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NEWS AND VIEWS

Do Fertile and Infertile People Think Differently About Ovum Donation?

INTRODUCTION

Ovum donation is an assisted reproduction technique developed to restore fertility in women with premature ovarian failure, in those with a severe decrease in the ovarian gametogenic reserve due to age or other factors, in those with very low-quality oocytes that cannot be corrected by changes in the stimulation, and in patients who are carriers of severe transmissible genetic diseases.

Psychological issues related to ovum donation are controversial and have generated worldwide discussion (1–4). Discrepancies may be due to the fact that people involved in these procedures do not agree on maintaining the status quo; nowadays patients express their needs for support and complete information. They form groups or associations trying collectively to support their rights (3), but many still fear the consequences that an adverse societal attitude could bring upon them and their children.

Due to the existence of major cultural differences between people in our country (most of Latin origin) and individuals from countries that provide most of the scientific information present in the literature regarding oocyte donation (generally of Anglo-Saxon origin), it seems pertinent to review some of these aspects generating differences within our own sociocultural context. This could be useful not only for investigators interested in transcultural models, but also for professionals working with similar populations.

The objective of this paper is to determine if there are different points of view about subjects related to ovum donation among infertile patients who need the technique, infertile patients who can be treated with their own gametes, and individuals without demonstrable fertility problems.

MATERIALS AND METHODS

One hundred fifty-seven subjects were recruited from March 1997 to February 1998. Each of them was personally asked to participate by one of the two psychologists involved in the project. Recruited people were grouped into three categories: the ovum donation (OD) group—55 infertile patients chosen consecutively from the waiting list for an anonymous ovum donation program; the infertile (INF) group—35 infertile patients who can use their own gametes undergoing assisted reproductive treatment; and the fertile (F) group—67 individuals without known fertility problems, recruited from ordinary citizens with different levels of education, jobs, income, and religion. Members of the OD and INF groups were attending our center and members of the F group were contacted at their own workplaces.

The experimental design required that the F group was composed of individuals with the widest possible age range in order to get a representative social opinion on the subject from people in different age cohorts. As it was anticipated that the OD and INF groups would have a much younger population than the F group, no age matching was attempted.

A self-administered survey having 28 questions

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to be answered using a 3-point scale (agreement, disagreement, and relative agreement) was given to the three groups. This questionnaire had an introductory paragraph stating the purpose of the study, and it was designed to probe five topics: (a) adoption vs egg donation, (b) the importance of the loss of genetic linkage between parents and offspring, (c) assumptions made by the recipient about the donor, (d) assumptions of the recipient about the future parent–child relationship, and (e) disclosure vs secrecy with regard to the donation procedure as related to the child and the general public. If the subjects were fertile or infertile but they were able to use their own gametes, they were asked to imagine how they would feel if they needed an ovum donation procedure to conceive a child. In the same way, men were asked to imagine the feelings of their wives when responding to woman-addressed questions. In all cases one of the psychologists was available to answer any questions that responders might have while answering the survey.

Answers to questions were anonymous, so no pair tests could be applied to the responses. Men's and women's responses were pooled, and they reflect only individuals' opinions, because statistical analysis did not reveal any gender-related differences in the responses (see results).

In our program of ovodonation the potential donors are recruited from the infertile patients who undergo assisted reproduction techniques, who are less than 35 years old, and who wish to donate their spare eggs. Donation is anonymous and altruistic, with no compensation of any kind. Potential egg donors receive medical and psychological counseling about the act of ovum donation.

A frequency distribution was established for every categorical variable. Analyzed parameters included the number of cases, maximum and minimum values found, median, aritmethic mean, and standard deviation. Statistical analysis was performed by the chi-square test and one-way analysis of variance of the Kruskall–Wallis test. Differences were considered significant at $P < 0.05$.

RESULTS

Differences in the number of responses between men ($n = 62$) and women ($n = 95$) were due to females being contacted at the clinic's waiting room, where they were not always accompanied by their husbands, and although the questionnaire was offered to couples whenever possible, several men did not answer it. On the other hand, some women from the F group were single. No sex-related significant differences were detected (Table I).

Adoption vs Egg Donation

When the choice of adoption or egg donation was considered, a statistically significant difference was found between the OD group and the others (see Table II); the choice of adoption increased as people felt less compelled to choose OD (OD, 87.3%; INF, 60%; F, 41.8%). Nevertheless, all the groups had the tendency to prefer OD over adoption.

The main reason motivating approximately one-third of the individuals from each group to participate in an OD program was to give their husband a genetic child of his own. The OD group was less anxious to experience pregnancy themselves (18%) than the other two groups (INF, 44.1%; F, 31.3%). No participants in any of the three groups believed that people who use donated ova are selfish.

Importance of the Loss of Genetic Linkage

Participants in the three groups showed a high degree of ignorance and confusion regarding the genetic makeup of the child when OD was used (Table II).

For the OD group it was easier to accept the lack of genetic contribution from one partner than for the INF group ($P < 0.036$), and they considered themselves less concerned and vulnerable to the comparisons of mother–child resemblance than individuals from the F group ($P < 0.01$).

Assumptions of the Recipient About the Donor

The majority of the patients in the OD group and the INF group would not select a relative as a donor, and the percentage was even lower in the group F; the difference was statistically significant (OD vs F, $P < 0.001$).

One-half of each group was concerned about future recipient–donor relationship problems if the donor was a relative or a friend. Only 16.4% of the OD group assumed that they might have legal problems with the donor in the future; this was significantly lower than the number of subjects with identical concerns in the INF group (31.4%) and the group F (25.8%) (Table II). One-half of the respondents of

Table I. Demographic Data for the Fertile (F), Ovum Donation (OD), and Infertile (INF) Groups

Group	Sex	*N*	Mean age (range)	Child of their own (%)	Previous marriage (%)	Child from previous marriage (%)	Religion (%)[a]				
							C	J	E	P	A
F	Female	42	34.6 (19–66)	56	5.9	2.9	80.9	11.9	2.4	—	4.7
	Male	25	38.8 (29–68)	56	2.9	2.9	88.0	8.0	—	—	4.0
OD	Female	31	40.2 (24–49)	9	10.9	7.2	87.1	—	3.1	—	9.6
	Male	24	39.6 (31–47)	9	3.6	1.8	79.1	4.1	—	—	16.6
INF	Female	22	33.8 (25–43)	20	5.7	—	86.3	9.1	—	—	4.6
	Male	13	36.9 (31–47)	20	—	—	84.6	7.7	—	7.7	—

[a] C, Catholic; J, Jewish; E, evangelic; P, protestant; A, agnostic.

the total sample thought that using a friend or a relative as a donor would damage their relationship.

Assumptions of the Recipients About the Future Parent–Child Relationship

Most of the subjects in the total sample thought that children born from donated oocytes were the same as any other children, but the number of patients with this view was significantly higher in the OD group (OD vs INF, $P < 0.05$; OD vs F, $P < 0.007$).

Despite the coincidence of the three groups on a possible normal parent–child relationship, the OD group showed a significantly smaller number of patients having doubts about this issue (Table II). The three groups again agreed that if the child fortuitously find out that their parents had hidden his/her origins, the relationship would be damaged.

Disclosure of vs Secrecy About the Donation Procedure to the Child

More than half of the participants from each group thought it important for the parents to tell their children that they were conceived through egg donation. They also considered it fundamental for the child to establish his/her identity (OD, 43.6%; INF, 42.9%; F, 50.7%).

A high percentage of subjects in the total sample (OD, 76.4%; INF, 62.9%; F, 66.7%) considered fundamental what, when, and how to tell the child. About one-half of the patients in the total sample did not agree with the idea that maintaining secrecy was a way of protecting the child. The OD group showed a significantly lower number of patients than the other two groups supporting the idea that they had to have the donor's information available in case the child wanted to have it (OD vs INF, $P \ll 0.001$; OD vs F, $P \ll 0.001$).

Disclosure of vs Secrecy About the Donation Procedure to the Public in General

More than half of the patients in the OD group (56.4%) stated that they would tell the child about his/her origin, but only 20% thought that they would tell their family also and 23.6% stated that they would tell their friends. There was a significantly larger number of subjects in the other groups that would disclose the OD to their families (OD vs INF, $P < 0.015$; OD vs F, $P < 0.007$) and friends (OD vs F, $P \ll 0.001$). More than 80% of the individuals surveyed would inform the child's pediatrician about the OD.

Only 2.9% of the INF group, 7.5% of the F group, and 20% of the OD group thought that it would be easy for them to keep the secret for their whole lives; these percentages showed statistically significant differences for OD vs INF ($P < 0.024$) and OD vs F ($P < 0.011$). The OD group showed a significantly higher number of patients who felt themselves capable of dealing with negative or embarrassing comments about their use of donated oocytes (OD vs INF, P 0.015; OD vs F, P 0.035). A small number of individuals in the sample thought that a child conceived through these techniques would be rejected if his/her origin was known (OD, 1.8%; INF, 11.4%; F, 4.5%).

DISCUSSION

All groups in our study showed a tendency to choose OD over adoption. The adoption choice increased as people felt less associated with the OD procedure. Surprisingly, only 18% of the patients in our OD group showed the desire to experience pregnancy as the main motivation to have the procedure performed, and 41.5% mentioned their interest in giving their husbands a genetic child. We believe

Table II. Answers to the Ovum Donation Questionnaire Collected from the Fertile, Ovum Donation, and Infertile Groups

	Frequency distribution					χ^2	
Statement	Group[a]	Agree	*P* disagree	Disagree	Total	Groups	χ^2 *P*[b]
I would chose adoption	F	29.9	28.4	41.8	100	F–INF	n/s
before ovum donation	OD	1.8	10.9	87.3	100	OD–INF	0.007
	INF	14.3	25.7	60.0	100	OD–F	0.000
To use donated ova is a	F	6.0	7.5	86.6	100	F–INF	n/s
act of selfishness	OD	1.8	9.1	89.1	100	OD–INF	n/s
	INF	0.0	14.3	85.7	100	OD–F	n/s
I accept ovum donation	F	37.9	16.7	45.5	100	F–INF	n/s
to give my husband a	OD	41.5	26.4	32.1	100	OD–INF	n/s
genetic child	INF	31.4	20.0	48.6	100	OD–F	n/s
I choose ovum donation	F	31.3	23.4	45.3	100	F–INF	n/s
due to the great desire to	OD	18.9	37.7	43.4	100	OD–INF	n/s
experience a pregnancy	INF	44.1	14.7	41.2	100	OD–F	n/s
Both my husband and I will	F	37.5	10.9	51.6	100	F–INF	n/s
have the same genetic	OD	24.5	20.8	54.7	100	OD–INF	n/s
linkage with the child	INF	26.5	38.2	35.3	100	OD–F	n/s
The loss of my genetic	F	47.7	29.2	23.1	100	F–INF	n/s
contribution is hard for	OD	20.4	33.3	46.3	100	OD–INF	0.036
me to accept	INF	50.0	17.6	32.4	100	OD–F	n/s
Mother–child comparisons	F	38.8	31.3	29.9	100	F–INF	n/s
about our resemblance will	OD	63.0	20.4	16.7	100	OD–INF	n/s
not affect me	INF	48.6	22.9	28.6	100	OD–F	0.010[c]
It is dangerous that the donor	F	25.8	36.4	37.9	100	F–INF	n/s
will regret and claim parental	OD	16.4	16.4	67.3	100	OD–INF	0.004
rights in the future	INF	31.4	37.1	31.4	100	OD–F	0.005
I would prefer a relative as	F	17.9	25.4	56.7	100	F–INF	n/s
donor to have genetic linkage	OD	0.0	14.5	85.5	100	OD–INF	0.001
with my family	INF	8.6	5.7	85.7	100	OD–F	0.007
Being a friend or a relative	F	25.8	25.8	48.5	100	F–INF	n/s
of the donor will not impair	OD	18.5	25.9	55.6	100	OD–INF	n/s
our relationship in the future	INF	22.9	20.0	57.1	100	OD–F	n/s
Children born from donated	F	77.6	13.4	9.0	100	F–INF	n/s
oocytes are the same as	OD	96.4	1.8	1.8	100	OD–INF	n/s
any other children	INF	82.9	17.1	0.0	100	OD–F	0.007
The mother of a child born	F	11.9	19.4	68.7	100	F–INF	n/s
through egg donation will	OD	3.6	9.1	87.3	100	OD–INF	0.003
never feel it is completely hers	INF	5.7	37.1	57.1	100	OD–F	0.027
We will always be annoyed by	F	11.9	29.9	58.2	100	F–INF	n/s
feelings about having a child	OD	0.0	3.6	96.4	100	OD–INF	0.000
through egg donation	INF	11.4	42.9	45.7	100	OD–F	0.000
The mother of a child	F	6.0	28.4	65.7	100	F–INF	n/s
conceived through egg donation	OD	1.8	7.3	90.9	100	OD–INF	0.016
will have mixed feelings	INF	5.7	25.7	68.6	100	OD–F	0.002
toward her child							
If my child finds out I hid	F	58.2	28.4	13.4	100	F–INF	n/s
his origins, the relationship	OD	52.7	25.5	21.8	100	OD–INF	n/s
will be damaged	INF	62.9	17.1	20.0	100	OD–F	n/s
It's important that parents	F	55.2	25.4	19.4	100	F–INF	n/s
tell their child that he was	OD	56.4	23.6	20.0	100	OD–INF	n/s
conceived through egg donation	INF	65.7	20.0	14.3	100	OD–F	n/s
To know about his genetic	F	50.7	22.4	26.9	100	F–INF	n/s
origin is important for the	OD	43.6	25.5	30.9	100	OD–INF	n/s
child's identity	INF	42.9	31.4	25.7	100	OD–F	n/s
The secret must be kept to	F	16.4	28.4	55.2	100	F–INF	n/s
protect the child	OD	23.6	27.3	49.1	100	OD–INF	n/s
	INF	22.9	25.7	51.4	100	OD–F	n/s
I do not care about what, when or	F	15.2	18.2	66.7	100	F–INF	n/s
how to tell the child because it is	OD	7.3	16.4	76.4	100	OD–INF	n/s
not convenient for him to know it	INF	17.1	20.0	62.9	100	OD–F	n/s
To have the donor's information	F	47.8	23.9	28.4	100	F–INF	n/s
available is important in case the	OD	12.7	32.7	54.4	100	OD–INF	0.000
child wants to have it	INF	42.9	40.0	17.1	100	OD–F	0.000

Table II. Continued

Statement	Group[a]	Frequency distribution: Agree	*P* disagree	Disagree	Total	χ^2: Groups	χ^2 P^b
No one should know the child was conceived through ovum donation	F	35.8	25.4	38.8	100	F–INF	n/s
	OD	40.0	32.7	27.3	100	OD–INF	n/s
	INF	28.6	34.3	37.1	100	OD–F	n/s
If we conceive a child through egg donation, we will tell our friends	F	40.7	25.8	27.3	100	F–INF	n/s
	OD	23.6	10.9	65.5	100	OD–INF	n/s
	INF	34.3	22.9	42.9	100	OD–F	0.000
If people became aware that my child was conceived through egg donation, they would reject him	F	4.5	20.9	74.6	100	F–INF	n/s
	OD	1.8	18.2	80.0	100	OD–INF	n/s
	INF	11.4	20.0	68.6	100	OD–F	n/s
It is important for the family to know our child was conceived through egg donation	F	35.8	41.8	22.4	100	F–INF	n/s
	OD	32.7	20.0	47.3	100	OD–INF	0.015
	INF	25.7	48.6	25.7	100	OD–F	0.007
It is important for the child's pediatrician to know he was conceived through egg donation	F	91.0	4.5	4.5	100	F–INF	n/s
	OD	81.5	9.3	9.3	100	OD–INF	n/s
	INF	77.1	14.3	8.6	100	OD–F	n/s
It will be easy for me to lie my whole life to keep the secret	F	14.9	7.5	77.6	100	F–INF	n/s
	OD	20.0	20.0	60.0	100	OD–INF	0.024
	INF	14.3	2.9	82.9	100	OD–F	0.011
To keep the secrete could make us feel lonely at some moment	F	42.4	21.2	36.4	100	F–INF	n/s
	OD	38.2	10.9	50.9	100	OD–INF	n/s
	INF	45.7	28.6	25.7	100	OD–F	n/s
I feel myself capable of dealing with negative or embarrassing comments about having used donated oocytes	F	53.0	27.3	19.7	100	F–INF	n/s
	OD	75.9	14.8	9.3	100	OD–INF	0.015
	INF	45.7	34.3	20.0	100	OD–F	0.035

[a] F, fertile ($n = 67$); OD, ovum donation ($n = 35$); INF, infertile ($n = 55$).
[b] Differences considered significant at $P < 0.05$.
[c] ANOVA of Kruskall–Wallis differences considered significant at $P < 0.05$.

that social desirability (5) could have an influence on these responses. Perhaps due to cultural differences, our findings do not agree with those reported by Bartlett (6), who found the desire to experience pregnancy present in 43% of her sample. Our community is highly influenced by psychoanalytic points of view and the word ''narcissism,'' which is commonly heard, is not always perfectly understood. The likelihood of being labeled as narcissistic added to the influence social desirability has on this population might be the reason so few women from the OD group mentioned the desire to experience a pregnancy as the main motivation to participate in these techniques.

We wanted to explore how much the subjects knew about the difference regarding the genetic makeup of the child when OD was used, and surprisingly we found that the three groups showed a high degree of ignorance and confusion about this topic. Most amazing results came from the OD group, since only half of the individuals had a clear concept of the different genetic linkage each parent would have with the offspring. This could occur for several reasons: (a) the common confusion and misunderstanding people have with regard to the terms ''biological'' and ''genetic,'' (b) communication problems between doctors and patients in transmitting or receiving the correct information, or (c) denial of the severe emotional impact the loss of genetic linkage with the child may pose on the parents.

The fact that the OD subjects show a better acceptance of the lack of genetic contribution from the mother than the F- and INF-group subjects may reflect the effect on them of dealing with prolonged sadness; they can now focus on the benefits rather than on the disadvantages of this way of building a family.

With regard to the recipient's assumptions about the potential donor, our findings differ from those of earlier studies (6–9): individuals participating in them would easily accept a relative or a friend as a donor, whereas our subjects showed a preference for an anonymous donor. The reason may be that our population was concerned about problems in the future relationship with the donor; it is also possible that in our country most physicians believe that anonymous donation is better for the welfare of the

couple and the child, and they may transmit this position to their patients.

Most of our professionals follow the ASRM guidelines for gamete donation, which recommends the use of anonymous donors. Although some programs in our country accept the use of a known oocyte donor, it is the most common belief among physicians in our culture that donor anonymity decreases the theoretical problems in future relationships between the parties. Therefore, very little nonidentifying information is given to the recipient couple (age, medical history, phenotype), who easily accepts this choice, perhaps to avoid the notion that the donor is someone ''real'' and that their future child will have his/her genetic material. In this approach the donor must be absent and denied, and therefore a relative or a friend does not fit into this scheme.

The use of secrecy or disclosure with regard to the origin of the child's conception when gamete donation is used is still controversial. There are clearly different points of view among countries, physicians, mental health professionals, and even, as Daniels (3) affirms, professionals at the same clinic or reproductive center staff.

There is no legislation in Argentina on gamete donation, but according to the United Nations Convention on the Rights of the Child (1989), of which Argentina is a subscriber, every child has the right to know his/her origin. Obviously professionals in Argentina do not have a unique approach regarding secrecy about or disclosure of the child's origin to the child or to anybody else. Most of the physicians at the clinic where the study was performed tend to consider sharing the OD with the children or others unnecessary.

Even though the OD-group subjects could have been influenced by their doctors' opinions, there were no differences among the three groups with regard to whether or not the child should be told about the method of conception used. About half of our sample was in favor of disclosing this information to the child, confirming the results previously reported by Pettee and Weckstein (10). Weil *et al.* (8), and Braverman and Corson (9) have reported a lower tendency to disclose the OD procedure to their offspring. Since people who preferred secrecy ranged from 7 to 30% in our three study groups, openness seems to be the main tendency in our population sample. The three groups agreed that secrecy was not a way of protecting the child; they thought that if the truth were discovered, the relationship with the offspring would be damaged. However, Klock *et al.*'s statement (11) that couples may have planned to tell the child before conception, but when the child is born they tend to keep the issue secret, may be operational. Several studies seem to point to this mechanism (12–14), but these longitudinal studies were performed in families where the donated gamete was the spermatozoa and the ''social'' father did not have any biological link. On the contrary, in the OD situation, a woman contributes her uterus and complete gestation, so she may feel reassured that the child would consider her the biological mother and therefore may have fewer objections to revealing his/her origins.

In our study sample the OD group showed little interest in having the details of the donor's identity available in case the child requested them. This may be due to different reasons: (1) even though they plan to tell the child the truth, they do not consider it important to include the donor's personal information; (2) women especially may fear that the child would try to find the donor and move away from them; or (3) they may have been influenced, as stated previously, by the doctor's opinions regarding the eventual harm to the child. Oskarsson *et al.* (15) similarly reported a low number of recipient couples showing an interest in having the donor's personal information.

With regard to disclosing the OD to family and friends, individuals in the OD study group showed less interest in doing so than those in the other groups. Only 20% thought that they would like to tell their families, and 23% their friends. Different results were obtained by Weil *et al.* (8), who found a figure twice as high, and Kirkland *et al.* (16), who described a higher proportion (74%). In our sample the disclosure position is higher regarding the child (56%) and decreases when it involves friends (23%) and family (20%); in the Weil *et al.* and Kirkland *et al.* series, the openness position is much higher when family and friends are involved.

On the other hand, since most of the OD group thinks that society would not reject a child born from donated oocytes, in agreement with the report by Klock *et al.* (11), we estimate that the attitude of the 80% of our sample who would not disclose the OD to family and friends is due to fear of being stigmatized.

In terms of the future parent–child relationship, more individuals in the OD group than in the F and INF groups shared the idea that both the child and

the parents would cope successfully with the situation. However, the three groups showed a similar trend in considering that the relationship would be normal.

CONCLUSIONS

The present study showed that although there were significant differences in the approach of the population to the five topics proposed, there is a general trend to support OD as a valid alternative to start a family. None of the three groups took either extreme or alarming positions with regard to the main questions proposed on the OD choice.

When people who were not candidates as ovum recipients placed themselves in that position, their opinions did not differ radically and they did not condemn those who chose OD.

The sample size of our study population is too small to be representative of the general public opinion on OD. A much larger sample would be necessary to obtain the information needed for patients' informed consent and for counseling them on what can be expected in the foreseeable future in terms of the reaction of the social environment to the donation procedure.

We hope that our findings will help to improve the psychosocial counseling of people trying to decide whether or not to have OD.

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L. Urdapilleta[1]
C. Chillik
D Fernández
Centre of Studies in
Gynaecology and
Reproduction (CEGYR)
Buenos Aires, Argentina

[1] To whom correspondence should be addressed at Department of Psychology, Centre of Studies in Gynaecology and Reproduction (CEGYR), Viamonte 1438, PC 1005, Buenos Aires, Argentina. Fax: (541) 4371-7275. e-mail: cegyr@impsatl.com.ar