ARTIFICIAL INSEMINATION USING DONOR SEMEN
AND THE ISSUE OF SECRECY: THE VIEWS OF
DONORS AND RECIPIENT COUPLES

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Abstract—The issue of secrecy and artificial insemination using donor semen has psychosocial, moral and legal implications. These implications are explored within the context of New Zealand AID practice, and particularly, recent legislation aimed at clarifying the status of the child. The results of two studies, one covering 37 donors involved in six AID programmes and the other covering 55 couples who had been accepted into one of the same six programmes, are reported. Recipient couples and donors, while thinking that secrecy is important, have told other people—a not dissimilar situation to what occurred in the adoption field 25 years ago. Forty-one per cent of recipient couples and donors do not believe children should be told of their origins. A high 46% of couples had not yet decided if they would tell their child. Donors are almost equally divided over the child’s right to non-identifying information about them. Donors are more likely than recipient couples to believe that the child who knows s/he has been conceived via AID will want information about them. Only 1% of donors and 5% of couples believe a child would want to know the identity of the donor, although for three quarters of both groups the issue is far from clear. Donors were not as opposed to the possibility of tracing occurring as some doctors suggest. Response to questions concerning the legal position suggests there is considerable confusion amongst both groups. The overwhelming majority of couples were intending to place the husband’s name on the birth certificate, regarding him as the father. The results of this study are compared with the results of similar studies undertaken in Australia. Secrecy operates to serve the interests of those who have the power to make the decisions. In this respect, the needs and rights of the children are likely to be ignored and this paper calls for greater recognition of their needs and rights.

Key words—donor insemination, secrecy, legal, psychosocial, children

INTRODUCTION

Artificial insemination using donor semen (AID) is a process whereby semen is placed into a woman’s vagina or uterus for the purpose of conception. The semen is obtained from a donor, that is, someone other than the woman’s partner. AID is most likely to be used with infertile couples where the male is azoospermic (absence of sperm in the ejaculate) or oligospermic (insufficient sperm in the ejaculate to lead to conception).

A survey [1] of New Zealand obstetricians and gynaecologists showed that in the 12 month period, February 1982-February 1983, approx. 159 women were inseminated with donor semen. Approximately 68 (54%) of conception had occurred with the results still awaited for a further 14 (9%). Forty-two live births had occurred during this period, with a further 18 awaiting delivery. On the basis of these figures, it would seem likely that one child per week is being born in New Zealand as a result of this procedure.

While AID is primarily a medical procedure (although there are informal indications that some people may use “do it yourself” kits), the issues associated with its use have much wider implications. These include legal, social, psychological and moral considerations and most of the public discussion of AID has concerned these non-medical issues. In an attempt to encourage public debate and discussion, the Law Reform Division of the Department of Justice published a discussion document, New Birth Technologies [2]. The booklet covers, in addition to AID, artificial insemination using husband semen (AH), in vitro fertilisation, and surrogate motherhood. In his introduction to the document, the Minister of Justice indicated that the legal status of the children conceived with the assistance of donor gametes—sperm or ova—needed to be clarified quickly and to this end he introduced, in August 1986, the Status of Children Amendment Bill [3], and this was enacted 12 months later [4].

The legal issues surrounding the status of the child, the donor and the parents are likely to have been one of the major reasons most couples using AID have kept their use of the procedure a secret. Other likely reasons are uncertainty regarding the community’s acceptance of the procedure, some doctors advising couples not to discuss AID with others, general attitudes towards infertility and in particular confusion regarding sexuality and procreation, and uncertainty on the part of some couples as to how to tell relatives and friends. Whatever the reason/s, AID has, as Snowden and Mitchell [5] put it, been “shrouded in secrecy”. Even although AID has been practised in New Zealand for at least 25 years, it has only been over the last 8 years that there has been any media coverage of the subject. The earliest known New Zealand journal article was one by Northey [6].

This paper is based on an address given at the American Society for Law and Medicine Conference, held in Sydney, Australia, in August 1986.
written in 1958 in which the legal issues associated with AID were discussed.

This paper explores the issue of secrecy as it relates to AID in New Zealand. The views of two of the main parties involved—sperm donors and recipient couples—concerning matters associated with secrecy are presented, compared with results from similar studies in Australia, and discussed. The views of the donors and couples indicate that a change in the law, while being very important, will go only part of the way in resolving the status and well-being of the child conceived as a result of AID.

THE ISSUE OF SECRECY

The word secrecy, implying as it does that something is being hidden, has emotive and value connotations. It is a word that has been used extensively in relation to the discussion of the psychosocial aspects of AID. Rowland [7] has suggested that the social taboos operating at the time that AID began were an important factor contributing to the desire for secrecy. She also suggests that secrecy was justified by early medical practitioners on the grounds that it was intended to protect the child from being regarded as 'different' and therefore stigmatised. Annas [8], on the other hand, says that the main reason that secrecy developed was because of the need to protect the donor.

Snowden [9], based on his review of over 1000 cases of AID (including in-depth interviews with 60 couples who are parents of one or more children conceived via AID), concluded that the main reason for secrecy in AID was to protect the husband who has been found to be infertile. From the above comments, it would seem appropriate to conclude that the main reason for secrecy is to protect people, which people being a matter of opinion. Perhaps the most pertinent questions that need to be asked are, who is deciding that certain people need to be protected, and what is the basis of information on which such decisions are made?

An alternative approach to the focus on secrecy, and one taken up by the British Agencies for Adoption and Fostering [10], is to talk of the need for openness in relation to AID. If secrecy and openness are seen as opposite ends of a continuum, then it is likely that different parties will adopt different positions on this continuum. Joyce [11] makes this point when he suggests that there can be four degrees of openness or breach of secrecy that can be considered. These are (1) the fact of AID may be shared with chosen members of the family or close friends, (2) the fact of AID may be shared with the child, (3) the fact of AID may be shared with society in general, and (4) the identity of the donor is made known to the AID child and family.

Snowden, Mitchell and Snowden [5, pp 102-104] argue for a different conceptualisation of the issues associated with secrecy. They suggest that there are three components involved, the first relating to the consultation between the health professionals (most notably the doctor) and the couple. This consultation is obviously covered by the expectation of confidentiality. The second component relates to the health professionals (usually the doctor or scientific officer) and the donor and this is covered by discussion of the right to anonymity on the part of the donor. The third component is that concerning the relationship of the parents and the child. Here the parents must make a choice between telling the child of the nature of his/her conception, or keeping this fact a secret and pretending that the child is the biological offspring of both of them. It is argued that this formulation, while being relevant to those directly involved, ignores the relationship of the family to society in general. Consideration of this point automatically involves discussion of whether AID is a private act, that is, something agreed to by the couple concerned, in consultation and with the assistance of a doctor, or whether there is a public component/factor involved in their decision making.

The Status of Children Amendment Act [4] clearly indicates that the government recognises the public component. Many countries have also recognised the 'public component' and set up commissions of inquiry, charged with making recommendations concerning government responses to developments in the birth technology field. Two other issues highlight the public aspect of AID—the social policy implications regarding the use of public health funds, and decisions regarding the keeping of records—what records are kept, by whom, and access to those records. Elias and Annas [12] conclude a discussion of the social policy issues relating to 'non-collateral reproduction', as they call it, by saying that decisions in this area cannot survive solely in the domain of fertility specialists. They suggest that the AID-private contract paradigm is outdated and inadequate to protect children, parents, the family and social values.

There is a growing body of opinion, mostly, it should be noted, from the social science disciplines, which advocates a greater openness in relation to AID in general and various aspects of AID practice in particular. Some of the major reasons for this advocacy are the recognition that secrecy—what secrecy, inasmuch as it deprives the child of the right to know of the nature of her/his conception—is not in its best interests, the recognition that family relationships are damaged when they are based on deception, a fact highlighted by Brandon and Warner [13], Sants [14], Rowland [7, p 80], and Snowden and Mitchell [15] and, furthermore, that such deception leads to stress and tension, a question of whose needs are best served by a policy of secrecy and the recognition that the answer is those who have the power to make the decision, acknowledgement of the social policy implication of AID, and the beneficial effect that has resulted from the change from secrecy to openness in the adoption field [16, 17].

A basic tenet of family law is that the rights and needs of the child are regarded as paramount, a fact enshrined in legislation. The Family Law Council of Australia takes up this point in its report Creating Children, when it recommends:

"That the principle of the paramountcy of the welfare and interests of the child born of reproductive technology be incorporated into all Federal, State and Territory legislation governing the operation and administration of reproductive technology programmes, including the provision that reproductive technology procedures only be administered when appropriate conditions exist for ensuring the welfare of the future child born" [18].
The principle of paramountcy of the welfare and interests of the child may well be in conflict with the desire for privacy on the part of recipient couples and anonymity on the part of the donor. It is such a potential conflict of rights and interests that has led governments in many western countries to consider what action they need to take.

The New Zealand Status of Children Amendment Act [4] represents an interesting example of attempted resolution. The Act enables the mother’s husband (in the case of AID) to be regarded as the father of the resulting child, provided he has consented to the procedure. The Act states that “the husband shall for all purposes be the father of any child of the pregnancy” (Sec 5(a)), and it enables the husband to enter his name on the birth certificate as the father. While this position has much to commend it, particularly in terms of rectifying the anomalous position regarding the donor and the husband, it creates problems in relation to the child. Most notably, it means that the law provides potential support to the notion of secrecy, insomuch that it implies that the husband is the biological father when he is not.

Part of the reason for this difficulty is lack of distinction between biological and social parents. It can be argued that by enabling husband and wife to enter their names as the biological parents, encouragement is being given to them to maintain the notion of secrecy. If the birth records were to acknowledge the facts of the conception (which would create other problems), the parents may be more likely to discuss the conception with their offspring. Thus, after all, was the pattern that was established with adoption—the biological link was acknowledged and then the law was used to recognise the social parents, created via adoption. To pretend that the social father is in fact the biological father is, as the Warnock Committee [19] recognised, legislating for a fiction. The Committee, however, justified its decision to recommend that the law be changed to permit the husband to be registered as the father on the grounds that such a position would be consistent with the husband assuming all parental rights and duties with regard to the child. Glazebrook [20] says that it is not the task of the law to conceal the truth.

He suggests that the Warnock Committee’s sympathy for the couple who use AID may have led them to pay insufficient regard to the interests of the child.

The child who owes his/her conception to AID must surely have the right to know of this and furthermore, particularly in the light of changes in relation to adoption, some rights concerning the tracing of the donor. In this respect, the New Zealand Act does not seem to incorporate the principle of paramountcy of the interests and welfare of the child.

The dramatic changes that have taken place in adoption policy and practice over the last 20 years may foreshadow similar changes for AID. Most of the changes in the adoption field emanated from concerns for the rights of adoptees, and to a lesser extent the rights of birth parents. The secrecy that was once encouraged and legislated for has gone. It would seem important that these experiences and the lessons learned be considered in relation to AID.

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**DONORS AND RECIPIENT COUPLES’ VIEWS ON ISSUES RELATED TO SECRECY**

The author is currently involved in or recently completed a number of studies related to the psychosocial aspects of AID and in vitro fertilisation [21]. The results of two of these studies, as they relate to issues associated with secrecy in AID, are reported here.

A study of donors involved in six New Zealand programmes was carried out in 1985 [22]. Thirty-seven donors completed questionnaires distributed via the medical or scientific staff of the programmes. As far as can be ascertained, 52 questionnaires were distributed, giving a return rate of 71%.

The results are reported and discussed under several headings: (a) when is a secret a secret? (b) to tell the child or not? (c) the child and what she/he may want, and (d) legal issues.

**(a) When is a secret a secret?**

Twenty-five years ago in New Zealand it was common for couples adopting a child to be advised to keep the adoption a secret—in other words, to pretend that the child was the biological offspring of both. It was, of course, virtually impossible to keep such a secret. Some people, often those in the immediate network, ‘knew’ and the secret therefore had limitations. The disclosure of the information to an adoptee, usually much later in life, and often in unfortunate and unhelpful circumstances, caused much distress.

In the AID field, many couples have been encouraged/advised to keep the nature of the conception of their child secret, although this seems to be changing. While some doctors have advised couples to ‘keep it a secret’, many have moved to the position adopted by the Royal College of Obstetricians and Gynaecologists [23], namely:

“Unless you decide to tell the child, there is no reason for him (or her) ever to know that he (or she) was conceived by AID. Whether or not you do so is entirely up to you.”

Such a position, while placing the responsibility firmly with the couple, strongly implies that there is no reason to share the information with the child. It is highly unlikely that any counsellor, social worker, psychologist or psychiatrist would advise a couple to keep such a secret, in fact quite the opposite is likely to be the case.
All recipient couples in the study report that they have discussed with others their difficulty in having children. Couples were not asked if they had told others that they were entering an AID programme, but of those that have conceived (eight couples), six (75%) said that other people knew that the child was conceived with the assistance of AID. Those who had been told were usually parents, immediate family and close friends, a not dissimilar pattern to that operating in the adoption field 25 years ago. In a similar study in Australia [24], 59% of respondents had told someone of their involvement in an AID programme. It was found that these couples expressed complete trust in the confidantes Rowland points out, however, that the adoption experience indicates that, in the secrecy situation of the past, it was often the confidante who disclosed information.

Of considerable importance are the figures showing that 37% of prospective parents and 27% of donors are unsure about whether or not children should be told. It could have been expected that, as both recipient couples and donors had been through assessment and work-up programmes, they would have considered this matter in some detail and arrived at a decision.

Recipient couples were further asked to indicate what they intended to do in relation to any children they might have and, as Table 1 indicates, a very high 46% had not yet decided. With 31% having decided not to tell the child and 23% having decided to tell these figures can be compared with those of Rowland [24, p 394] who found that 35% were unsure of whether or not to tell the child. It is difficult to be certain about what accounts for the greater willingness of New Zealand couples to share the nature of the child's conception with her/him. One possible explanation is that the variation reflects the different policies of the staff seeing couples prior to admission to the programme. With 46% not having yet decided, questions arise as to how recipient couples are going to make the decision, and who is going to be available to assist them should they need assistance in arriving at their decision. It would seem to the author that consideration of this issue, and the many other psychosocial factors associated with AID, need to be fully discussed before couples are admitted to an AID programme. To suggest, as the Royal College of Obstetricians and Gynaecologists [23, p 4] does, that it is the couple's decision may be a way for the doctor to absolve him/herself from any responsibility. There is a difference, however, between a couple taking responsibility for their decision and the doctor taking responsibility for ensuring that the issues and implications of the decision they must make are raised with them. A comprehensive AID programme would require that couples discuss and clarify all of the issues, looking at them from their own and the child's perspective.

Table 1 shows that 41% of both those wishing to become parents via AID and donors do not feel that the children should be told of the nature of their conception. Twenty-two per cent of recipient couples and 32% of donors felt that the children should be told. These figures can be contrasted with the views (regarding the same question) of AID practitioners—30% believing children should not be told and 45% believing they should be [1, p 238], and respondents to a women's magazine survey—59% believing children should be told and 24% believing they should not be [25]. These figures may suggest that the further the distance from and personal investment in the issue, the greater will be the ability of people to look at the issue from the child's perspective.

(b) To tell the child or not

The conflict of interests between the various parties involved in AID is portrayed most powerfully in relation to whether the children should be told of the nature of their conception. Table 1 shows that 41% of both those wishing to become parents via AID and donors do not feel that the children should be told of the nature of their conception. Twenty-two per cent of recipient couples and 32% of donors felt that the children should be told. These figures can be contrasted with the views (regarding the same question) of AID practitioners—30% believing children should not be told and 45% believing they should be [1, p 238], and respondents to a women's magazine survey—59% believing children should be told and 24% believing they should not be [25]. These figures suggest that the further the distance from and personal investment in the issue, the greater will be the ability of people to look at the issue from the child's perspective.

(c) The child and what he/she may want to know

Donors were asked if they felt that children who knew they had been conceived via AID had a right to non-identifying information about the donor. Non-identifying information would normally include age, physical characteristics, interests, marital status, etc. It does not include the name of the donor. Sixteen donors (43%) felt that children did have the right to such non-identifying information, while 14 (36%) felt they did not have the right. The remaining seven (19%) were unsure. Donors are therefore almost equally divided regarding the child's right to non-identifying information.

Table 2 shows that 38% of donors believe that children who know they were conceived via AID had a right to non-identifying information about the donor. This is in comparison to only 12% of recipient couples who believe children will want information. Thirteen percent of recipients believe that children will not want information about the donor, compared with 5% of donors holding this belief. The donors are therefore more likely than recipient couples to believe the child (who
knows he/she has been conceived via AID) will want information about them. One possible explanation for this belief is that it is due to the donor identifying with the child in whose creation he has played a part. The couple’s views may be occasioned by seeing a child’s (presumably when an adult) desire for information about the donor as a threat and as maximising the analogy between adoption and AID. The reactions to these changes in Sweden have been swift with suggestions that the legislation signals the end of AID programmes [27]. The belief is that donors will not wish to be donors if there is the possibility of their being ‘traced’ in the future. This is a commonly held view amongst doctors and scientific officers involved in AID programmes. However, the results of surveys that have been carried out do not present such a clear-cut viewpoint. Ewerlof [26, p 7] says that the Insemination Committee in Sweden found in its investigation that four out of 12 donors would be prepared to continue as donors, even if they were not allowed to remain anonymous. Rowland [24, p 394] found that “60% of donors would not mind if their AID offspring contacted them after the age of 18, in order to discuss family background and so on”.

Table 2 shows that the likelihood of a child wanting to know the identity of a donor is not seen as great. 19% of donors and 5% of recipients holding this view. It is of interest to note the difference between the two groups again, perhaps for the same reasons outlined above.

If the ‘possibly’ and ‘unsure’ responses to the question of knowing the donor’s identity are combined, then 78% of respondents are included, suggesting that for three quarters of all respondents that issue is far from clear cut.

At the time the studies were undertaken, there were proposals to change the law relating to adoption. The proposal (since enacted) would make it possible, amongst other things and with certain restrictions, for adopted people, once they had reached the age of 20, to trace their origins. Respondents were asked if they believed that people conceived via AID, once they had reached the age of 20, should be able to trace the identity of the donor. These figures, which are from the most recent study available (1986) seem to indicate a changing attitude amongst donors. It does seem clear that Australian donors have a more ‘open’ approach to the issue of secrecy and future contact with their offspring than do New Zealand donors. This is not surprising given the much greater media and professional coverage of the topic in Australia, which has resulted in a more informed approach.

(d) Legal issues

Discussion of the issue of secrecy and AID is often portrayed (particularly by those most closely involved) as a private matter between the couple and the health professionals. The fact that there are legal issues arising from AID clearly indicates a public dimension that must be considered. The interplay between secrecy and legal matters has already been highlighted. Recipient couples and donors were asked to give their views on some of the legal issues, and more specifically on what action they would contemplate.

Table 3 shows that 87% of recipients and 80% of donors believe that the husband is the legal father of the child. At the time the studies were undertaken, the husband was not the legal father of the child, and it therefore seems that these figures may represent the ‘wishful thinking’ of those involved. Discussion with couples showed that they viewed this legal position as wrong and out of date. They did not perceive themselves as law breakers, and argued that they should have the right to register the child as being a child of the marriage.
It is a matter of concern that 17% of donors are 'unsure' about whether the husband is the legal father of the child. To have become a donor without clearly understanding the legal position is an indication of the need for the full sharing of information, so that the donor may give informed consent [28]. Ninety-two percent of recipients intended to enter the husband's name on the birth certificate. In so doing they would have broken the then current law. The alternative would have been to enter 'father unknown' on the birth certificate, and then undertake adoption procedures. Such a course of action is obviously difficult, time-consuming and costly. It would appear from responses to a further question—regarding changes to the legal situation—that many recipients didn't understand the legal position. Twenty-six per cent of recipients said they did not know if they wished to see the 'present' legal position changed in any way. A further 8% said they did not wish to see any change, thus giving over a third of recipients not wanting or not knowing if they wanted change to the 'present' legal position.

Again the obvious question to be asked is the extent to which couples were being informed about the legal issues involved. Discussion of the legal situation would have the effect of couples and health professionals having to confront some of the issues emerging from secrecy and it would appear that there is some discomfort about, and resistance to, doing this.

Only 5% of couples had discussed the legal issues with a lawyer, who, it could be presumed, would be the expert on such matters. Such a low proportion would further suggest that legal matters are not regarded as being important or relevant. Another explanation is that it may reflect the stage that the couples are at, namely, having been accepted into an AID programme and awaiting their first insemination. They may be wondering if there will be a child and, if so, they will be thinking of a baby and not someone who in a few years will be an adult. Rowland and Ruffin [29] have made the point that it is easy to infantilise the child and as a result not be confronted with questions and issues being raised by a fellow adult. Three quarters (76%) of recipients had discussed the legal aspects of AID with a gynaecologist, 20% with a general practitioner, 18% with family, 11% with a counsellor or social worker, and 4% with friends.

An issue that arises for donors, particularly those that are married, is the involvement of the spouse in the decision to be a donor. Non-agreement to a husband being a donor may have legal implications for the marriage. Some gynaecologists feel that one way of ensuring that the spouse has been informed and involved is to ask them to sign a consent form. It needs to be recognised that such a consent requirement may serve to protect the gynaecologist's position more than the marriage's. Only 15% of donors who had a spouse/partner had had to obtain consent, 85% not being so required. The major advantage of a consent form being signed is that it ensures the spouse's involvement in an area that has important implications and meaning for her and her marriage. The legal protection that may be afforded seems less important, but not irrelevant.

**CONCLUSION**

New Zealand, along with most other Western countries, has been faced with formulating responses to developments in the birth technology field. The psychosocial, moral and legal issues raised by these developments present enormous challenges, not only to those most closely involved, but also to society as a whole. The focus of this paper, the secrecy surrounding AID, highlights the conflict of rights, responsibilities and needs associated with the different parties involved. The New Zealand government's response on AID has been to enact legislation to clarify the status of the child and the responsibilities of the donor and the husband. It has been argued that such legislation, while setting out to protect the child's status, may have an adverse effect in relation to the issue of secrecy. Evidence presented from two of the main parties involved, namely, recipient couples and donors, shows that most of them do not feel that the child needs to know, or should be told of, the nature of their conception. The legislation, it is argued, will make it easier for parents to pretend that the child is biologically theirs, thus perpetrating a myth regarding their family formation. The implication of such myths and secrets, especially insomuch as they involve deception, are widespread. The evidence from the field of adoption, where 25 years ago a similar pattern existed, has been highlighted. This evidence clearly points to the need for openness rather than secrecy.

The debate regarding secrecy and legislation takes place between those who have the power to decide. The children—later adult women and men—who result from the AID procedures, have no say in the decisions that are being made, decisions that are likely to have a major impact on their lives. This paper takes an advocacy position for these people. It does so in the belief that their needs have not been fully recognised and the legislative changes in New Zealand are short-sighted. If any of the various parties' interests are to be paramount in the conflict of rights and responsibilities, it must be the children, a position well recognised and accepted in family law.

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