and for those who have already gone through the experience. The medical community also plays a role in determining how surrogate mothers “should” behave. Many of the participants in this study mentioned the role of medical practitioners when it came to certain decisions. Finally, the legal discourse plays a major role in protecting intended parents and, in doing so, lays out several rules for the surrogate mother, both implicit and explicit. Perhaps most difficult to discern is how altruism, particularly in Canada, shapes surrogate mothers’ experience. What are included below are brief summaries of rules that were embedded within the participant descriptions.

Refrain from Public Displays of Emotions: No Crying or Grieving

One rule in being a good surrogate is not to cry when separating from the baby, whether this occurs in the hospital immediately after delivery or any time following the birth. The dominant discourse of the good surrogate imposes this rule as a way to ignore any possible feelings of a close relationship that may occur between the gestational surrogate and the baby. In essence, this rule requires a woman to disregard the embodied relationship that develops in utero from growing and gestating the child. None of the surrogates interviewed discussed any feelings of grief or loss due to separating from the child after nine months of gestation. Instead they discuss their feelings of loss and vulnerability within the parameters of the good surrogate discourse, which states that it is only acceptable to discuss these feelings due to the loss of their relationship with the intended parents. Within this relationship it is acceptable for a surrogate to express feelings of grief due to the change in relationship dynamic, but not because of the loss of the baby.

Five of the surrogates shared their disappointment about the relationship dynamic change with the intended parents after the baby was born. This is not to say that feelings of grief were not experienced by surrogates with the change of their relationship with the intended parents post-birth. Rather, it is important to note that the surrogates unanimously discussed it in this manner, with no mention of a relationship change with the surrogate baby. No participant in the study discussed emotions of loss concerning her surrogate baby. Given all of the care and attention that was provided to the foetus during the pregnancy, the lack of acknowledgement of loss seemed unusual to the researchers. Whether or not the participants experienced loss and whether their lack of acknowledgement is a result of the dominant discourse on attachment within surrogacy remains unknown. Future research on this issue is needed.

Ownership of the Child: Don't Form a Close Relationship with the Baby

One of the main concerns in forming a close relationship to a surrogate baby is that it creates ambiguity in the gestational surrogacy process, causing discomfort for everyone involved from the fertility clinic staff to the intended parents (Thomp-

son, 2005). Ambivalence is considered to be a threat because a gestational surrogate who is unsure about her relationship with her surrogate baby may choose to keep the baby, which is a personal, political, and legal problem in surrogacy agreements.

Thompson (2005) states that recipient parents and surrogates expressed a “zero-tolerance” paradigm for ambiguity when it comes to claiming the role of mother. The good surrogate discourse stipulates that a surrogate exudes certainty about her decision to pass on the baby, her parental rights, and the parental role to the intended parents. The importance of role certainty was noted in all participant narrative accounts in this research, as surrogates conformed to the good surrogate discourse. It is the scenarios when a surrogate changes her mind about relinquishing a baby and her parental rights that become media sensations, although there are relatively few of these situations given “the surrogate baby boom” (Twine, 2011, p. ix). Still, the dominant discourse of the good surrogate emphasizes detachment behaviours and techniques, such as not naming the baby, and building a relationship with the intended parents in place of forming a close relationship with the surrogate baby to reduce feelings of closeness and notions of ownership. All of these “rules” are intended to make the surrogacy process go as smoothly as possible, especially for the intended parents. The emotional well-being of the surrogate mother in many of the participant accounts appears to be secondary.

The Needs of the Surrogate versus the Intended Parents: Don't Expect Too Much or Make Demands on Intended Parents

In the relationship between the intended parents and the surrogate, power dynamics shift before, during, and after pregnancy. In most pre-surrogacy situations, the surrogate holds more power in the relationship as her potential to bear a child for the intended parents renders them vulnerable, given that there are more intended parents than surrogates. The intended parents are positioned as the “desperate other” in the good surrogate discourse, in which the surrogate must help as a moral agent. The relationship imbalance continues, yet it shifts because the surrogacy contract stipulates that the intended parents have power over the surrogate and her body during pregnancy. Once the baby is born, the power dynamic changes, rendering the surrogate completely powerless in the relationship as her role is complete and the intended parents assume their parental responsibility for the baby. At this point, the surrogate must wait for contact with the baby when the intended parents desire such interactions. Most of the participants in the study acknowledged their anxiety post-birth about their relationship with the intended parent(s) but did not mention these feelings (in relation to the baby) because a surrogate must not expect too much from the intended parents.

Thompson (2005) states surrogates are “dekinned” once the baby is born and the contract ends, allowing the recipient parents to sever their relationship with the surrogate mother. When a surrogate is “dekinned” by the intended parents, she is expected to abide by the good surrogate discourse and avoid placing demands on the recipient parents. The majority of the surrogates in this study mention feeling uncertain, vulnerable, and uneasy about the shift in dynamics in their relation-

ship with the intended parents once the baby is born. Accordingly, they wait for the intended parents to make first contact. Ambiguity surfaces at this point as the surrogate's position and power changes. In her desire to be a good surrogate, she moves to the background so that the intended parents can assume their new role with the baby. This process was unclear, vague, and awkward for all of the gestational surrogates in this research, according to descriptions post-delivery.

Private versus Public Space: It's a Secret

Assisted reproductive technology challenges dominant discourses of motherhood, the nuclear family, and fidelity. Infidelity is a storyline that reproductive practitioners aim to avoid by focusing on treatment outcomes through medical practices, especially in cases where a surrogate is a family member or a friend of the intended parent(s) (Thompson, 2005). Some participants in this study discuss awkward public conversations about gestational surrogacy and the assumption of infidelity as part of this family-building practice: hence the intended parents' desire to maintain secrecy. Surrogacy practices are also shrouded in secrecy due to the shame associated with infertility that is experienced by many intended parents (Daniluk, 2001; Hammer Burns & Covington, 2006; Hanafin, 2006). When intended parents discuss their gestational surrogate pregnancy publicly, they are also disclosing their private struggles with infertility. As a result of these social taboos, it is also unacceptable to discuss surrogate motherhood arrangements and experiences. In many situations, hiding the surrogate pregnancy seems like a viable option for intended parents, their family members, and the surrogate herself, as there is currently only a small repertoire of available stories.

In exploring the secrecy that surrounds surrogacy, it is important to discuss the legalities of surrogacy contracts, as there is often a confidentiality clause stipulating that the surrogate is not allowed to discuss the surrogacy experience. This frequently has the effect of silencing her and eventually rendering her invisible. Thompson (2005) suggests that a shift is occurring in assisted reproduction—from the best interest of the child to a privileging of reproductive privacy, which fosters secrecy in gestational surrogacy. Further, it is assumed that the ambiguity of motherhood and parenthood is reduced when the recipient couple keeps the surrogate pregnancy a secret outside of the fertility clinic setting (Thompson, 2005). Most of the participants requested permission from the parents to participate in the study.

Altruism versus Self Interest: Only Display Selflessness

The discourse of altruism that is embedded in surrogacy in Canada further restricts a surrogate in what she believes she can and cannot do. Requesting contact with the child post-birth is not a feasible request. For the most part, it is assumed that the surrogacy contract ends after delivery, yet for many of the participants the relationship does not end when the baby is handed over. As this research revealed, the ending is often messy for many surrogates, in what is often referred to as the "fourth trimester." Plus, the assumption that the gestational surrogacy story ends

when the baby is born may possibly pose psychological and emotional issues for many surrogates years later. Currently, there are no long-term studies available.

LIMITATIONS AND RECOMMENDATIONS

A limitation of this study is that only eight participants volunteered for inclusion in this research, which limits the generalizability of the findings. This research is based solely in a Canadian context, thus limiting its scope. Finally, it is early research that is not able to build on other research.

Recommendations for Counsellors

Counsellors need to be mindful of their own beliefs and attitudes surrounding surrogacy. They also need to be aware of the dominant discourses that affect women considering surrogacy. The discourse of the good surrogate potentially restricts surrogates in how they experience gestational surrogacy, limits how they think about their experience, and confines how they tell their surrogacy stories. This research has highlighted the need to further consider how the single and dominant “positive” storyline can be problematic for women. We say this, however, with some caution because this may not be the case for all women. Counsellors need to be mindful of what might occur. There are no “how to’s” in supporting women who engage in gestational surrogacy, but counsellors need to be present, in tune with loss, and mindful of tensions and contradictions in the field that impact women’s experiences. That said, counselling interventions need to centre on specifics regarding delivery plans and decisions, transferring the baby, closure practices (Hanafin, 2006; Ragone, 1994), and post-delivery identity shifts that may occur for surrogate mothers.

Counsellors can engage in conversations with surrogate mothers to discuss the various assumptions that are taken for granted about detaching from the baby, maintaining a selfless attitude, dealing with ambiguity and uncertainty, and imagining their future relationships with intended parents so that they may feel better prepared when the time comes to relinquish the child. In addition, counselling dialogue needs to focus on gestational surrogates’ expectations of relationships with the intended parents and baby post-delivery. Currently, surrogacy counselling tends to avoid these kinds of conversations for a multitude of reasons. Some explanations may be due to a lack of education and awareness; other reasons may be more political in that the surrogacy “movement” is definitely in its infancy stage. There are many stakeholders involved.

In the counselling setting, professional helpers need to be open to discussing, prior to the gestational surrogacy experience, themes of grief and loss related to the experience. Such feelings may not occur for all surrogates, but counsellors need to be willing to be open to the possibility that some women may feel ambiguous about their decision. This appears from the data to be part of the overall experience. In addition, surrogate experiences with grief and loss illustrate the need for professional post-pregnancy counselling. Hanafin (2006) reports that

pre-surrogacy counselling has become standardized practice in the United States, but post-surrogacy counselling is not mandatory and only some fertility clinics, agencies, and/or legal contracts stipulate post-birth support in either group or individual counselling (Hanafin, 2006). Optional post-surrogacy counselling is a double-bind issue for gestational surrogates because, in their desire to comply with their agreements with intended parents, they may be reluctant to disrupt the good surrogate discourse. Discussions about grief and loss issues and the good surrogate discourse may be beneficial in post-pregnancy counselling to help prevent emotional challenges and support surrogate mothers' overall well-being.

CONCLUSIONS

This is the first of what will be a series of articles and writings on this topic. Clearly, knowledge of the good surrogate discourse, and its potential for exacerbating grief and loss issues, needs to become part of the fertility clinic and counselling support dialogue overall, and especially post-delivery—the recovery stage—of the gestational surrogacy process. Likewise, it is important for professionals to allow space for grief and encourage surrogates to share their feelings of loss after the surrogacy experience is over. Medical, legal, and counselling professionals might also encourage multiple storylines in gestational surrogacy to develop a proliferation of narratives in third-party reproductive discourse.

In the future, hearing more about surrogacy from the voices of gestational surrogates may encourage a shift in or enhance counselling and clinic practices in gestational surrogacy cases. For example, how might group counselling possibilities support or hinder gestational surrogate experiences? How might fertility clinic practices and procedures facilitate or impede gestational surrogacy experiences? Continued research on gestational surrogacy in the areas of counselling, contract issues, clinic practices, and policy change is needed.

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