Partners in Healing
OF MINNEAPOLIS
A CENTER FOR HOLISTIC HEALTH

My name is Dr. Deborah Simmons. I received a PhD from the University Minnesota and am licensed by the Minnesota Board of Marriage and Family Therapy. I have been a mental health professional specializing in primary and secondary infertility and third party reproduction (i.e., egg donation, sperm donation, gestational surrogacy, and donor embryos) since 1997. I also specialize in miscarriage, stillbirth, fetal anomalies, premature delivery, and reproductive decision-making. In addition to my private practice at Partners in Healing of Minneapolis, I practice at the Center for Reproductive Medicine in Minneapolis.

I have been a clinical member of the American Society for Reproductive Medicine's (ASRM) Mental Health Professional Group since 1999. ASRM is the U.S. medical society for all professionals that work in the reproductive medicine field. I have presented at ASRM national annual conferences on clinical hypnosis for infertility and on reproductive decision-making. I am also a member of the European Society of Human Reproduction and Embryology. I am a professional member of RESOLVE: The National Infertility Association and a frequent speaker. I am a professional member of Path2Parenthood, formerly the American Fertility Association, and a member of that organization's Mental Health Advisory Council. I work with OB/GYN clinics, infertility clinics, surrogacy and egg donation agencies, mental health professionals, and reproductive attorneys in the Twin Cities and around the country. Helping people to build their families is a blessing. Gestational carriers are a blessing, too.

I frequently evaluate and provide psychoeducation to potential gestational carriers and their partners. Each potential gestational carrier must do psychological testing with me and achieve acceptable scores on the MMPI-2 (Minnesota Multiphasic Personality Inventory) and/or the PAI (Personality Assessment Inventory). At this point I have evaluated more than 200 women who have sought to be gestational carriers. I saw my first gestational carrier in 1999. I now might see one or two potential gestational carriers a week. These are some of the most psychologically stable, intelligent, and empathetic people I have ever met. They are usually employed and happy with their work.

The appropriate name for these women is gestational carrier or gestational surrogate. They do not identify as mothers to the children they carry. They are very clear about that. They describe themselves and what they are doing for someone else in this way:

"I feel like I'm just the carton holding the eggs. Decisions and responsibilities go to the intended parents."

"I'm just the oven baking the buns."

"I'm just the B&B welcoming a guest."

"I'm just carrying the package."

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"It's not just about my body. I'm just loaning my body to someone to have baby."

"It's their baby. I'm just carrying the baby. They are mom and dad."

"I am just babysitting the baby for 9 months and then give it back. It's not mine to keep."

It's my body but it's their baby."

The research literature on the psychological health of gestational carriers is small but extremely consistent. Susan Golombok, Professor of Family Research and Director of the Centre for Family Research at the University of Cambridge in England, has been the primary researcher in this area. Her longitudinal research has shown consistently that gestational carriers are happy with their decision to carry a baby for someone else. They have very good self-esteem. They are positive about the experience with the intended parents and in fact many maintain relationships with the intended parents after delivery. Gestational carriers enter into this process after a deliberate and thoughtful process. They are proud of the choice they make to help intended parents.

A study that just came out in *Human Reproduction Update* (Volume 22 Issue 2 March/April 2016) reported that at the age of 10, there are no major differences in psychological well-being between children born from surrogacy and children born from natural conception. They are doing well, as they have been at ages 3 and 7.

The risks that surrogates in Minnesota face often derive from the fact that gestational surrogacy is not defined in Minnesota law, not from the process of carrying a baby for someone else. Unlike our neighboring states, North Dakota, Wisconsin, and Iowa, there are no state standards for either gestational surrogates or the intended parents. While many Minnesota surrogacy arrangements meet the norms of the American Society for Reproductive Medicine, it is the lack of state laws that puts some surrogacy arrangements – and the gestational surrogates and intended parents – at physical, emotional and legal risk. I strongly encourage the Commission to address this gap in our State laws.