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SYMPOSIUM: CROSS-BORDER REPRODUCTIVE CARE
ARTICLE

CBRC and psychosocial counselling: assessing needs and developing an ethical framework for practice

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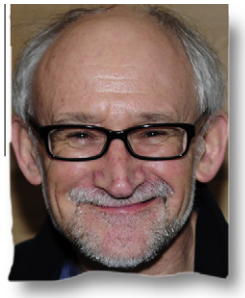

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Abstract Encountering infertility and involuntary childlessness and undergoing infertility treatment are acknowledged as stressful experiences that impact on individuals' psychological and emotional health — and for which access to psychosocial counselling by a skilled mental health professional may be beneficial. Evidence of patients', gamete donors' and surrogates' experiences indicates that utilization of infertility treatment in another country may not only exacerbate these psychosocial adversities, but may also pose additional risks to the psychological or physical health of participants, thus further emphasizing the need for competent psychosocial counselling services in cross-border reproductive care. However, this is a largely neglected topic in recent discussions of both CBRC itself and of infertility counselling practice. This paper extends the previous work undertaken by two of the authors to begin to map out practice issues within an ethical framework for counsellors when working with clients, donors, surrogates, individuals conceived following infertility treatment and existing children in clients', donor's and surrogates' families where cross-border reproductive treatment is considered or undertaken.

KEYWORDS: assisted-conception offspring, cross-border reproductive treatment, donors, patients, psychosocial counselling, surrogates

Introduction

This paper highlights an important, but so far largely neglected, component of cross-border reproductive care (CBRC): the need for competent psychosocial counselling services.

In keeping with the focus of this Symposium issue, this paper uses the term 'cross-border reproductive care'. However our work — and that of others — suggests that the benevolent image that 'care' conveys is not always present in the experiences of patients seeking fertility services in a country other than their own, donors, surrogates or the

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children born as a result of the procedures undertaken. Our preference is for the term 'cross-border reproductive services' which we consider to be less value laden than 'cross-border reproductive care'.

With the exception of Thorn and Wischmann (2010), who specifically refer to work with German clients who have undertaken or are seeking treatment in another country, no publication has previously articulated specific issues that need to be considered by infertility counsellors when working with clients who are contemplating or who have undertaken reproductive services in another country (or in another state in federated nations). This paper builds on and extends these authors' earlier work to outline the need for such services and to begin to map out an ethical framework for psychosocial counselling practice in CBRC for professionals in both home (i.e. the country of residence from which CBRC is sought, that may or may not, also be the country of which the individual is a citizen) and destination countries.

It is widely accepted that undertaking infertility treatment is often stressful, as it adds to existing pressures on individuals and couples experiencing involuntary childlessness (Cousineau and Domar, 2007). This has generated an acknowledgement of the value of psychosocial counselling as an important adjunct to medical and technical services, an importance that is reflected in mandatory infertility counselling requirements in some jurisdictions and prescriptions for the qualifications of professionals providing counselling.

For example, New Zealand and most Australian states have enacted legislation and regulations concerning infertility counselling. Although there are some variations between different jurisdictions, a common factor to all is the remit of the Fertility Society of Australia (FSA), which accredits fertility clinics in both countries. Through its Reproductive Technology Accreditation Committee, FSA requires accredited clinics to ensure access to counselling and recipients of donated gametes or embryos and their partner — and donors and their partner (if any) — to meet with an infertility counsellor prior to the commencement of any donation procedure. All counsellors hired by clinics must be members of the Australian and New Zealand Infertility Counsellors Association (ANZICA) and meet ANZICA's eligibility requirements, i.e. to:

(i) possess a minimum 4 year tertiary academic qualification from a recognized institution and:
   (a) be registered to practise as a psychologist in a state of Australia or in New Zealand; or
   (b) be a member of (or be eligible for membership of) the Australian Association of Social Workers or the New Zealand Association of Social Workers; or
   (c) be registered to practise as a psychiatrist in a state of Australia or in New Zealand; and

(ii) be counselling clients who are concerned about issues related to infertility; and
(iii) possess at least 2 years full-time or equivalent supervised postgraduate counselling experience; and
(iv) demonstrate current knowledge of infertility and infertility treatments.

In the UK, under provisions of the Human Fertilisation and Embryology Act 1990, all individuals seeking a licensed fertility treatment — and donors of gametes or embryos used in such treatments, non-medical fertility services or research — must be offered a 'suitable opportunity' to receive 'proper' counselling (Schedule 3(3)(1)(a)). Guidelines issued by the UK's statutory regulatory body, the Human Fertilisation and Embryology Authority, specify that counselling should be provided only by a qualified counsellor who:

(i) possesses specialist competence in infertility counselling; and
(ii) holds a recognized counselling, clinical psychology, counselling psychology or psychotherapy qualification at least to the level of diploma of higher education; and
(iii) is an accredited member of, or working towards accredited membership of, a recognized professional counselling body that has a complaints/disciplinary procedure; and
(iv) agrees to abide by an appropriate code of conduct or ethics (Human Fertilisation and Embryology Authority, 2009, 2.12—2.13).

In other jurisdictions where the concept of infertility counselling is well developed, similar emphasis is placed on ensuring high quality standards (Covington and Hammer Burns, 2006). On the other hand, while guidelines for the provision of infertility counselling as well as qualification guidelines for infertility counsellors have been established in several jurisdictions, most have minimal or no guidance for infertility counselling (Blyth, 2011). Counselling is referred to only tangentially (and incompletely) in the International Federation of Fertility Societies' triennial global compendium of national rules and regulations for assisted reproductive services. In the most recent report (Jones et al., 2011), providing information for 105 countries, the following references only are made to counselling: in Croatia, Ireland and the Netherlands in respect of oocyte donation; a 'few' (unspecified) jurisdictions in regard to embryo donation; Nepal as regards sperm donation; Belgium in respect of 'welfare of the child' requirements; and general references to counselling for IVF surrogacy.

As is elaborated upon below, undertaking fertility services in another country or jurisdiction almost invariably adds a further level of practical and emotional complexity to the pressures already noted (Blyth, 2010; Infertility Network UK, 2008; Thorn and Dill, 2010; Thorn and Wischmann, 2010). Psychosocial counselling, therefore, can play a key role in raising awareness of the complexity of carrying out infertility treatment abroad, providing basic knowledge about infertility treatment in other countries to facilitate informed consent and exploring psychological and social implications, especially where an anonymous or identifiable donor or a surrogate are used, as these also raise ethical and legal challenges. At the present time, however, there has been scarcely a reference to counselling in the existing literature and research. Where any such reference is made, it is to highly idiosyncratic models of 'counselling'. For example, Pande (this volume) notes the role of the counsellor in