

Guidelines for infertility counselling in different countries: Is there an emerging trend?[†]

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BACKGROUND: It is widely accepted that infertility and involuntary childlessness, and the decision to engage with assisted reproduction technology (ART) services as a patient, donor or surrogate can entail wide-ranging psychosocial issues. Psychosocial counselling has, therefore, become valued as an integral element of ART services. The objective of this study was to begin to map out what exists globally by the way of guidelines for infertility counselling.

METHODS: Data were analysed from formal guidelines produced by seven national infertility counselling bodies, onetransnational infertility counselling organization, reports of the American Society for Reproductive Medicine Ethics Committee and Practice Committee and the ESHRE Task Force on Ethics and Law. Additional sources of data were the International Infertility Counseling Organization and counselling colleagues internationally.

RESULTS: Four broad areas concerning contemporary practice in infertility counselling are identified: (i) the legal mandate for counselling; (ii) eligibility credentials for individuals carrying out professional counselling activities; (iii) different forms of counselling and (iv) counselling practice in relation to specific elements of assisted reproduction treatment.

CONCLUSIONS: Internationally, the development of infertility guidelines is best described as a 'work in progress', although key trends are evident.

Key words: counselling / ethics / psychology

Introduction

It is widely accepted that the experience of infertility and involuntary childlessness, the decision to engage with assisted reproductive technology (ART) services as a patient, donor or surrogate, or of being born following ART services, can entail wide-ranging and long-lasting psychosocial issues and impacts (Cousineau and Domar, 2007). From around the mid 1980s, the need for psychosocial counselling provided by a skilled specialist professional to ensure comprehensive holistic care in ART began to be recognized by government-appointed committees in ART such as the Waller Committee in Victoria, Australia (Waller, 1983) and the Warnock Committee in the UK (Department of Health and Social Security, 1984).

Since then, a number of jurisdictions have mandated either the receipt of psychosocial counselling in relation to specific elements of ART provision (New Zealand, South Australia, Victoria), or require

such counselling to be made available (New South Wales, the UK, Western Australia).

However, these remain in the minority, and globally a very mixed picture emerges of the current state—and status—of infertility counselling. For example, the report of the Australian Senate Legal and Constitutional Affairs References Committee concerning donor conception practices (2011) has recommended 'mandatory' counselling for donors and donor recipients, access to counselling for parents of donor-conceived individuals following the birth of their child, and for donor-conceived individuals. In Canada, the federal government's attempts to prescribe counselling requirements (along with other measures to regulate ART nationally) were struck down by Canada's Supreme Court in December 2010 on the grounds that they violated provincial government powers (Supreme Court of Canada, 2010). Even in the UK, 14 years after infertility counselling was afforded a legal mandate following implementation of the

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Human Fertilisation and Embryology Act 1990, a committee of law-makers undertaking an inquiry into the regulation of ART concluded:

It has been apparent during this inquiry that the value of counselling is not fully appreciated by clinicians, and indeed some seem to regard it with thinly disguised contempt. This is, in our view, at the heart of the problem (House of Commons Science and Technology Committee, 2005: p. 76).

Evidence of the paucity of systematic information regarding the state of infertility counselling globally, and its apparent marginality when compared with clinical aspects of ART, can be gauged by the most recent International Federation of Fertility Societies' 'Surveillance' report (Jones *et al.*, 2011)—a report compiled exclusively by clinicians, itself suggesting the sidelining of counselling from the mainstream. The sole references to counselling in this report are in respect of: oocyte donation in Croatia (p. 44; p. 53, p. 56), the Netherlands (p. 44, p. 56) and the Republic of Ireland (p. 45, p. 59); embryo donation in a 'few' (unspecified) jurisdictions; sperm donation in Nepal (p. 45); 'welfare of the child' requirements in Belgium (p. 87) and generally to counselling for gestational surrogacy (p. 107) and a single reference to counselling in respect of 'inter-country reproductive tourism' (p. 109). Ironically, jurisdictions that have been regarded as leaders in placing infertility counselling on a statutory footing, such as New South Wales, South Australia, Victoria, Western Australia, New Zealand and the UK, and where—in the case of Australia and New Zealand—infertility counselling has been championed by the professional and accreditation body, the Fertility Society of Australia (discussed further below), are not even mentioned in this regard in the 'Surveillance' report.

It was in this context that the current study was undertaken in an attempt to begin to map out what existed globally by way of guidelines for infertility counselling.

Materials and Methods

Three primary sources have been drawn on for the purposes of this study. First, formalized guidelines for infertility counselling produced by seven national infertility counselling associations and whose existence was widely known within the infertility counselling community: Argentina (Fernández and Girolami, 2006a, b); Australia and New Zealand [Australian and New Zealand Infertility Counsellors Association (ANZICA), 2003]; Canada (Counselling Special Interest Group of the Canadian Fertility and Andrology Society, 2009); Germany (Beratungsnetzwerk Kinderwunsch Deutschland e.V. (BKID) (Counselling Network for Infertility Germany, 2009a, b, c, 2010a, b; Thom and Wischmann, 2009); Spain [Grupo de Interés de Psicología Sociedad Española de Fertilidad (Psychological Interest Group of the Spanish Fertility Society, 2010); the UK] (Naish, 1997; Snowden and Snowden, 1997; Wheeler, 1998; Bingley Miller, 2005; Baron, Blyth and Haigh, 2007; British Infertility Counselling Association, 2007; Blyth, 2007a; Read, 2011); the USA (American Society for Reproductive Medicine Mental Health Professional Group, 1995) and one supra-national European organization (Psychosocial Special Interest Group of the European Society of Human Reproduction and Embryology, 2001).

Second, the International Infertility Counseling Organization (IICO) provided contact details of known infertility counsellors in various countries, providing the closest approximation to a sampling frame. Employing a snowball technique, in order to access any grey literature, otherwise unpublished information of relevance and information regarding 'work in progress', direct contact was made with counsellors in Argentina, Australia,

Belgium, Brazil, Canada, the Czech Republic, France, Germany, Japan, Mexico New Zealand, the Republic of Ireland, Spain, Switzerland, the UK and the USA.

Third, published reports of the American Society for Reproductive Medicine Ethics Committee, the American Society for Reproductive Medicine Practice Committee and the ESHRE Task Force on Ethics and Law, that often include references to counselling, were analysed for specific citations relating to psychosocial counselling or where reference to psychosocial counselling could be reasonably inferred (i.e. excluding references to general counselling provided by clinicians or by other non-counsellor professionals, or to other specialist counselling such as genetic counselling). In order to minimize bias and to ensure consistency, two members of the ASRM Mental Health Professional Group independently reviewed the author's analysis of the ASRM reports and one member of the ESHRE Psychosocial Special Interest Group undertook a similar task as regards the ESHRE reports. This exercise resulted in complete unanimity. While, for the most part, such references are somewhat cursory, they nevertheless indicate multi-professional body acknowledgement of the role to be played by infertility counselling as part of ART service provision.

Results

While one can be reasonably confident that these sources have ensured identification of the 'principal' developments in contemporary infertility counselling, self-evidently this must be considered as simply the start of an exercise to map trends in infertility counselling from an international perspective—as indicated through formal guidelines.

Drawing on these sources, this article outlines four broad areas concerning contemporary practice in infertility counselling:

- (i) the legal mandate for counselling;
- (ii) eligibility credentials for individuals carrying out professional psychosocial counselling activities (whether formalized in legislation or guidelines; recommended or required academic and/or professional qualification; recommended or required additional qualifications and/or experience);
- (iii) different forms of counselling (implications counselling; decision-making counselling; support counselling; crisis counselling and therapeutic counselling) and
- (iv) counselling practice in relation to specific elements of ART.

The legal mandate for counselling

Several jurisdictions have mandated either the receipt or the provision of counselling. Counselling is mandatory for patients, for donors and their partners and for surrogates and their partners in South Australia and Victoria, and in New Zealand, counselling is 'mandatory' for patients using donated gametes, for donors and their partners and for surrogates and their partners. Counselling must be made 'available', although the take-up of counselling is not obligatory, to patients and donors in New South Wales, the UK and Western Australia.

Notwithstanding jurisdictional variations throughout Australia and New Zealand, as indicated above, all ART service providers fall within the accreditation system administered by the Reproductive Technology Accreditation Committee (RTAC) of the multi-disciplinary professional body, the Fertility Society of Australia (whose remit also includes New Zealand). As a condition of accreditation, RTAC requires clinics to ensure that both recipients of donated gametes or embryos and their partner and donors and their partner meet

with an infertility counsellor prior to the commencement of any donor procedure ([Fertility Society of Australia Reproductive Technology Accreditation Committee, 2008](#)).

Additional legislative or regulatory requirements relating to patient/donor evaluation are discussed later in this article.

Eligibility credentials for professional psychosocial infertility counsellors

In the early days of ART, such counselling as was available tended to be provided by nurses and doctors rather than by specialist psychosocial counsellors, as reported in the first report of the UK's Voluntary Licensing Authority for Human *in vitro* Fertilisation and Embryology—later the Interim Licensing Authority (ILA):

In all centres the medical staff are involved in the initial counselling of patients, but subsequently follow-up discussions are frequently arranged with the qualified nursing staff involved in the programme. Some centres employ specially-trained counsellors. Most centres also go to some considerable trouble to ensure that patients who fail to achieve a pregnancy have the opportunity to discuss their problems and decide on future treatment with either the medical or nursing staff. In general, the care which staff take over their patients is most impressive' ([VLA, 1986: 16](#)).

Such reliance on professionals providing medical and nursing care in ART care was barely surprising, since few individuals possessed relevant clinical psychosocial skills, knowledge or experience. However, 2 years later, the Authority painted a more circumspect picture of counselling and highlighted the need for specialist professionals:

There is confusion about the definition of counselling... Proper counselling is possible only if space and time are available to the couple in a neutral atmosphere with a fully-trained counsellor ([VLA, 1988: 15](#)).

It is also of note that contemporary references to counselling pertained only to those contemplating or undertaking ART—and not to donors of gametes or embryos, surrogates or individuals born as a result of ART procedures.

A 1989 study undertaken to ascertain levels of counselling provision in the 25 clinics in the UK then licensed by the ILA confirmed continuing confusion regarding perceptions of counselling and found that only a quarter of clinics provided the services of a designated counsellor, while in 60% of clinics counselling was provided by a doctor and in 65% by a nurse ([Inglis, 1989](#)). By 1991, when the ILA was replaced by the statutory Human Fertilisation and Embryology Authority (HFEA), the outgoing chair of the ILA noted:

There is a shortage... of trained counsellors ([Donaldson, 1991: 5](#)).

Legislation in the jurisdictions that have mandated infertility counselling has also specified conditions regarding the academic and professional qualifications and additional qualifications and experience required of those offering psychosocial counselling in accredited fertility clinics (Table I). In New Zealand and Australian states, this is achieved by reference to the accreditation criteria of RTAC which require membership of the professional infertility counselling organization for Australia and New Zealand, the Australia and New Zealand Infertility Counsellors' Association. In the UK, necessary qualifications and experience expected of counsellors are taken into account as part of the licensing procedures for infertility clinics undertaken by the statutory regulator, the HFEA. These are specified in the HFEA's Code of Practice, the

most recent issue of which makes specific reference to the recently introduced accreditation system developed by the UK's professional infertility counselling organization, the British Infertility Counselling Association ([Human Fertilisation and Embryology Authority, 2009](#)). As far as is known, Spain and Switzerland are the only two other jurisdictions that provide formal regulatory backing for infertility counselling, both specifying recommended (although not necessarily required) academic and professional qualifications.

Professional body guidelines for counsellors in Canada ([Canadian Fertility and Andrology Society Counselling Special Interest Group, 2009](#)); Germany ([Beratungsnetzwerk Kinderwunsch Deutschland, 2009a, b, c, 2010a, b; Thorn and Wischmann, 2009](#)); Europe ([Psychosocial Special Interest Group of the European Society of Human Reproduction and Embryology, 2001](#)) and the USA ([American Society for Reproductive Medicine Mental Health Professional Group, 1995](#)) also specify recommended/required academic and professional qualifications and any additional qualifications/experience as detailed in Table I. In these latter jurisdictions, none of these requirements/recommendations is reinforced by legislation or formal regulations, except insofar as individual states in the USA each operate a licensing system for mental health professionals, including those offering infertility counselling, although there is no separate license for mental health professionals offering infertility counselling or any specialized diploma or board certification for infertility counselling.

Whether or not the specific system is founded on legislation, accreditation requirements, or is reliant on professional body guidelines only, there is a broad measure of agreement that individuals offering psychosocial counselling should:

- (i) hold at least graduate level qualifications in a relevant professional field (e.g. counselling, psychiatry, psychology, psychotherapy or social work), with a prescribed relevant curriculum;
- (ii) hold at least a relevant professional license to practice;
- (iii) demonstrate relevant training in the medical and psychosocial aspects of infertility;
- (iv) demonstrate a minimum level of relevant clinical experience providing infertility counselling and
- (v) demonstrate continuing engagement in continuing professional education (CPE).

Different forms of counselling

The UK's Human Fertilisation and Embryology Act 1990 was the first statute to provide a legal mandate for counselling in ART, through its requirement on fertility clinics licensed by the HFEA to provide 'proper' counselling. The Act did not define 'proper' counselling; instead responsibility for operationalizing the concept was handed to the HFEA. In the first place, however, the UK's Department of Health commissioned the Kings Fund Centre, a health think tank, to assist the HFEA in this task. The Kings Fund Centre, in turn, appointed a dedicated infertility counselling committee to flesh out the remit and content of infertility counselling ([King's Fund Centre, 1991](#)). The way in which forms of infertility counselling were subsequently differentiated, not only in the UK, but more widely, owes much to the work of this Committee, which identified four components of 'proper' counselling: (i) information counselling; (ii) implications counselling; (iii) support counselling and (iv) therapeutic counselling. The HFEA subsequently adopted the Committee's notions of implications,

Table I Comparison of standards/guidelines for infertility counsellors.

Country or jurisdiction	Legislation or guidelines	Required academic/professional qualification	Additional qualifications/experience
Australia/New Zealand	Legislation [Human Assisted Reproduction Act, 2004 (New Zealand); Assisted Reproductive Technology Act 2007 (New South Wales); Assisted Reproductive Treatment Act 1988 (South Australia); Assisted Reproductive Treatment Act 2008 (Victoria); Human Reproductive Technology Act 1991 (Western Australia)] Fertility Society of Australia Reproductive Technology Accreditation Committee accreditation requirements apply to all clinics in Australia and New Zealand ^a Guidelines of Australian and New Zealand Infertility Counsellors Association Guidelines for professional standards of practice in infertility counselling ^b	Required by Australia/New Zealand Infertility Counselling Association: minimum 4 year tertiary qualification in psychiatry, psychology, social work	Registered as psychiatrist or psychologist, or eligibility for membership of Australian Association of Social Workers or New Zealand Association of Social Workers; membership of ANZICA; current knowledge of infertility; counselling clients regarding infertility; minimum 2 years supervised post-graduate counselling
Canada	Guidelines of Counselling Special Interest Group of Canadian Fertility and Andrology Society ^c	Postgraduate/medical degree in mental health field	Membership of relevant professional body with code of ethics; membership Counselling Special Interest Group of Canadian Fertility and Andrology Society; comprehensive/current knowledge of infertility; competence in counselling; engaged in CPE
Europe	Guidelines of Psychosocial Special Interest Group of European Society of Human Reproduction and Embryology ^d	Graduate level degree	Varies among countries
Germany	Guidelines of Beratungsnetzwerk Kinderwunsch Deutschland ^e	Professional qualification in a psychosocial discipline	Accredited membership of Beratungsnetzwerk Kinderwunsch Deutschland; completed training in counselling/therapy; minimum 2 years clinical experience; minimum 12 months clinical experience providing infertility counselling; engaged in CPE; evidence-based knowledge of psychosocial implications of infertility
Spain	Legislation (Law 14/2007, of 3 July, on Biomedical Research) and professional guidelines of Grupo de Interés de Psicología Sociedad Española de Fertilidad	Professional qualification in psychology; Masters level recommended	None specified
Switzerland	Legislation (Loi fédérale sur la procréation médicalement assistée (LPMA) of 18 December 1998)	Recommended graduate level degree in psychology, psychiatry, ob/gyn special counselling	None specified
UK	Legislation (Human Fertilisation and Embryology Act 2008); regulatory requirements ^f and professional guidelines of British Infertility Counselling Association ^g	Diploma level or above in counselling, clinical psychology, counselling psychotherapy, psychotherapy	Accreditation by British Infertility Counselling Association (or working towards accreditation); membership (or working towards membership) of recognized professional counselling body with complaints/disciplinary procedure
USA	Professional guidelines of Mental Health Professional Group of American Society of Reproductive Medicine ^h	Graduate level degree in mental health profession	State license to practice; minimum 12 months clinical experience providing infertility counselling; engaged in CPE; training in medical and psychological aspects of infertility

Adapted from: Haase and Blyth (2006) Global perspectives. In: Covington, S. and Burns, L.H. (eds). *Infertility Counseling: A Comprehensive Handbook for Clinicians*, 2nd edn. New York: Cambridge University Press, pp. 561–562, Appendix 2.

^aFertility Society of Australia Reproductive Technology Accreditation Committee (2008).

^bAustralian and New Zealand Infertility Counsellors Association (2003).

^cCanadian Fertility and Andrology Society Counselling Special Interest Group (2009).

^dPsychosocial Special Interest Group of the European Society of Human Reproduction and Embryology (2001).

^eBeratungsnetzwerk Kinderwunsch Deutschland e.V. (2009a, b, c, 2010a, b).

^fHuman Fertilisation and Embryology Authority (2009).

^gBritish Infertility Counselling Association (2007).

^hAmerican Society for Reproductive Medicine Mental Health Professional Group (1995).

Table II Areas of practice and counselling guidelines.

	Australian and New Zealand Infertility Counselling Association	American Society for Reproductive Medicine	British Infertility Counselling Association	Beratungsnetzwerk Kinderwunsch Deutschland e.V.	Counselling Special Interest Group of the Canadian Fertility and Andrology Society	European Society of Human Reproduction and Embryology	Grupo de Interés de Psicología Sociedad Española de Fertilidad	Sociedad Argentina de Medicina Reproductiva
Semen donation	I	2	16, 17, 18	25	28	29	34	35, 36
Oocyte donation	I	2	16,17		28	29	34	35, 36
Patients using own gametes	I		16		28	29	34	35, 36
Donors/surrogates	I	3	16, 17, 19	25**	28		34***	
Embryo donation	I	2	17		28	29	34	
Donation involving family members/known donation	I	4		25	28	29		
Multiple pregnancy/births	I				28	29	34	35, 36
Pre-implantation genetic diagnosis			16		28	30	34	35, 36
Lesbian couples	I		16			29	34	35, 36
Patient/donor evaluation/assessment		5		26		29; 31	34	35, 36
Single women without a partner	I		16			29	34	35, 36
Gestational surrogacy	I*	4	19		28	29; 32		
Disclosure of information to donor-conceived children		6	20				34	35, 36
Concluding treatment, without achieving pregnancy	I					29	34	35, 36
Genetic surrogacy	I*	4	19			29; 32		
Sexual problems			21			29	34	35, 36

Continued

Table II Continued

	Australian and New Zealand Infertility Counselling Association	American Society for Reproductive Medicine	British Infertility Counselling Association	Beratungsnetzwerk Kinderwunsch Deutschland e.V.	Counselling Special Interest Group of the Canadian Fertility and Andrology Society	European Society of Human Reproduction and Embryology	Grupo de Interés de Psicología Sociedad Española de Fertilidad	Sociedad Argentina de Medicina Reproductiva
Adoption			22,23			29	34	35, 36
Donor-conceived children/adults			20	25	28		34	
Fertility preservation for medical reasons		7			28		34	35, 36
Fertility preservation for social reasons		8			28		34	35, 36
Pregnancy following treatment	I					29	34	35, 36
Posthumous-assisted conception		9	16		28			
HLA tissue typing			16		28		34	
Cross border reproductive care				27		33	34	
Group work/ counselling			24				34	35, 36
Pregnancy loss during fertility treatment	I						34	35, 36
Treatment when prognosis is poor		10					34	35, 36
Financial compensation of donors		11					34	35, 36
Repetitive oocyte donation (donors)		12					34	35, 36
Oocyte donation for post-menopausal women		13					34	
Human somatic cell nuclear transfer (cloning)		14						

Human immunodeficiency virus and infertility treatment	15		
Migrant populations		29	
Sex selection			35, 36
Telephone counselling		29	

1. Australian and New Zealand Infertility Counsellors Association (2003); *ANZICA does not distinguish different types of surrogacy.
2. American Society for Reproductive Medicine Practice Committee and Society for Assisted Reproductive Technology Practice Committee (2008a).
3. American Society for Reproductive Medicine Ethics Committee (2009a).
4. American Society for Reproductive Medicine Ethics Committee (2003).
5. American Society for Reproductive Medicine Ethics Committee (2009b).
6. American Society for Reproductive Medicine Ethics Committee (2004a).
7. American Society for Reproductive Medicine Ethics Committee (2005).
8. American Society for Reproductive Medicine Practice Committee and Society for Assisted Reproductive Technology Practice Committee (2008b).
9. American Society for Reproductive Medicine Ethics Committee (2004b).
10. American Society for Reproductive Medicine Ethics Committee (2009c).
11. American Society for Reproductive Medicine Ethics Committee (2007).
12. American Society for Reproductive Medicine Practice Committee (2008).
13. American Society for Reproductive Medicine Ethics Committee (2004c).
14. American Society for Reproductive Medicine Ethics Committee (2000).
15. American Society for Reproductive Medicine Ethics Committee (2010).
16. British Infertility Counselling Association (2007).
17. Blyth (2007a).
18. Snowden and Snowden (1997).
19. Baron *et al.* (2007).
20. British Infertility Counselling Association (2003).
21. Read (2011).
22. Bingley Miller (2005).
23. Naish (1997).
24. Wheeler (1998).
25. Beratungsnetzwerk Kinderwunsch Deutschland (2009a); ** Sperm donors only since oocyte and embryo donation and surrogacy are not permitted under German legislation.
26. Beratungsnetzwerk Kinderwunsch Deutschland (2009b).
27. Thorn and Wischmann (2009).
28. Canadian Fertility and Andrology Society Counselling Special Interest Group (2009).
29. Psychosocial Special Interest Group of the European Society of Human Reproduction and Embryology (2001).
30. Shenfield *et al.* (2003).
31. Pennings *et al.* (2007).
32. ESHRE Task Force on Ethics and Law *et al.* (2005a).
33. Pennings *et al.* (2008).
34. Grupo de Interés de Psicología Sociedad Española de Fertilidad (2010); ***Donors only since surrogacy illegal in Spain.
35. Fernández and Girolami (2006a).
36. Fernández and Girolami (2006b).

support and therapeutic counselling, although it did not separately distinguish information counselling (Human Fertilisation and Embryology Authority, 1991). Two other counselling bodies, the Psychosocial Special Interest Group of the European Society of Human Reproduction and Embryology (2001) and the Australian and New Zealand Infertility Counsellors Association (2003) have subsequently endorsed implications, support and therapeutic counselling and—like the HFEA—neither adopted the notion of ‘information counselling’. ANZICA proceeded to identify two additional forms of counselling: decision-making counselling and crisis counselling. These five different forms may be defined as follows:

- (i) *Implications counselling*: the exploration of personal and family implications of infertility and infertility treatments and gamete donation, requiring the skills of a trained psychosocial counsellor. In general such counselling would be undertaken prior to commencement of the procedure or whenever a significant change in treatment is contemplated, so as to allow sufficient reflection before making any irrevocable decision. Implications counselling may also be necessary after treatment, for example, when an individual or couple has to deal with the reality, as opposed to contemplating the possibility, of parenting an ART-conceived child.
- (ii) *Support counselling*: the provision of emotional and psychological support throughout the process of diagnosis, investigation and treatment and gamete donation, to assist patients to deal most appropriately with the experience and/or consequences of their treatment. Such counselling may be provided by the range of professionals working in the team, and not only by the designated infertility counsellor.
- (iii) *Therapeutic counselling*: focused on mediating the more pervasive upsetting and stressful consequences of both impaired fertility and fertility treatment. Such counselling may require skills and expertise beyond those possessed by the clinic counsellor, and may require referral to a specialist counsellor, e.g. bereavement counsellor, sex therapist. In such situations, it is especially important for the infertility counsellor both to recognize the limits of their own competence and to know when to seek the specialist help required.
- (iv) *Decision-making counselling*: counselling available to patients at significant points in their decision-making around management of fertility treatment. (Although ANZICA refers to decision-making counselling in respect of patients only, operation of a sufficiently holistic service suggests that this should also be offered to donors and surrogates and to their spouse/partner (if any).
- (v) *Crisis counselling*: for patients experiencing a crisis or adverse outcome while undertaking fertility treatment. (as with decision-making counselling, ANZICA relates crisis counselling to involvement with patients only, however, there would seem to be every reason to offer such counselling also to donors and surrogates and to their spouse/partner (if any).

Counselling practice in relation to specific elements of ART

As noted above, several national infertility counselling associations have produced general guidelines, while both Beratungsnetzwerk Kinderwunsch Deutschland and the British Infertility Counselling

Association have produced guidelines dealing with specific practice areas and issues.

In addition to guidelines produced specifically by, or for, psychosocial counsellors, an analysis was undertaken of reports produced by the American Society for Reproductive Medicine Ethics and Practice Committees, and the European Society for Human Reproduction and Embryology Task Force on Ethics and Law, published in ‘Fertility & Sterility and Human Reproduction’ respectively, that contained specific reference to ‘counselling’.

This review identified reference to ‘counselling’ in 12 ASRM Ethics Committee reports, 24 ASRM Practice Committee reports and 9 ESHRE Law and Ethics Task Force reports, of which references to psychosocial counselling in 11 ASRM Ethics Committee reports, 3 ASRM Practice Committee reports and 4 ESHRE Law and Ethics Task Force reports were either specific or could be reasonably inferred.

References to counselling in several ESHRE Law and Ethics Task Force reports proved especially challenging. Unambiguous recognition of psychosocial counselling is acknowledged in a single report, pre-implantation genetic diagnosis (Shenfield *et al.*, 2003). The Task Force’s report on oocyte donation for non-reproductive purposes (2007: 1213) refers to counselling by an ‘independent counsellor not involved in the research project’ that ‘should be obligatory for all donors’ (2007: 1212). The report on posthumous-assisted reproduction (2006: 3053) makes an ambiguous reference to ‘the usual counselling’. In its reports on ethical considerations for the cryopreservation of gametes and reproductive tissues for self-use (2004: 461) and the application of pre-implantation genetic diagnosis for human leukocyte antigen typing of embryos (2005a, 846) reference is made not only to counselling in general but also to ‘implication counselling’. However, it is unclear whether the latter term has the same meaning as has been used previously in this article and would be understood as such in psychosocial counselling circles. The report on cross border reproductive services specifies that:

When a physician refers patients to centres abroad, he or she should also provide counselling in order to make sure that they know what will happen, what kind of questions they should ask etc’ (Pennings *et al.*, 2008: 2183).

While the report expands on this to some extent by advocating the establishment of a system of clinic certification to include the provision of adequate psychological counselling in order to ensure the provision of ‘safe and effective treatment’ (Pennings *et al.*, 2008: 2184), the report overall is notable for its exclusive focus on patients only, with no reference to the interests of any third party who might be involved in, or affected by, cross border services.

Specification of the topic areas from all the above sources illustrates the broad range of areas in which a role for psychosocial counselling has been identified (Supplementary data, Table SI)—35 in total. This categorization also highlights general areas of consensus among different professional bodies and across national boundaries as well as differences in emphasis. Twenty one, i.e. almost two-thirds, of the 35 specified areas received four or more citations (i.e. they were cited in at least half of the eight geographical areas for which information is available):

- (i) semen donation,
- (ii) oocyte donation,

- (iii) patients using their own gametes,
- (iv) donors/surrogates,
- (v) embryo donation,
- (vi) donation involving family members/known donation,
- (vii) multiple pregnancy/births,
- (viii) pre-implantation genetic diagnosis,
- (ix) lesbian couples,
- (x) patient/donor evaluation/assessment,
- (xi) single women without a partner,
- (xii) gestational surrogacy,
- (xiii) disclosure of information to donor-conceived children,
- (xiv) concluding treatment without achieving pregnancy,
- (xv) genetic surrogacy,
- (xvi) sexual problems,
- (xvii) adoption,
- (xviii) donor-conceived children/adults,
- (xix) fertility preservation for medical reasons,
- (xx) fertility preservation for social reasons and
- (xxi) pregnancy following treatment.

On the basis of an, albeit overtly simplistic, frequency count, it could be tentatively proposed that these represent an identifiable core of psychosocial counselling interest and activity, in which collaborative reproduction involving a third-party features prominently.

Counselling and evaluation/assessment

The frequency of citations to patient/donor evaluation/assessment is also a noticeable feature and represents a fault-line that has exercised the profession from its earliest days (Blyth and Hunt, 1994). For example, the UK's Warnock Committee unequivocally stated that:

the counselling that we envisage is essentially *non-directional*. It is aimed at helping individuals to understand their situation and to make their own decisions about what steps should be taken next (DHSS, 1984, 3.4—my emphasis).

This is a model of counselling that the majority of infertility counsellors would endorse and, indeed, one authoritative infertility counselling text is unambiguous on this point:

We [...] believe that because fertile individuals are not assessed for parental fitness in advance of becoming parents, it may be discriminatory to assess infertile individuals for parental fitness in advance of becoming parents (Horowitz, Galst and Elster, 2010: 41).

However, reference to the need to take account of the 'welfare of child', whether given statutory force or emphasized in professional body guidance only (Blyth, 2007b) has confounded infertility counsellors' ability to completely distance themselves from undertaking evaluative and gate-keeping functions. The UK's statutory requirement to take account of the welfare of the child impacted the deliberations of the influential Kings Fund Counselling Committee (1991), which concluded that 'it will be impossible to separate the process of counselling from consideration of the welfare of the child' (King's Fund Centre, 1991). While the inherent tensions between the provision of counselling and assessment were subsequently acknowledged by the HFEA (HFEA, 2009: 3.7), the HFEA also endorsed the King's Fund's observations, and infertility counsellors are explicitly enjoined to participate in welfare of the child assessments that may determine

the eligibility of individuals to donate gametes or embryos and to receive treatment (HFEA, 2009: 8.7; 8.16).

Victoria's Assisted Reproductive Treatment Act 2008, has probably gone furthest in involving counsellors in formal assessment processes. The Act requires a counsellor providing counselling to any patient, and her partner (if any), to confirm that a criminal records check has been undertaken in relation to the woman (and her partner). The Act further specifies that a presumption against treatment will apply where a criminal record check specifies that either the woman or her partner have been convicted of a specified sexual or violent offence, or have been subjected to a child protection order removing a child from the custody or guardianship of either partner. In New Zealand, embryo donation attracts more stringent requirements than does gamete donation, where prospective recipients of donated embryos must also submit to a criminal record check as well as obtain advance permission from the Advisory Committee on Assisted Reproductive Technology (ACART). Similarly, permission from ACART is required in advance of any surrogacy arrangement in New Zealand, while broadly similar provisions apply in respect of a gestational surrogacy arrangement in Victoria, which requires the advance approval of a Patient Review Panel. A request for a surrogacy arrangement in Western Australia requires prior approval from the state Reproductive Technology Council. In addition, patients and the surrogate (and the surrogate's partner if she has one) are required to undergo one or more implications counselling sessions with an infertility counsellor and a psychometric evaluation conducted by a clinical psychologist. In addition, the arrangement cannot proceed until expiry of a 3 months 'cooling off' period following initial counselling.

Three of the reports produced by the ESHRE Task Force on Law and Ethics [surrogacy (2005b); the welfare 351 of the child in medically (Pennings et al., 2007)] and the ASRM Ethics Committee 352 [child-rearing ability (2009b)] also refer to the legitimacy of undertaking evaluations to determine patient eligibility for treatment and the proposed surrogate's suitability to proceed with the arrangement. Neither of the ESHRE reports specify who should undertake these tasks and while the ASRM report focuses predominantly on the responsibilities of physicians, it acknowledges that assessment of a patient's child-rearing ability should be made jointly among programme members: 'This might involve evaluation by a mental health worker and consideration by psychological or other consultants culminating in a group assessment or review prior to a final determination'. (American Society for Reproductive Medicine Ethics Committee, 2009b: 867).

Another shift from purely non-directive intervention may be discerned in the provision of psycho-educational information provided by counsellors (and by other professionals providing treatment) as illustrated by changing attitudes towards gamete donation. Historically—and especially when secrecy and donor anonymity tended not to be viewed by professionals, lawmakers or regulators as at all untoward—potential recipients of donated gametes tended to be advised to consider the 'pros and cons' of disclosure versus non-disclosure in a characteristically *laissez-faire* fashion. However, in a surprising change of tack following its review of the operation of the 'welfare of the child' requirement, the UK's HFEA abandoned its hitherto 'even-handed' stance and openly advocated for parents to be advised of the benefits of early disclosure to the child. Even more remarkably, perhaps, this injunction has now received statutory reinforcement following the 2008 revisions to the Human Fertilisation

and Embryology Act (Blyth, 2008). Similar developments are evident in Australia (National Health and Medical Research Council, 2007) and the USA (American Society for Reproductive Medicine Ethics Committee, 2004a)—albeit without legislative underpinning.

Discussion

This article represents the first attempt to bring together the various elements that comprise contemporary guidelines for infertility counselling issued by national and supra-national professional bodies. It has charted the continuing evolution in the role of infertility counselling and examined the commonalities and disparities between these guidelines. It shows the need to strengthen international support for psychosocial counselling for infertile individuals whether they are using their own or donated gametes or embryos, or whether they are assisted by a surrogate, as well as for any donors and surrogates and their partners, so as to reduce its marginalization in comparison to medical aspects of ART.

This review has identified four broad areas providing a lens through which contemporary infertility counselling may be examined: (i) the legal mandate for counselling; (ii) eligibility credentials for individuals carrying out professional counselling activities; (iii) different forms of counselling and (iv) counselling practice in relation to specific elements of assisted reproduction treatment. Considerable variations exist regarding the mandating of counselling and prescription of counsellors' roles. In jurisdictions in Australia, New Zealand and the UK, counselling is both mandated and prescribed, and counsellors have been actively engaged in defining both its role and scope (Blyth and Hunt, 1994; Haase and Blyth, 2006; Blyth, 2008). In other areas, professional guidelines produced either by dedicated infertility counselling organizations or by multi-disciplinary professional bodies have endeavoured to achieve similar objectives but, for obvious reasons, with less prescriptive influence. Taken as a whole, however, while the remit of current legislation and professional guidance impacts the major geographical sites of service provision in reproductive technology, the exclusion of large swathes of the world where ART is practiced is evident (Jones *et al.*, 2011). Much the same is true of the second area identified in this review, eligibility credentials for individuals carrying out professional counselling activities. The third area identified, discrete forms of infertility counselling, highlights the impact of the UK's King's Fund (1991) in drawing the conceptual map for psychosocial counselling. While this framework has largely withstood the test of time, it has now been extended through additional work undertaken by the Australian and New Zealand Infertility Counsellors Association (2003). The final area examined here has begun to identify an emerging core of infertility counselling practice in which collaborative reproduction features very strongly and which also exposes the tension evident between counsellors' role as gatekeepers to services versus their non-directive role as psychological counsellor or impartial provider of psycho-educational information. This issue will almost inevitably continue to be a major discussion point within the profession.

In the three decades during which infertility counselling has evolved, a fairly sound base has been established from which improved international standards can be further developed. Two specific areas require the immediate attention of national and supra-national infertility counselling bodies and by national and supra-national bodies that ostensibly represent a range of professional interests within the ART community.

First, is how to address the challenge for small countries with few ART providers and therefore few counsellors, without unnecessarily 'reinventing the wheel' or importing/exporting models developed elsewhere that pay scant regard to local conditions. For example within Europe alone, Iceland and Latvia are each reported to have a single ART clinic, Albania and Montenegro each have two clinics, and Lithuania, Macedonia and Slovenia each have three (de Mouzon *et al.*, 2010). In this regard, there would seem to be a role for the international infertility counselling community in developing a mutually agreed framework and facilitating the sharing of expertise from well-established national bodies that can be appropriately indigenized, especially as regards local laws, customs and values.

The second area warranting prompt remedy is, to ensure an effective counselling 'voice' within the multi-disciplinary professional bodies. This is especially pertinent in the production of reports that have not been authored specifically by infertility counsellors, so as to ensure appropriate acknowledgement of psychosocial issues and draw on the knowledge and expertise that counsellors have to offer. While it is impossible to infer a simple cause–effect relationship, arguably, the greater recognition of the role of psychosocial counselling in ASRM Ethics committee reports may be due to the membership on the committee of a member of the Mental Health Professional Group. By contrast, membership of the ESHRE Task Force on Ethics and Law represents the perspectives and expertise of ethicists and clinicians only, and thus, given the focus of most of the Task Force reports, opportunities for the professional body to ensure adequate recognition of the role and contribution of psychosocial counselling have been missed. Consequently, there would appear to be a strong case for mental health professional members to argue for more broadly based representation on opinion-forming bodies within ESHRE in order to facilitate a more holistic approach to the specific issue under review. Allied to this latter point, at the global level, the lack of accurate information regarding counselling in the IFFS 2010 Surveillance report (and previous IFFS Surveillance reports) needs to be redressed expeditiously. There is a clear case for IICO and IFFS to establish effective liaison to ensure that the next surveillance survey is used to generate more extensive and accurate information regarding psychosocial counselling.

Conclusions

This article has identified and evaluated the current evidence-base that comprises documented guidelines for infertility counselling. Although the global picture is mixed, in some parts of the world, counselling has established a measure of professional security through legislation and regulation. Although the development of infertility counselling must still be considered a 'work in progress' the article indicates directions in which further progress and development can be undertaken (Table II).

Supplementary data

Supplementary data are available at <http://humrep.oxfordjournals.org/>.

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