# Australian & New Zealand Infertility Counsellors Association

## GUIDELINES FOR PROFESSIONAL STANDARDS OF PRACTICE

### INFERTILITY COUNSELLING

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INFERTILITY COUNSELLING

Preamble: The laws, and regulations, relating to the treatment of infertility differ for each Australian state/territory and New Zealand. It is the responsibility of individual infertility counsellors to be fully aware the laws and regulations of their particular legislature.

SECTION 1 COUNSELLING & INFERTILITY TREATMENT

1.1 GENERAL PARAMETERS

1.1.1 Infertility counselling is a specialist form of counselling. Infertility counsellors are tertiary trained with a primary qualification in social work, psychology or psychiatry. They will be eligible for full membership of their appropriate professional association and/or registered to practise within their state (or equivalent jurisdiction). ANZICA (Australian and New Zealand Infertility Counsellors Association) is the professional association for infertility counsellors practising in Australia and New Zealand. Infertility counsellors are expected to be members of ANZICA. (ANZICA membership is required if attached to an ART clinic) It is incumbent on all infertility counsellors to have and maintain a comprehensive knowledge of the contemporary human reproductive technologies, the legislative frameworks within which the technologies are practised and the emotional/ psychological experiences and needs of infertility patients and other relevant third parties.

1.1.2 ART clinics are required by both the various regulatory/licensing bodies and by the FSA (Fertility Society of Australia) through RTAC (Reproductive Technology Accreditation Committee) to engage the services of at least one suitably qualified, accredited and affiliated infertility counsellor. Infertility counsellors may be employed by the clinics, or may be engaged on a sessional/ contractual basis. Infertility counsellors also practise independently in the community, either as private practitioners, through generic medical practices, or attached to other specialist services such as genetic counselling services. It is preferable that all persons requiring infertility counselling can access a counsellor in the setting and at a time which best suits their needs.

1.1.3 ANZICA strongly recommends that all participants in infertility treatment should attend counselling at least once during treatment. It is preferable that the counselling be made available prior to the commencement of treatment (and the completion of informed consent) and that additional sessions be available on an “as needed” basis, before, during and after treatment.
1.1.4. It is a requirement of RTAC that all parties to a treatment involving other parties to the treatment must have counselling prior to commencing treatment (see Section 2).

1.1.5. In order to make infertility counselling accessible to all who require it, it is important that it be available in various modalities (singularly or in combination). These include face-to-face counselling, telephone counselling and support groups (professionally facilitated). Counsellors also use resources such as written and video presentations and e-mail in the provision of services.

1.1.6. Whilst a mandate for assessment per se does not exist, counsellors in the course of their work may identify significant “risk factors”. In extreme circumstances these may impact on clinical decision making. NHMRC guidelines recommend that: reproductive procedures should only be carried out with due regard to the long term health and psychosocial welfare of all participants, in particular the men and women who undergo treatment. When considering treatment, clinicians should take particular care with participants who are at serious risk of substantive adverse affects on their health as a result of either treatment or pregnancy. Such concerns should be discussed and resolved within the clinic setting.

1.2. TYPES OF COUNSELLING; FOCUS & CONTENT OF SESSIONS

It is generally understood that there are different forms of counselling that can be provided in conjunction with infertility treatment, these are implications counselling, decision making counselling, supportive counselling, crisis counselling, and therapeutic counselling.

1.2.1 IMPLICATIONS COUNSELLING

Counselling prior to the commencement of treatment is “implications counselling”. This is an opportunity to ensure that the patient(s) understand the implications of the proposed treatment for themselves(s), their family and any child born as a result of treatment. It is important that patients’ concerns/questions are addressed, in addition to the counsellor providing relevant information.

Specifically, the counsellors’ tasks are to:

- acknowledge the impact and meaning of infertility for the patient(s),
- describe the role and availability of the counsellor in the clinic,
- establish rapport in the event that further counselling is necessary,
- assist with the clarification of the potential impact of the proposed treatment (particularly the psychosocial), identify the more demanding aspects of treatment, address the patients’ concerns and provide supplementary information and resources as appropriate,
• encourage patients to develop realistic expectations about the outcome of treatment,
• promote discussion about appropriate coping strategies, and
• support and enhance the patients’ capacity for decision making in relation to treatment.
• assist patients to understand the legal framework and limitations within which infertility treatment is available.

1.2.2 DECISION MAKING COUNSELLING

Counselling must be available to patients at significant points in their decision making around management of ART treatment. The counsellor’s role is to enhance the patients’ capacity for informed decision making in relation to treatment and in particular to reflect on the short and long term psychological implications of the decision. Points for decision making would include,
• consideration of undertaking treatment involving further parties to the treatment (see Section 2),
• stopping treatment,
• disposition of embryos.

1.2.3 SUPPORT COUNSELLING

Support counselling can be provided at any phase of the treatment process. It’s primary purpose is to provide emotional/psychological support to assist patients better deal with the experience and/or consequences of their treatment. Support counselling may be brief or long term. During these sessions, the counsellor will assist the patient(s) to mobilise their own resources. Common antecedents for seeking support counselling are:
• non pregnancy cycles/treatment failure,
• facilitating cognitive and affective shifts so that patients can better manage the emotional and physical demands of treatment (eg. balancing failure, fear and hope; regaining a positive attitude),
• reviewing stress management/coping skills and self care strategies, and
• preparing for a multiple birth.

1.2.4 CRISIS COUNSELLING

Counselling must be available to patients who experience a crisis or adverse outcome whilst undertaking ART treatment. Common reasons for seeking crisis counselling are:
• unexpected outcome of treatment e.g. no fertilisation
• pregnancy loss

Appropriate counselling models for Support Counselling and Crisis Counselling include problem solving, cognitive behavioural and brief therapy/solution focussed approaches.

1.2.5 THERAPEUTIC COUNSELLING

Therapeutic counselling is most often concerned with the more pervasive, disturbing and distressing consequences of both infertility
and fertility treatment. It will assist patients to address their
distress and facilitate movement toward adjustment, resolution and/or
acceptance. Common antecedents for seeking therapeutic counselling are:
• clinical disorders such as depression, anxiety and panic states,
• marital/relationship difficulties, including sexual difficulties
and dysfunction,
• damaged self esteem,
• grief and loss issues related to infertility, pregnancy loss,
repeated treatment failure,
• development of alternative self concepts and life plans, and
• preparing for and adjusting to parenthood after a long period of
infertility.

A range of models have been applied to Therapeutic Counselling for
infertility patients. These have been shaped by a variety of
theoretical frameworks including cognitive behavioural techniques,
problem solving approaches, experiential grief counselling, Brief
Therapy and Solution Focussed models, crisis intervention,
relationship/marital therapies and more psychodynamically oriented
psychotherapy.

1.3 PARTICULAR ISSUES

1.3.1 CONCLUDING TREATMENT, WITHOUT ACHIEVING PREGNANCY

The decision to conclude treatment where the patient(s) have not been
successful in achieving a pregnancy is usually a very difficult and
protracted decision to make. Issues which may need to be addressed
are:
• Assisting couples to end treatment despite the continuing
availability of treatment which could still offer them the chance
of a pregnancy.
• Exploring the meanings, for them, of the loss/end of a
significant life goal. Facilitating their emotional responses to
this loss and their movement toward alternative life goals.
• Addressing the differences between the partners as to their
readiness to conclude treatment.
• Assisting patients to explore other options to achieve
parenthood.

1.3.2 FERTILITY TREATMENT & PREGNANCY LOSS

The emotional experiences and needs of infertility patients who lose
the pregnancy that they achieved through fertility treatment are often
intense and complex. Issues to be addressed in counselling may include:
• The need for patients to actively grieve their loss, adopt
effective self care strategies, elicit appropriate support and
make decisions re future treatment.
• Variable responses between partners to their loss; this can lead
to experiences of being misunderstood by the other, a perceived
lack of support by one partner to another and a loss of intimacy.
1.3.3 PREGNANCY AFTER TREATMENT

Infertility patients often struggle to make the transition to being pregnant, especially after a difficult and lengthy period of treatment. Examples of the type of issues that they may need to address are:

- Dealing with the multiplicity of emotions, often conflictual, in the early stages after the patient(s) first learn of the pregnancy (e.g., joy and excitement, disbelief and ambivalence, apprehension and fear, “infertile” now pregnant).
- Facilitating role transitions and managing/adjusting to the different demands and experiences of the different roles (e.g., no longer attending the fertility clinic and accessing the supports available in that context).
- Addressing concerns about the patient(s) future ability to parent.

1.3.4 MULTIPLE PREGNANCY

Patients vary in their responses to the news of a multiple pregnancy. It is more likely that patients who are distressed and experiencing difficulties adjusting to the reality of a multiple pregnancy will present for counselling. Typical issues for this patient group include:

- Adjusting to the realities of a “high risk” pregnancy, the antenatal and post-natal implications, for the mother and the babies.
- Preparing for parenting two or three children of the same age and the emotional, practical, physical and financial implications for the couple/parent.
- Explore the possibility of foetal reduction, where this is legally permissible. If proceeding, prepare patients for the emotional consequences.
- Enable patients to explore their emotional responses to their “high risk” pregnancy. This is often a complex emotional experience, with a range of conflicting emotions.
SECTION 2 DONATION OF GAMETES & EMBRYOS

2.1 GENERAL PARAMETERS

2.1.1 It is an RTAC requirement that all donors, recipients and their respective partners must have counselling prior to treatment commencing from an accredited ANZICA counsellor.

2.1.2 Counselling prior to the commencement of treatment utilising donated gametes will include in particular therapeutic counselling and decision making counselling. The other forms of counselling, supportive, crisis and implications counselling should also be available.

2.1.3a THERAPEUTIC COUNSELLING

Therapeutic counselling for the recipients will assist them to address their adjustment, resolution and decision to use donated material. In particular

- grief and loss issues associated with not using their own gametes
- impact of self esteem and identity
- impact of use of donor material on relationship, including sexual relationship.
- development of amended self concept and plans re conception.

2.1.3b DECISION MAKING COUNSELLING

Counselling patients in relation to the donation/ receipt of donated gametes and embryos must include:

- motivations of donor and recipients, in the context of their family and social history
- recipients’ and donors’ feelings about non genetic parenting
- examination of the risks and benefits of donation
- short and long term consequences for all parties concerned, including the donation may result in an adverse outcome
- exploration of the acknowledged importance that donor information be accessible for any donor conceived person and the future availability of donors for information about identity
- attitudes to telling others and plans to disclose donor conception to children
- relevant federal and state legislation
- relevant RTAC/NHMRC guidelines.

2.1.4 Counselling must be provided prior to the signing of (informed) consent and treatment commencing.

2.1.5 At least one session of counselling per party is to be provided, with further sessions to be available should any party consider this necessary. “Known” donors and recipients are to attend separate sessions in addition to a joint session involving all parties prior to proceeding with signing of consent.
2.1.6 A “cooling off” period is recommended for all parties before signing consent and proceeding to treatment to allow thorough consideration of the issues raised in counselling.

2.2 CONTENT OF SESSIONS – ALL DONORS

This section will highlight issues to be included in a thorough counselling session for a donor (and their partner) by clarifying issues pertaining to motivation, their social situation, their understanding of the implications of treatment including legal and procedural issues, and issues related to the donor conceived person.

2.2.1 MOTIVATION
- Reasons for wishing to be a donor.
- Exploration of factors motivating donation (eg altruistic/compassionate; moral/ethical; financial reimbursement; personal, including genealogical posterity).
- Catalyst for presenting for donation.
- Donor’s knowledge and experience of infertility on a personal, familial and social level.
- Length of time they have considered decision to become a donor.
- Comfort with donation evidenced by discussion with others.
- Expectations of donation.

2.2.2 SOCIAL SITUATION
- Current family situation and the implications of donation for significant others.
- Partners attitude to donation and implications of donation on possible future partners.
- Donor’s reproductive status. Does the donor have their own children or have plans for future children? Any issues related to age, custody, gender, past reproductive losses.
- How might donating gametes/embryos impact on existing and future children, or future fertility?
- Relevant psychosocial history. Consider adoption experiences, major psychopathology or chemical dependency, physical, sexual or emotional abuse.
- Relevant family of origin issues.
- Evidence of stable and satisfying relationships.
- Cultural, religious and moral issues to be addressed.
- Extent to which they will be able to “let go” of their gametes/embryos; any potential that they will inadvertently creating a burden through continuing curiosity, concern for donor conceived person, risk for grieving the loss of perceived potential child.

2.2.3 LEGAL ISSUES
- Extent of donor’s/recipients right to change their mind/withdraw consent.
- Implications of anonymity and confidentiality of medical records.
- “Ownership” of gametes/embryos and legal parentage of donor conceived person, disposition of remaining embryos.
• Donor conceived persons’ legal entitlements for information including information to be kept with Donor Register or a voluntary register if existent.
• Possibility of future legislative changes.

2.2.4 PROCEDURAL ISSUES
• Understanding of the process in becoming a donor and procedures involved when donating.
• Understanding of the implications of pre-screening tests for themselves and their extended families
• Realistic expectations about physical discomfort of treatment and time commitments.
• Understanding of the chances of a successful outcome as a result of the donation. Consideration of the impact of possible treatment failure.
• Availability of support (emotional and practical) during course of treatment.

2.2.5 ISSUES RELATED TO DONOR CONCEIVED PERSON
• The concept of “in the best interests of the child” should be reflected in policies and procedures of clinics and infertility counsellors. Donors and recipients need to be educated regarding this concept, particularly in relation to the right of an individual to information about their genetic origins

2.2.6 EMBRYO DONATION - ADDITIONAL ISSUES
• Discuss the decision making process and the extent of agreement between the couple about donating their embryos.
• Origins of gametes (couple’s sperm and ova, donated sperm or ova) and any influence this may have on their decision to donate.
• Outcome of their fertility treatment and how this relates to their decision to donate now. Implications should they consider resuming treatment at a later date.
• Exploration of attachment to their embryos and their capacity to “let go”.

2.3 CONTENT OF SESSIONS - ALL RECIPIENTS
This section will highlight issues to be included in a thorough counselling session for the recipients by clarifying issues pertaining to motivation, their social situation, their understanding of the implications of treatment including legal and procedural issues, and issues related to the donor conceived person.

2.3.1 MOTIVATION
• Meaning of infertility to the couple and their resolution of infertility issues (is there any anger, resentment or blame?)
• Catalyst for initiating treatment.
• Consider the couple’s decision making process regarding treatment and the extent of agreement between the partners.
• Review the decision making and the recipients’ preference(s) for “recipient” or “clinic recruited” donation. Satisfaction with their choice of donor.
2.3.2 SOCIAL SITUATION

- Age(s).
- Any existing children (e.g. from a previous relationship) and possible impact on them?
- Wishes regarding family size.
- Relevant "family of origin" information/ issues.
- Any relevant social, psychological, psychiatric history (e.g. adoption experiences, depression)?
- Any issues that may impact on existing personal relationships?
- Desire/ opportunities to discuss plans with others; their reactions/ support?
- Are there any cultural, ethical/ moral issues to be addressed?
- Their understandings/ beliefs regarding the impact of genetic and social parentage.

2.3.3 LEGAL ISSUES

- Extent of donor’s/recipient’s right to change their mind/ withdraw consent.
- Information to be provided/ kept, and the Donor Register (and Voluntary Register where such exists).
- Implications of anonymity/ confidentiality of medical records.
- Donor offsprings’ legal entitlements for information.
- “Ownership” of gametes/ embryos and legal parentage of offspring, disposition of remaining embryos.
- Possibility of future legislative changes.

2.3.4 PROCEDURAL ISSUES

- Awareness of all aspects of treatment.
- Awareness of procedures specifically related to donation (e.g. matching/allocation, quarantine periods).
- Expectations of clinic, donor.
- Impact of possible treatment failure.

2.3.5 ISSUES RELATED TO DONOR CONCEIVED PERSON

- Their understanding of the needs of offspring (e.g. to be told of the nature of their conception, information available to them etc.).
- Current guidelines/ suggestions for “telling” donor offspring about the story of their conception.
- Knowledge of the donor’s motivation and the importance of having some information for the benefit of their offspring.

2.4 CLINIC RECRUITED DONOR –

2.4.1 ADDITIONAL ISSUES – DONOR

2.4.1 MOTIVATION

- Attitudes to prospective recipients of their donation.
- Their preference for the recipients of their donation and any wishes for restrictions. Who do they wish/ imagine the potential recipients to be; do they identify with potential recipients in any way, and is this related to their motivation?
2.4.2.2 LEGAL ISSUES

• Legal limit to number of recipients who can receive donated gametes.

2.4.1.3. ISSUES RELATED TO DONOR CONCEIVED PERSON

• attitude to the possibility that their donation may be used to assist conception in several different families.
• Their willingness to meet with recipients both prior to and after treatment (depending on clinic practice)
• Openness to providing more information and meeting offspring in the future, should this be possible and sought.
• Exploration of the issue of being genetically related to offspring that they may never know or meet.
• Discussion of possible actions should a previously unidentified heritable disorder be identified within their family subsequent to the donation.
• Exploration of whether they would, at some time, like to know the outcome of their donation, including non identifying information about the recipients, the number and gender of children born.
• Intentions about telling existing/ future children about unidentifiable genetically related siblings.
• Encouragement if necessary of donor(s) to provide detailed non identifying information in the event that they are not contactable or deceased when the donor offspring seeks information.

2.4.2 ADDITIONAL ISSUES RECIPIENTS

2.4.2.1 ISSUES RELATED TO DONOR CONCEIVED PERSON

• Attitude to donor(s) receiving non identifying information about the child(ren) born, and of themselves.
• Openness to the offspring meeting donor(s) in the future, should this be possible.
• Openness to providing updated information (identifying and/or non identifying) to the “Donor Register” and/or the “Voluntary Register”.

2.5. RECIPIENT RECRUITED DONORS

Where there are differences between the parties on significant matters, these should be identified to all parties and addressed in counselling. Further discussion would also focus on the parties preferred means of resolving any future differences.

If there are any indications that proceeding with treatment could result in tension or estrangement between any of the parties, then these could be discussed in counselling and the implications for treatment should be considered by the team.
2.5.1 ADDITIONAL ISSUES – DONOR

2.5.1.1 MOTIVATION

- Who initiated the possibility of donating (potential recipients, donor, family member, other)? Reactions and implications.
- Personal reasons for wishing to donate.
- Relationship (actual and desired) to the potential recipient(s). How does this relate to motivation. How could this impact on way in which important issues are discussed/ negotiated?
- Extent to which any coercion/ expectations exist.
- Expectations (overt and covert) the donor has of the potential recipients, now and in the future.
- Limits or conditions to their donating.

2.5.1.2 SOCIAL SITUATION

- Reactions, involvement and support, if applicable.
- Possible involvement of other family members/ friends (knowledge of the situation, their reactions, level of support).
- Plans re future children (especially relevant if potential donor has not yet had children.)
- Supports available to themselves, in addition to the anticipated support from the recipients.
- Consider possibility that they may not be a suitable donor, or may not be able to donate
- Capacity to “let go”, in view of this being a “known” donation.
- Expectations of the recipients in relation to treatment, post treatment (including ante natal testing of the foetus), future relationships with the recipients and the donor offspring.
- Impact on other children in their family; short and long term concerns and implications.
- Wishes regarding the disposition of remaining embryos (which belong to the recipients).
- If donation is cross generational, consider perceived and possible implications for donor, recipients, offspring and other family members; consider longer term implications.

2.5.1.3 ISSUES RELATED TO DONOR CONCEIVED PERSON

- Wishes regarding “disclosure”, in relation to offspring; implications for self and others. Need for discretion, given offspring need to be told the story of their conception by the recipients/ their parents.
- Wishes regarding their future relationship with offspring(s) and their role in the recipients’ and offspring(s)’ life.

2.5.2 ADDITIONAL ISSUES – RECIPIENTS

2.5.2.1 MOTIVATION

- Review choice of donor. Explore any concerns/ unresolved issues re choice.
- Explore any differences between the partners regarding choices and possible coercion /submission by one partner.
2.5.2.2 SOCIAL SITUATION

- Relationship with the donor(s); past, current and anticipated future relationship. Any concerns?
- Availability of support.
- Impact on the infertile partner (if applicable) of receiving “known” donated gameotes from a person that they know and are likely to have a future relationship with.
- Any other implications for the couple relationship?
- Implications for future relationship with the donor(s).
- If “interfamilial” / cross generational donation, implications for other family members, in both the short and long terms.

2.5.2.3 ISSUES RELATED TO DONOR CONCEIVED PERSON

- Recipients’ understanding of the needs of ‘donor offspring’ as they move through life, and of their responsibilities in relation to their needs.
- Their plans/ concerns re disclosure. The need for discretion by extended family members/ friends (and their children) where they are aware of the situation, so as to preserve the recipients’ right/responsibility and need to tell offspring themselves about the circumstances of their conception.
- Anticipated role of the donor(s) and the relationship between the donor(s) and the offspring.
- Anticipated relationship with possible (genetic) half siblings, full siblings in donor(s) family.

2.6 SOCIAL INFERTILITY

Women present for fertility treatment in the absence of a medical condition, rather they wish to become pregnant and they do not have a male partner. These women are either lesbian, with or without a partner, or they are single women, often of an older age. Treatment for these women will involve donated sperm (at least), where available. In addition to the above the following issues may also need to be addressed:

2.6.1 LESBIAN COUPLES

- The degree of resolution between the partners as to who will receive treatment and choice of donor.
- Explore any fears and anxieties they may have in relation to becoming parents and their sexuality, any concerns as to how this may impact on a child and how they might deal with this.
- Discuss matters in relation to “disclosure” and how their sexuality/family structure may influence the timing and the child’s need to understand their different circumstances
- Discuss the legal status of the child and the non biological mother.
- Explore how they will integrate the child into the extended family and social environment. Contact with families similarly constituted.
- Ascertain level of support, now and in the future, for their choice of family formation.
• Discuss the implications of the absence of a father for a child.

2.6.2. SINGLE WOMEN
• Explore their motivation to, and expectations of, becoming a mother.
• Explore the extent to which they have resolved the loss of their dreams to become a parent in the context of a relationship
• Discuss the personal, social and economic consequences of becoming a single parent.
• Discuss the imperative for support (immediately and in the short term) in relation to their decision, for the duration of treatment and during pregnancy/childbirth. If appropriate, suggest that they nominate a support person who can be available to them for the duration of treatment.
• Discuss matters related to “disclosure” and how their family structure may influence the child’s needs to understand their particular circumstances and the timing of the “disclosure”.
SECTION 3  SURROGACY

A significant degree of variation in the laws and practice of surrogacy exists between the Australian states/territories and New Zealand. In jurisdictions where surrogacy is legally sanctioned, the role and responsibilities of the infertility counsellor are very clearly defined. In other jurisdictions where surrogacy is not legally sanctioned, the role of the infertility counsellor has generally not been established or defined.

(If /when surrogacy becomes a more established and widespread practice, these guidelines will be further developed).

- It is an RTAC requirement that all parties to a surrogacy arrangement must have counselling prior to proceeding from an accredited ANZICA counsellor.
- All parties must have separate interviews with a minimum of 2 interviews for each party, one session each for information/treatment implications counselling and one session each for psychosocial/surrogacy counselling.
- The prior assessment of all parties to a prospective surrogacy is considered to be essential.
- The additional demands on, and expectations of, the birth mother, her partner and her existing children are matters to be addressed.

Issues to be address in surrogacy counselling include:
- Motivations of surrogate and commissioning couple, in the context of their family and social history
- Recipients’ and surrogates’ feelings about parenting arrangements
- Examination of the risks and benefits of the surrogacy arrangement
- Short and long term consequences for all parties concerned, including the possibility of an adverse outcome(s)
- Perception of the needs of any children born as a result of the surrogacy arrangement
- Attitudes to telling others and plans to disclose method of conception to the child
- Relevant federal and state legislation
- Relevant FSA/NHMRC guidelines.
SOURCES / REFERENCES


Western Australian Reproductive Technology Council. (Draft) Guidelines for Approved Counsellors in Western Australia, 2003.

October, 2003