
CANADIAN FERTILITY AND ANDROLOGY SOCIETY
SOCIÉTÉ CANADIENNE DE FERTILITÉ ET D'ANDROLOGIE

**Counselling Special Interest Group**

# Assisted Human Reproduction Counselling Practice Guidelines (Revised, September 2023)

# Assisted Human Reproduction Counselling Practice Guidelines (Revised, September 2023)

## PREAMBLE

The Counselling Special Interest Group (CSIG) was inaugurated at the joint meeting of the Canadian Fertility and Andrology Society (CFAS) and the American Society of Reproduction Medicine (ASRM) in 2005.

The initial Counselling Practice Guidelines Committee was established by CSIG in 2008 to fulfill the Assisted Human Reproduction Act's mandate of developing standards of practice for Canadian fertility counsellors (AHRA, 2004). The committee included CSIG members Susan Bermingham MPs, Judith Daniluk PhD, Christopher Newton PhD, Janet Takefman PhD, and Samantha Yee MSW, PhD. Additional contributions were made by Sherry Dale MSW and Jean Haase MSW from the former Assisted Human Reproduction Canada (AHRC) organization, and by Valerie Wilkie RN of the CFAS Nursing Special Interest Group (NSIG). Their work resulted in the publication of the Assisted Human Reproduction Counselling Practice Guidelines (2009).

Fertility counsellors belonging to CSIG are encouraged to develop and maintain the highest standards of practice in their field (CSIG Terms of Reference, 2021). As such, it was determined in 2021 that a revision to the Guidelines was necessary to reflect current practices in the fertility counselling and assisted human reproduction fields. A new Counselling Practice Guidelines Committee was established that included CSIG members Irene Glavac Petric MSW, Emily Koert PhD, and Holly Yager MEd. Their work resulted in the September 2023 revised version of the CSIG Assisted Human Reproduction Counselling Practice Guidelines.

The revised Assisted Human Reproduction Counselling Practice Guidelines document is considered current from the date of publication. Any reference to the Guidelines should use the date of the most current published version. The Counselling Practice Guidelines Committee will continue to review and revise these guidelines as deemed necessary.

CFAS acknowledges the support of the former organization, Assisted Human Reproduction Canada (AHRC) in the development of the initial 2009 Guidelines document. The 2023 revision continues to follow recommendations from the AHR Act (AHRA, 2004) and its subsequent updates, but does not necessarily represent the views of the Government of Canada or any of its departments or agencies. The Guidelines are intended to reflect the views of the CSIG membership, based on an extensive review of current research on the best clinical practices in the field of fertility counselling.

Cite this document as:
Canadian Fertility & Andrology Society (2023). *Assisted human reproduction counselling practice guidelines (Revised September 2023*). Counselling Special Interest Group. www.cfas.ca

**TABLE OF CONTENTS**

## INTRODUCTION

### Purpose

The Canadian Fertility & Andrology Society's (CFAS) Assisted Human Reproduction Counselling Practice Guidelines (Revised, September 2023) of the Counselling Special Interest Group (CSIG) are intended to reflect the best practices in the field of fertility counselling. The Guidelines were developed by the CSIG to ensure optimum care for individuals who are trying to conceive and who are considering the use of assisted human reproduction.

The development of the Guidelines is in keeping with recommendations of: 1) Canadian legislation (AHR Act, 2004); 2) the CSIG Terms of Reference to "respond to the complex social, psychological, legal, ethical, [and medical] dimensions of assisted human reproduction" (CFAS, 2021, p. 1); and 3) research in the fields of fertility counselling and assisted human reproduction.

The Guidelines are relevant for mental health professionals who provide fertility counselling in Canada. Several disciplines exist in the field of mental health within Canada (e.g., psychologists, psychotherapists, counsellors, social workers, etc.). In this document, we will refer to the practitioners in the various related disciplines as counsellors or mental health professionals (MHPs), consistent with terminology used by fertility counselling organizations internationally (e.g., Australia and New Zealand, ANZICA); Europe, ESHRE; the United Kingdom, BICA; and the United States, ASRM).

## SECTION I: FERTILITY COUNSELLING

### A. The Fertility Counselling Session

The main focus of fertility counselling is to provide support to those who are trying to conceive a child. Fertility counsellors see individuals at any stage in the family building process (i.e., prior to, during, or after medical treatment/conception/pregnancy). Individuals may be referred for counselling by their medical clinic or other health care provider, or may self-refer. It is recommended that counselling take place with a mental health professional (MHP) who is qualified in the area of fertility counselling.

### B. Qualifications of Fertility Counsellors

Fertility counsellors have attained additional training and experience in reproductive health, reproductive mental health, infertility, and assisted human reproduction (AHR) in addition to the requirements for mental health professionals (MHPs) in general.

As stated in the CSIG Terms of Reference (CFAS, 2021), and consistent with fertility counselling organizations internationally (e.g., Blyth, 2012; ASRM, 2021a), it is recommended that Canadian counsellors have, at minimum, the following qualifications prior to the provision of fertility counselling:

- Hold a post-graduate degree (or equivalent) in a mental health discipline from an accredited institution. Acceptable disciplines may include, but are not limited to: clinical psychology, counselling psychology, clinical social work, psychiatry, marriage and family therapy
- Be a member in good standing of a provincial and/or national regulatory body, college, or professional organization that requires adherence to a code of ethics and standards of practice
- Have several years of post-graduate clinical experience working in mental health for individual, relationship, and family counselling
- Participate in ongoing professional development
- Engage in clinical supervision and/or professional consultation as relevant
- Have respect for issues of privacy, confidentiality, consent, and patient rights
- Have competency in working with people of diverse backgrounds (e.g., race, ethnicity, culture, language, gender, sexual orientation, family structure, religion)

Fertility counsellors will strive above the minimum standards for mental health professionals and ensure that they have the following qualifications specific to fertility and assisted human reproduction:

- Psychosocial aspects of fertility/infertility, perinatal health, and parenting
- Knowledge of the specific ethical, legal, medical, and psychosocial issues related to AHR and to third-party reproduction

- Regulatory legislation governing AHR activities in Canada
- Have a solid understanding of the medical diagnoses and treatments available for infertility
- Theories of grief & loss, particularly reproductive loss
- Reproductive mental health/perinatal mental health
- Impact of psychotropic or fertility medications on mood, function, and pregnancy
- Potential effects on relationship with partner(s) including sexual functioning
- Theories of stress and coping
- Short-term and long-term needs for parents and their children
- Understanding of the diversity of individuals and families, including the multiple ways that families can be created
- Adherence to the recommendations in the *CFAS Position Statement Update: Right to Family* encouraging providers of fertility care to respect the human rights of all people by providing an experience that is "free from discrimination [against]… disability, race, family status, sexual orientation, gender identity, and gender expression" (CFAS, 2020a, p. 1).
- Availability of relevant community resources and supports
- Be a member in good standing of CFAS and the Counselling Special Interest Group (CSIG)
- Participate in relevant professional development and learning opportunities, including CFAS or CSIG meetings
- Awareness and ability to refer patients to other professionals if presenting with issues beyond their professional scope of practice (e.g., psychological testing, sex therapy, genetic counselling)
- Liaise with the patient's multi-disciplinary treatment team regarding psychosocial issues that may affect treatment (if applicable)

C. The Role of a Fertility Counsellor

Consistent with fertility counselling organizations internationally (see Blyth, 2012), the primary roles of a fertility counsellor may include any of the following, as applicable:

- Psychosocial support
- Psychotherapeutic interventions
- Psychoeducation
- Psychometric testing
- Evaluation
- Advocacy

The CSIG Terms of Reference (CFAS, 2021) further describes the role of a fertility counsellor as including, but not limited to, any of the following:

- Provision of counselling and psychosocial support to individuals who are tying to conceive and/or who are experiencing fertility challenges (e.g., infertility,

reproductive loss, third-party reproduction)
- Provision of counselling and psychosocial support at all stages of family building
- Provision of psychoeducation and support to assist individuals in considering the implications of various family building options
- Provision of psychoeducation and support to assist individuals in making informed choices
- Provision of support, to prepare for and cope, with AHR treatments and their outcomes
- Provision of 'implications counselling' when participating in third-party reproduction
- Provision of support, consultation, and education to members of the individual's medical team (when applicable)

D. Additional Considerations in Fertility Counselling

1. Infertility

It is important for fertility counsellors to recognize that not all individuals who seek fertility counselling will experience infertility. Individuals may seek fertility-related counselling for a variety of reasons. Additionally, individuals may use assisted reproduction for many reasons, including the creation of families as a solo parent and/or as LGBTQ+ parents.

2. Grief & Loss

Fertility counsellors are in a unique position to provide support to patients who are experiencing the many losses associated with trying to conceive. Many patients express a desire for additional support, particularly those experiencing infertility, repeat treatment failure, or recurrent pregnancy loss (Koert et al., 2019).

Some examples of fertility-related losses include:

- A diagnosis of infertility
- Failed cycles
- Reproductive loss (miscarriage, stillbirth, neonatal loss, recurrent loss
- Reproductive age; reproductive stage of life
- Ending treatment; involuntary childlessness
- Losses related to perceived (or actual) loss of belonging, identity, confidence, spontaneity, control, faith in self or higher power

Counselling considerations:

- Establishing coping strategies; self-care; support network
- Re-organizing of sense of self, identity, purpose
- Encouraging meaning-making and fulfillment in other ways

## SECTION II: ASSISTED HUMAN REPRODUCTION COUNSELLING

### A. Definition

This section refers to the counselling of individuals who are participating in assisted human reproduction (AHR) to conceive a child, such as with the use of intrauterine insemination (IUI) or in vitro fertilization (IVF). This section will focus mainly on AHR for individuals using their own gametes or embryos. (See Section III for counselling individuals when pursuing third-party reproduction).

The pursuit of AHR may be an option for one or more of the following reasons:

- A diagnosis of infertility
- Existence of conditions that may impact fertility or be a contraindication to pregnancy (e.g., cancer treatment)
- A desire to cryopreserve gametes or embryos (e.g., fertility preservation)
- A need for genetic testing of embryos (e.g., to avoid the passing on of a heritable condition)
- Individuals wanting medical assistance to conceive without a diagnosis of infertility

### B. The AHR Counselling Session

When seeing individuals who are pursuing AHR, fertility counsellors should be prepared to address, at minimum, any of the following in their sessions:

- Obtaining a psychosocial history and informed consent (see Appendix A)
- Exploration of attitudes towards treatment options
- Identification of psychosocial variables that may help or hinder medical treatment
- Coping with treatment/procedures such as blood tests, injections, oocyte retrieval, transvaginal ultrasound, sperm collection, etc.
- Concerns about the impact of medications on mood or functioning
- Managing workplace issues such as absences, privacy, loss of income
- Ability to follow medication protocols, attend appointments, and travel if necessary
- Relevant factors that may negatively affect participation in treatment such as financial stress, diminished quality of life and functioning, relationship distress
- Managing expectations concerning outcomes/success rates
- Practicality of cycle tracking; time needed to achieve adequate number of cycles
- Attitudes towards clinic policies regarding conversion of IUI to IVF (or IVF to IUI) or the cancellation of a cycle when indicated
- Exploration of other family-building options
- The influence of lifestyle factors on medical treatment
- Perceived support
- Recommendations to provide to the clinic team (when applicable)

C. The Continuum of Fertility Counselling

1. Below are some of the most common psychosocial challenges experienced by individuals who are trying to conceive:

a. Intrapersonal

- Prolonged stress, anxiety, and uncertainty
- Issues related to confidence, self-esteem and identity
- Fear of not being able to achieve family goals
- Negative thoughts, feelings, and beliefs
- Mental health concerns (e.g., depression, anxiety, psychosomatic complaints)
- Experience of grief and loss

b. Interpersonal

- Expectations of all parties involved
- Relationship issues with significant others (e.g., communication, boundaries, negotiating needs, sexual/intimacy concerns, privacy)
- Communication with medical professionals

c. Ethical/Cultural/Spiritual

- Ethical beliefs, cultural and societal beliefs, religious/spiritual beliefs
- How beliefs may impact fertility-related or family-building decisions
- How beliefs may impact meaning-making

d. Medical/AHR-related

- Decision-making and comfort level regarding AHR options
- Coping with diagnostic procedures, medical interventions
- Coping with treatment failure, repeat cycles, and treatment termination

2. Stages in the Fertility Counselling Continuum

Fertility counsellors will benefit from awareness of the stages that individuals may experience when pursuing assisted human reproduction (AHR):

a. Contemplation stage

Patients may struggle to make decisions concerning the pursuit of AHR options. Feelings of uncertainty or ambivalence may arise, and conflicting emotions may be present. Disagreement between partners can occur, and individuals may need assistance with topics such as communication or decision-making.

Counselling interventions in the ‘contemplation stage’ may include:

- Discussion of attitudes towards various family-building options
- Examination of concerns, values, and beliefs relevant to AHR
- Provision of information and emotional support
- Exploration of the impact of infertility (or involuntary childlessness) on individuals and on their relationships

b. Preparation stage

Patients may be apprehensive about, or lack familiarity with, the demands of the treatment protocols and the short-term and long-term implications of their decisions.

Counselling interventions in the ‘preparation stage’ may include:

- Emotional preparation for treatment
- Managing stress and uncertainty
- Decision-making
- Assisting patients to access social support

c. Treatment stage

Patients at a clinic may report that the demands of medical treatment are a challenge to their coping capacities. Doubts or anxieties about medical treatment, side effects related to the medications, disappointment with failed cycles, and relationship challenges my occur.

Counselling interventions in the ‘treatment stage’ may include:

- Emotional support; crisis intervention
- Managing stress and uncertainty
- Management of expectations
- Addressing relationship distress
- Decision-making
- Assisting patients to access social support

d. Post-treatment stage

Following completion of a treatment cycle, patients may want assistance in managing outcomes. Individuals may benefit from emotional support in the event of an unsuccessful cycle, and may equally benefit from support during a successful cycle (e.g., transition to parenthood). Some individuals may want additional support if deciding to end treatment (Takefman, 2006). Fertility counsellors are in a good position to support patients who are experiencing ‘treatment burden’ (Gameiro et al., 2012), one of the most common reasons to discontinue treatment.

Counselling interventions in the 'post-treatment stage' may include:

- Adjustment to pregnancy and parenthood; or to involuntary childlessness
- Decision-making
- Grief & loss; crisis intervention
- Identifying strategies to facilitate coping; access to social support
- Making recommendations to the medical treatment team (if applicable)
- Ongoing psychosocial support

D. Additional Considerations in AHR Counselling

1. Fertility Preservation

Preservation of fertility may be possible through a variety of procedures, such as sperm cryopreservation, oocyte cryopreservation, embryo cryopreservation, ovarian tissue cryopreservation, and ovarian transposition.

Cryopreservation may be an option for one or more of the following reasons:

- Medical: Where a medical condition, or treatment of that condition, is likely to impact fertility (e.g., chemotherapy)
- Planned: For elective or social reasons (e.g., when delaying parenthood)
- Gender: Prior to gender affirming medical care (e.g., gender transition, sex assignment)

Counselling considerations related to fertility preservation:

Counselling prior to fertility preservation can be helpful, especially when the individual is looking for emotional support, resources, or assistance with decision-making (Ainsworth et al., 2020; ANZICA, 2018; Baram et al., 2019; BICA, 2019; ESHRE 2020; Inhorn et al., 2019; Yee et al., 2012; Yee et al., 2021).

a. General considerations when counselling individuals who are pursuing cryopreservation of gametes:

- Motivations and readiness for cryopreservation; where do fertility and family building fit into their priorities
- Informed decision-making about the risks, limitations, complications, and outcomes of cryopreservation options (with partners, if applicable)
- Review of possible treatment outcomes including costs, timeline, and success rates
- Awareness of the treatment process at the time of cryopreservation, and at time of intended usage of gametes
- Decision-making around treatment options for preservation
- Alternative options for family building such as the use of oocyte/sperm

donation, adoption, etc.
- Emotional preparedness for the cryopreservation cycle
- Storage and disposition considerations for frozen embryos or gametes

b. Counselling considerations specific to cryopreservation for medical reasons:

- Impact of dealing with two significant life issues simultaneously
- Coping with a wide range of emotions (isolation, frustration, fear, despair, anger, etc.)
- Anxiety around physical changes (e.g., medical menopause, hair loss, mastectomy, etc. in the case of cancer)
- Coping with grief and loss (or depression) that may accompany medical treatment
- Impact of medical condition/resulting infertility on identity, sexuality, self-esteem, etc.
- Uncertainty about the future use and disposition of cryopreserved gametes or embryos
- Partner's reaction to medical treatment and fertility preservation, if applicable
- Perceived risks of the procedure, such as the possibility of exacerbating the disease
- Capacity to cope with procedures given current state of health/mental health
- Posthumous donation requests
- In the case of minors, inclusion of parents in the decision-making process
- Provision of resources and information related to fertility preservation, such as reading materials, websites, support groups, and community resources

c. Counselling considerations specific to cryopreservation for planned/elective reasons:

- Emotional issues that may arise due to the pursuit of cryopreservation
- Understanding that based on current research, fertility preservation is not a guarantee and a way to 'stop the biological clock'
- Alternatives to gamete freezing (e.g., creating embryos with donor sperm) for better success rates
- In the case of oocyte cryopreservation, coping with the possibility that several cycles may be required in order to obtain enough oocytes to achieve a birth
- Possible failure to collect many or good quality oocytes; necessity of serial trials
- Financial implications of fertility preservation and future use
- Current life stresses, and coping skills, and support network
- Disclosure to friends, family, and future offspring

- Implications for future relationships
- Managing the stresses of the cryopreservation process
- Possibility of future solo parenting or parenting at an older age
- Family-building plan for the future (e.g., when and how to use gametes/embryos)

d. Counselling considerations specific to cryopreservation for gender-related reasons:

- Impact of any gender affirming medical treatment on fertility
- Attitudes towards cessation of gender affirming hormones when stimulating oocytes, when providing a sperm sample, or when pregnant
- Managing the invasiveness of cryopreservation procedures (e.g., transvaginal ultrasound)
- Support system in relation to the decision to cryopreserve (or transition)
- Plans and preparedness for the future (e.g., when and how to use frozen gametes/embryos; knowledge of costs and success rates)

2. Pre-Implantation Genetic Testing

Patients pursuing AHR at a clinic may be offered pre-implantation genetic testing to test for chromosomal aneuploidy (PGT-A) or to reduce the risk of passing on a genetic condition (PGT-M) (Chan et al., 2021). Patients may want to discuss with a counsellor any psychosocial or ethical concerns around testing. Fertility counsellors should be aware that some patients prefer to obtain as much information as possible, while others find discomfort when confronted with too much information (Hammer Burns et al., 2006). Fertility counsellors should be prepared to refer individuals to other professionals when the discussion is beyond their scope of practice (e.g., genetic counsellor, ethicist, physician).

Counselling considerations related to genetic testing:

- Informed decision-making related to the potential risks of testing, which may include: no embryos to transfer, risk of a false result, time constraints, costs
- Emotional support to those discovering they contribute a gene mutation
- Exploring the impact on relationships and identity
- Disposition plans for affected embryos, and for surplus unaffected embryos

3. Posthumous Assisted Reproduction

Posthumous assisted reproduction (PAR) involves the retrieval and/or use of gametes or embryos of a deceased person who provided their explicit consent prior to death. Fertility counsellors should be prepared to discuss psychosocial and ethical concerns of PAR, and to refer individuals to other professionals when the discussion is beyond their scope of practice (e.g., physician, lawyer, ethicist).

Counselling considerations related to PAR:

- Effects of the bereavement period on decision-making:
  - Stage of the grieving process
  - The presence of complicated or unresolved grief
  - Capacity to make a rational and informed decision, given the emotional impact of loss and the emotional reactions of the survivor
- Capacity to rear a child as a solo parent (or in another family role) at this time
- Religious/spiritual, cultural, and ethical implications
- Psychosocial impact on the resulting 'commemorative child' (ASRM, 2018b), including addressing any implications on potential changes to identity, role, and family structure (Brede & Sabanegh, 2014)
- Disclosure of 'origin story' to resulting child(ren)
- Awareness of possible legal complexities related to the future child(ren)'s status (i.e., wills and estates) and referral of patient to a lawyer with familiarity in this area
- Possibility of emotional coercion (e.g., from surviving family members of the deceased)
- Expectations towards medical treatment processes and possible outcomes (success rates, preparation for additional loss if treatment failure or pregnancy loss occurs)

4. HLA-Typing ('Saviour Sibling')

A 'saviour sibling' is a child born into a family for the benefit of treating an older sibling's life-threatening or life-limiting disease. The parents create embryos through IVF, which are then tested to allow for the selection of HLA-matched embryos. When a 'saviour sibling' is born, stem cells (e.g., from cord blood or bone marrow) can be collected and donated to the older sibling via haematopoietic stem cell transplantation (Kuek, et al., 2021).

Counselling considerations related to HLA-typing:

- Facilitation and promotion of informed decision-making regarding the risks, complications, and chances of success
- Implications of treatment on all members of the family, including future child
- Grief and loss regarding existing child's illness, fears regarding the child's ongoing health
- Preparedness for the chance that no HLA-compatible embryos will be found
- Disposition of embryos that are not HLA-compatible; disposition of surplus embryos that are HLA-compatible
- Current life stressors, including caring for a critically ill child
- Implications of a pregnancy (and care of a new baby) while simultaneously caring for an older, critically ill child
- Congruence between partners in desires, motivations, coping

- Disclosure of the circumstances of future child's birth to the children, to others
- Evaluation of the risk of psychological harm to the child(ren)
- Religious, spiritual, ethical, or moral implications
- Parents' commitment to the best interests and well-being of the future 'saviour sibling' child
- Readiness to expand family when they may not otherwise choose to do so
- Possibility of a consultation with an ethicist to address the implications of creating one life to save another

## SECTION III: THIRD-PARTY REPRODUCTION COUNSELLING

### A. Definition

Third-party reproduction is the use of at least one other party's gametes, embryos, and/or uterus to create a child for the intended parent(s). Third-party reproduction may include any combination of gamete donation, embryo donation, and surrogacy.

### B. The Third-Party Reproduction Counselling Session

#### 1. Definition

A third-party reproduction counselling session is recommended prior to the commencement of donation or surrogacy. This recommendation is consistent with the guidelines of many fertility organizations internationally (e.g., ASRM, 2021a; ESHRE, 2001, 2022). This session may be most useful prior to the finalization of a legal agreement (e.g., in identified/designated/known donation). It is intended to occur prior to the commencement of medical/fertility treatment.

One session is recommended for each party involved in third-party reproduction. The parties are identified as follows:

- Intended parent(s) / Recipient(s)
- Donor(s)
- Surrogate

Note: Legal partners of recipients, donors, and surrogates are expected to be present at this counselling session, as many the psychosocial implications will apply to all involved. In some cases, partners may also be affected by legal and medical implications. Legal partners are defined as married and/or co-habiting or living in a marriage-like relationship for at least 12 months (i.e., common-law) (AHR, 2004).

Typically, one counselling session occurs for each party. In third-party reproduction arrangements between identified/known parties, an additional joint session may be recommended. A joint session can be helpful if there are any issues needing further exploration, and to ensure that expectations are mutually acceptable to all.

The third-party reproduction counselling session starts with informed consent and with taking a complete psychosocial history (see Appendix A). The provision of psychoeducation and emotional support is key to helping individuals to prepare for third-party reproduction (Sachs & Toll, 2023). A large part of the session involves an in-depth discussion of the 'implications' involved in third-party reproduction. After completion of this session and with consent of the patients, it is recommended that fertility counsellors forward a report to the referring clinic, confirming that the

recommended topics were discussed and providing any relevant recommendations that would assist in their care (see Appendix B).

2. Implications Counselling

The following is a list of the most common implications that can arise in third-party reproduction:

a. Psychosocial implications

- Psychosocial outcomes for children and families
- Disclosure of 'origin story' to future child, and to others
- Attachment between all parties
- Plans for contact between all parties
- Communication strategies between parties who are identified/known/designated
- Grief & loss
- Mixed-conception or blended families
- Parenting after infertility or loss; parenting at an advanced age
- Resources for support and information

b. Ethical implications

- Awareness that anonymity cannot be guaranteed
- Ability to contact donor/surrogate in future
- Screening and motivations of donors or surrogates
- Limits on the number of births via donation or surrogacy

c. Legal implications

- Parental rights and responsibilities; guardianship
- Restrictions on payment of donors and surrogates
- Referral to legal professionals (when applicable)

d. Medical implications

- Assistance with decision-making regarding selection of donor, recipient, or surrogate
- Awareness of the differences in types of donation (e.g., identified, non-identified)
- In identified/known/designated arrangements, preferences for including the other party in appointments, medical updates, etc.
- Ability to attend appointments and complete tasks involved in medical treatment (e.g., following instructions, ability to travel)
- Expectations regarding time commitment, number of appointments, etc.

- Addressing fears over potential reactions to procedures or medications (i.e., effect on mood)

C. Gamete Donation

1. Definition

Gamete donation occurs when the intended parent(s) create a child through the use of another person's gametes. Gamete donation may involve the use of donated sperm, donated oocytes, or donated sperm and oocytes ('double donation').

Gamete donation may be an option for one or more of the following reasons:

- Infertility diagnosis
- To avoid the passing on of a heritable condition
- Individuals without access to gametes (e.g., solo parents, LGBTQ+ parents)

Two types of gamete donation exist:

a. Identified

In identified donation (sometimes also referred to as designated or known donation), the donating party and the recipient party either know one another prior to donation (e.g., friends, family), or have become acquainted for the purpose of donation (e.g., matched). During the third-party reproduction counselling session, a discussion will take place regarding implications and expectations between parties.

b. Non-identified

Non-identified donation is typically what occurs when using a cryobank (sperm bank and/or egg bank). In non-identified donation, the donating party and the recipient party do not know one another prior to the donation.

Two types of non-identified donation exist:

i. Closed: In closed non-identified donation through a cryobank, recipients have access to the information provided in the donor's profile. Closed donation is the more current term for 'anonymous donation' (ASRM, 2019; Bourne, 2023).

i. Open: In open non-identified donation through a cryobank, donors are closed at the time of donation. Once reaching adulthood, donor-conceived individuals have the option to contact open donors, facilitated by the cryobank. This option provides donor-conceived adults an important opportunity to access information from/about their

donor, should they desire it (Lycett et al., 2004; Golombok, 2021).

2. Counselling Recipients of Donated Gametes

   a. Common considerations when counselling recipients of gamete donation (identified and non-identified):

      - Motivations, readiness, and acceptance of the use of donation; consideration of other family-building options
      - Understanding of the complexities of this type of family building for all involved
      - Support system, throughout and following donation
      - Implications for the partners, family members, and children of recipient(s) (if applicable)
      - Relationship/marital and/or familial challenges
      - Extent to which the decision to participate is free of coercion
      - Cultural or religious/spiritual concerns
      - Unresolved grief and loss
      - Attachment concerns
      - Selection of donor(s)
      - Limitations of information-sharing between donor(s) and recipient(s)
      - Managing expectations regarding possible outcomes
      - Legal issues that may affect the donation process; awareness of Canadian laws
      - Disclosure issue; expectations concerning disclosure of child's 'origin story'; disclosure of donor's identity to resulting child(ren) and to others
      - Implications of cross-border reproduction (if applicable)
      - Resources such as reading material and community supports
      - Awareness that not all prospective donors or recipients will be appropriate candidates, depending on medical or psychosocial evaluations

   b. Considerations specific to recipients of identified gamete donation:

      - Psychosocial implications such as privacy, boundaries, relationships, roles, and expectations between parties
      - Reactions of significant others (partners, family, children, friends, mutual friends/family of the donor(s))
      - Impact on emotions, and on relationships with other party, if a negative outcome occurs (e.g., failed donation, pregnancy loss, genetic anomaly)
      - Implications of non-compliance from either party
      - Perceived obligation to the donor(s)
      - Expectations regarding the number of treatment cycles required by the intended parents, and intentions for the use and disposition of surplus gametes/embryos

c. Considerations specific to recipients of non-identified gamete donation:

- Differences between open and closed donation
- Availability of donor information; limitations on the information provided by donors and cryobanks
- Uncertainty related to the donor's medical/genetic and social history; implications for future child(ren)
- Thoughts on donor-related peers (e.g., donor sibling registries)
- Availability of the same donor for subsequent pregnancy attempts

3. Counselling Donors of Gametes

a. Common considerations when counselling donors of gametes (identified and non-identified):

- Motivations and readiness for donation
- Understanding of the steps involved in the donation process, such as time commitment and use of medications
- Current life stresses
- Understanding of the psychosocial complexities of this type of family building for all involved
- Support system, throughout and following donation
- Implications for the partners, family members, and children of donor(s) (if applicable)
- Extent to which the decision to participate is free of coercion
- Cultural or religious/spiritual concerns
- Unresolved grief and loss
- Attachment concerns
- Selection of recipient(s)
- Limitations of information sharing between donor(s) and recipient(s)
- Personal family building desires and implications for existing and future children
- Managing expectations regarding possible outcomes
- Legal issues that may affect the donation process; awareness of Canadian laws
- Disclosure issues; expectations concerning disclosure of donor's identity to the resulting child(ren) and to others
- Implications of cross-border reproduction (if applicable)
- Resources such as reading material and community supports
- Awareness that not all prospective donors or recipients will be appropriate candidates, depending on medical or psychosocial evaluations

b. Considerations specific to identified gamete donors:

- Psychosocial implications, such as privacy, boundaries, relationships,

roles, and expectations between parties
- Reactions of significant others (partners, family, children, friends, mutual friends/family of the recipient(s))
- Impact on emotions, and on relationships with other party, if a negative outcome occurs (e.g., failed donation, pregnancy loss, genetic anomaly)
- Implications of non-compliance from either party
- Perceived coercion; perceived obligation to/from the recipient(s)
- Expectations regarding the number of treatment cycles required by the intended parents, and intentions for the use and disposition of surplus gametes/embryos
- Expectations about future contact or relationship with recipient(s) and resulting child(ren)

c. Considerations specific to non-identified gamete donors:

- Differences between open and closed donation; ethical concerns
- Availability or limitations of information on the recipient(s) and child(ren)
- Living with any uncertainty regarding the outcome of the donation
- The existence of a number of donor-conceived children
- Awareness that anonymity cannot be guaranteed

4. Exclusion Criteria

Psychosocial criteria for the potential exclusion of gamete donors:

- Outside of age- and health-related criteria indicated by clinic
- Presence of, or family history of, inheritable psychiatric disorders that are severe in impact and/or that are unknown/undisclosed to the recipient(s)
- Presence of acute and untreated psychopathology
- Extreme psychosocial distress (e.g., current relationship abuse; relationship instability; acute, unresolved grief or trauma; etc.)
- Current high-risk behaviours, including substance use
- History of being a perpetrator of abuse
- Unresolved or current legal issues potentially disrupting or complicating the donation process
- Inability to cope with the stresses of the donation process
- Issues related to communication with the intended parent(s), including respect for boundaries (in identified/known/designated donation)
- Evidence of coercion (see Section
- Problematic attachment to the resulting child
- Lack of access to emotional and practical support
- Incongruence between partners in motivation/desire to participate, creating significant relationship instability (if applicable)
- Lack of psychological or cognitive capacity to provide informed consent

D. Embryo Donation

1. Definition

Individuals who have completed their families through IVF and have surplus frozen embryos, may choose to donate them to another party. In embryo donation, the recipient party will have no genetic link to the resulting child(ren), but any resulting children will share a full genetic link with the donating party's children. The embryos may have been created with the donating party's gametes, or in some cases, with donor sperm and/or donor oocytes. In Canada, embryo donation arrangements most commonly occur between parties who are known to one another prior to donation (identified/designated).

Embryo donation may be an option for one or more of the following reasons:

- Infertility diagnosis
- To avoid the passing on of a heritable condition
- Individuals without access to gametes (e.g., solo parents, LGBTQ+ parents)

2. Counselling Recipients of Donated Embryos

Counselling considerations relevant to gamete donation are applicable to embryo donation. In addition, counselling should include consideration of the following:

- Capacity of recipients to form an emotional attachment as non-genetic parents
- Implications of raising a child who may have full-genetic links to children in the donating party's family, and in other families that may be involved (Gordon & Grobel, 2023)
- Assisting each party in determining their expectations for contact, relationships, roles, disclosure, and boundaries with the other party (when in known/identified/designated arrangements)
- Awareness of differential success rates when using surplus embryos

3. Counselling Donors of Embryos

- Implications for donors knowing they may have full-genetic offspring whom they are not parenting; attachment concerns
- Implications for donating party's family members
- Assisting each party in determining their expectations for contact, relationships, roles, disclosure, and boundaries with the other party (when in known/identified/designated arrangements)
- Exploring preferences for future contact with recipient(s) and the related implications (Fuchs Weizman et al., 2023)
- Living with uncertainty; a lack of information on outcomes

4. Exclusion Criteria

Refer to the section on psychosocial exclusion criteria for gamete donation.

E. Surrogacy

1. Definition

Surrogacy occurs when an individual (surrogate) carries (gestates) a pregnancy for another party. The parties may have known one another prior to surrogacy (e.g., friends, family), or may have met specifically for this purpose (e.g., matched). In Canada, the law allows for altruistic surrogacy only. During the third-party reproduction counselling session, a discussion will take place regarding implications and expectations between parties.

Surrogacy may be an option for one or more of the following reasons:

- Infertility diagnosis
- Contraindications to pregnancy or fertility/medical treatment
- Individuals without a uterus (e.g., hysterectomy, LGBTQ+ parents)

Two types of surrogacy arrangements exist:

a. Traditional surrogacy

In traditional surrogacy, a surrogate carries a pregnancy for the intended parent(s). In this type of surrogacy, the surrogate's oocytes are fertilized with sperm from an intended parent (or from donor sperm selected by the intended parent(s)). The traditional surrogate will have a genetic link to the resulting child and it is sometimes referred to as 'genetic surrogacy'. The traditional surrogate is not intending to be a parent. Traditional surrogacy occurs rarely at Canadian fertility clinics, and is thought to have the potential to carry more psychosocial, ethical, and legal complexities (Kim, 2020). Fertility counsellors should be prepared to consult with medical and legal professionals if counselling individuals participating in traditional surrogacy.

b. Gestational surrogacy

In gestational surrogacy, a surrogate (gestational carrier) carries a pregnancy for the intended parent(s). In this type of surrogacy, the embryos are created using gametes from the intended parent(s) or one or more donors selected by the intended parent(s), or from donated embryos. The gestational carrier's gametes are not used, so there is no genetic link between the gestational surrogate and the resulting child. The gestational carrier is not intending to be a parent to the child.

The following guidelines are specific to gestational surrogacy.

2. Counselling Intended Parents/Recipients of Surrogacy

Common considerations when counselling intended parents/recipients of surrogacy:

- Motivations, readiness, and acceptance of the use of surrogacy; consideration of other family-building options
- Understanding of the complexities of this type of family building for all involved
- Support system, throughout and following surrogacy
- Implications for partner, family, or children (if applicable); relationship/marital and/or familial challenges
- Extent to which the decision to participate is free of coercion
- Choice and availability of a surrogate; implications if surrogate is in another location
- Limitations of information-sharing between surrogates and recipient(s)
- Managing expectations regarding possible outcomes (e.g., success rates)
- Legal issues that may affect the surrogacy process
- Awareness of the laws stating that surrogacy in Canada is altruistic
- Implications of cross-border surrogacy/treatment (if applicable)
- Perceptions of outcomes (e.g., success rates, number of embryos to transfer)
- Stability of the intended parents' relationship, and congruence of family building desires and expectations
- Limitations of information-sharing between all parties involved
- Concerns about the accuracy of the information provided by the surrogate
- Managing the relationship with the surrogate (and partner/family, if applicable), including boundaries
- Managing expectations of the surrogate (e.g., lifestyle choices, travel, attendance at medical appointments, perinatal testing and procedures, delivery, and lactation/breastfeeding, etc.)
- Cultural beliefs, spiritual beliefs, and values that may affect behaviours and health care decisions
- Managing the impact to relationships in the event of a potential negative outcome
- Expectations around disclosure of surrogacy to the child(ren), family, friends, mutual acquaintances, including the timing
- Attitudes of extended family and community towards surrogacy
- For female intended parents who were hoping to experience pregnancy: Grief and loss, attachment concerns
- Resources such as reading material and community supports
- Psychological or cognitive capacity to provide informed consent
- Awareness that not all prospective surrogates or intended parents/recipients will be acceptable candidates, depending on medical or psychosocial evaluation

## 3. Counselling Surrogates

Common counselling considerations for individuals intending to become surrogates:

- Obtaining a psychosocial history (see Appendix A and Appendix B) including history of severe perinatal mood and anxiety disorders (PMADs)
- Psychosocial preparation, including exploration of motivations and readiness
- Perceptions of success rates, medical expectations (e.g., number of embryos to transfer), and possible risk factors (e.g., pregnancy complications including multiple birth, pregnancy loss, fetal reduction, pregnancy termination)
- Understanding of the complexities of this special form of family building for all involved
- Support system, throughout and following surrogacy
- Implications for partner, family, or children (if applicable); relationship/marital and/or familial challenges
- Extent to which the decision to participate is free of coercion.
- Choice of intended parents; implications if they are in another location
- Limitations of information-sharing between surrogates and recipient(s)
- Legal issues that may affect the surrogacy process
- Awareness of the laws stating that surrogacy within Canada is for altruistic purposes
- Implications of cross-border surrogacy/treatment (if applicable)
- Perceptions of outcomes (e.g., success rates, number of embryos to transfer)
- Limitations of information-sharing between all parties involved
- Concerns about the accuracy of the information provided by the intended parents
- Managing the relationship with the intended parents (and family, if applicable), including boundaries
- Managing expectations of the intended parents (e.g., lifestyle choices, travel, attendance at medical appointments, perinatal testing and procedures, delivery, and lactation/breastfeeding, etc.)
- Cultural beliefs, spiritual beliefs, and values that may affect behaviours and health care decisions
- Managing the impact to relationships in the event of a potential negative outcome
- Expectations around disclosure of surrogacy to the child(ren), family, friends, mutual acquaintances, including the timing of disclosure
- Managing expectations during pregnancy such as lifestyle choices, travel, attendance at medical appointments, perinatal testing and procedures
- Managing expectations regarding the delivery and postpartum period, including birth plan, location of and type of delivery, who will be present, and lactation/breastfeeding, etc.
- Stability of surrogate's relationship with partner (if applicable)
- Availability of partner/family support (practical and emotional support)
- Attachment to the resulting child(ren)

- Social implications such as perceptions and reactions of friends and family
- Understanding of medical procedures and risks; psychological or cognitive capacity to provide informed consent
- Resources such as reading material and community supports
- Psychological or cognitive capacity to provide informed consent
- Awareness that not all prospective surrogates or intended parents/recipients will be acceptable candidates, depending on medical or psychosocial evaluation

4. Exclusion Criteria

Psychosocial criteria for the potential exclusion of surrogates:

- Outside of age-related and health-related criteria indicated by clinic
- Not having had a live birth
- Presence of acute and untreated psychopathology
- Extreme psychosocial distress (e.g., current relationship abuse; relationship instability; acute, unresolved grief or trauma; etc.)
- History of reproductive loss (e.g., stillbirth, neonatal loss, placing a child for adoption, miscarriage) with unresolved emotions or trauma
- Current high-risk behaviours, including substance abuse
- Current engagement in high-risk sexual practices
- History of being a perpetrator of abuse
- Unresolved or current legal issues potentially disrupting or complicating the surrogacy process
- Inability to cope with the stresses of the surrogacy process
- Issues related to communication with the intended parent(s), including respect for boundaries
- Evidence of coercion
- Problematic attachment to the resulting child
- Lack of access to emotional and practical support
- Incongruence between partners in motivation/desire to participate, creating significant relationship instability (if applicable)
- Lack of psychological or cognitive capacity to provide informed consent

## F. Additional Considerations in Third-Party Reproduction Counselling

### 1. Counselling LGBTQ+ Individuals

When intended parents who identify as LGBTQ+ participate in counselling, it is important for fertility counsellors to understand that the use of AHR and third-party reproduction is not typically related to a diagnosis of infertility, but to a need for access to a uterus or gametes. Fertility counsellors, particularly those who identify as cisgender or heterosexual, have a responsibility to demonstrate cultural competency in working with individuals who identify as LGBTQ+ (Green, Tarasoff & Epstein, 2012; Holley & Pasch, 2023; Joseph et al., 2023).

When counselling individuals who identify as LGBTQ+ and who are pursuing medical assistance to conceive, fertility counsellors may include a discussion of any relevant topics in Section I, Section II, or Section III and the following considerations:

- Decision-making regarding family-building options and their implications
- Decision-making around which partner's gametes to use; who will be the gestational parent; managing disclosure to child and others
- Navigating the heteronormativity and cisnormativity in the medical system (e.g., misuse of pronouns, use of gendered terminology)
- Potential impact of fertility medications on mood or identity, with knowledge that the experience of gender dysphoria may or may not be present for transgender or non-binary individuals (Joseph, Reese & Moravek, 2023)
- Access to support (e.g., family acceptance, social support, resources)
- Expectations for family structure, roles, terminology
- Managing an unexpected diagnosis of infertility
- Provision of "affirmative fertility counselling" that is validating, supportive, and inclusive to transgender individuals (Joseph, Reese & Moravek, 2023).
- Navigating barriers in the workplace (e.g., parental leave)
- Processing any implications such as grief or sense of inequity between the genetic-/gestational- and non-genetic/non-gestational parent
- Encouragement of attachment between parent(s) and child(ren)
- Managing disclosure of the origin story to future child(ren) while ensuring that the privacy and safety needs of the parent(s) are being met
- Provision of information on where to access legal resources

### 2. Counselling Donor-Conceived Individuals

An individual's perspective on being donor-conceived will vary, with the timing and manner of disclosure being an important factor. In general, early and gradual disclosure is preferable (Jadva et al., 2009; ASRM, 2018a; Golombok, 2020). An individual's perspective on being donor-conceived can also depend on the individual's desire for, and subsequent access to, information about the donor. Fertility counsellors are in a unique position to provide support to donor-conceived individuals, when indicated (Bourne, 2023).

Counselling considerations:

- Emotional impact of the timing and manner of disclosure
- Psychological implications on self-esteem, identity, attachment, etc.
- Issues of loss; disenfranchised grief if accidental discovery (Bourne, 2023)
- Potential trust issues with parent(s)/family if disclosure is withheld or delayed
- Desire for information about the donor (or donor's family members)
- Availability of information about the donor(s) (or donor's family members)
- Expectations around contact with the donor(s) (or donor's family members)
- Implications of the presence of any donor-peers
- Awareness of supports and resources for donor-conceived individuals

3. Disclosure

For individuals who are conceived with the use of third-party reproduction (donation and surrogacy), there exists a growing body of evidence to support the benefits of disclosure of their 'origin story' (e.g., ASRM, 2018a). Disclosure is thought to be more beneficial when it occurs earlier in life and at developmentally appropriate stages (Jadva et al., 2009; Golombok, 2020; Gordon & Grobel, 2023).

When seeing individuals participating in third-party reproduction counselling, fertility counsellors engage in an in-depth discussion of disclosure that includes expectations for privacy, secrecy, and openness. The fertility counsellor will address any concerns of the intended parent(s) and provide ideas for how and when to disclose to the child(ren) and to others. It is important for fertility counsellors to understand that intended parents' ideas for disclosure may be based on a variety of factors including cultural beliefs or unresolved grief or fear (Golombok, 2020).

4. Coercion

Coercion is defined as influencing the actions of another by taking advantage of a weakness (exploitation), or by unduly exerting power or influence. It is important to be alert for possible coercion, which can be explicit or implicit and can be financial, personal, familial, or stem from dual relationships between parties (ASRM, 2022a).

To identify evidence of coercion, fertility counsellors may inquire about:

- Motivations for participation
- Expectations around financial compensation
- Perception of any pressure from others
- Sense of obligation, indebtedness; feelings of guilt
- Consequences of withdrawing consent

## REFERENCES


Ainsworth, A. J., Allyse, M., & Khan, Z. (2020). Fertility preservation for transgender individuals: A review. *Mayo Clinic Proceedings, 95*(4), 784-792. https://doi.org/10.1016/j.mayocp.2019.10.040

Assisted Human Reproduction Act (2004). *Assisted human reproduction act*, SC 2004, c. 2. http://laws.justice.gc.ca/en/A-13.4/index.html

Australian and New Zealand Infertility Counsellors Association (ANZICA) (2018). *Guidelines for professional standards of practice in infertility counselling.* https://www.fertilitysociety.com.au/wp-content/uploads/Guidelines-for-Professional-Practice.pdf

Baram, S., Myers, S. A., Yee, S., & Librach, C. L. (2019). Fertility preservation for transgender adolescents and young adults: A systematic review. *Human Reproduction Update, 25*(6), 694-716. https://doi.org/10.1093/humupd/dmz026

Blyth, E. (2012). Guidelines for infertility counselling in different countries: Is there an emerging trend? *Human Reproduction, 27*(7), 2046-2057. https://10.1093/humrep/des112

Bourne, K. (2023). DNA and the end of anonymity: Disclosure, donor-linkage and fertility counseling. In S. N. Covington (Ed.), *Fertility counseling: Clinical guide* (2nd ed., pp. 134-143). Cambridge University Press.

Brede, C., & Sabanegh, Jr., E. (2014). Medical aspects of posthumous reproduction. In J. M. Goldfarb (Ed.), *Third-party reproduction: A comprehensive guide* (pp. 183-195). Springer.

British Infertility Counselling Association (BICA) (2019). *Guidelines for good practice in fertility counselling* (4th ed.). Exactis Interactive Print. https://www.bica.net/item/1/BICA/Guidelines-for-Good-Practice-in-Infertility-Counselling.html

Canadian Fertility & Andrology Society (CFAS) (2009). *Assisted human reproduction counselling practice guideline of the Counseling Special Interest Group*. https://cfas.ca/_Library/clinical_practice_guidelines/CSIG_Counselling_Practice_Guidelines_August_2009_.pdf

Canadian Fertility & Andrology Society (CFAS) (2020a). *CFAS position statement update: Right to family*. https://cfas.ca/_Library/2020positionstatements/CFAS-Position-Statement-UPDATE-Right_to_Family-Apr_2020-EN.pdf

Canadian Fertility & Andrology Society (CFAS) (2020b). *Starting conversations: Donor conception resource list*, *Updated 2020.* https://cfas.ca/_Library/CSIG/Donor-Conception-Resource-List_2020.pdf

Canadian Fertility & Andrology Society (CFAS) (2021). *Counselling Special Interest Group Terms of Reference*, Updated 2021. https://cfas.ca/8_terms-of-reference.html

Chan, C., Ryu, M., & Zwingerman, R. (2021). Preimplantation genetic testing for aneuploidy: A Canadian Fertility and Andrology Society Guideline. *Reproductive Biomedicine Online, 42*(1), 105-116. https://doi.org/10.1016/j.rbmo.2020.10.020

Ethics Committee of the American Society for Reproductive Medicine (ASRM) (2018a). Informing offspring of their conception by gamete or embryo donation: An Ethics

Committee opinion. *Fertility and Sterility, 109*(4), 601-605. http://dx.doi.org/10.1016/j.fertnstert.2018.01.001

Ethics Committee of the American Society for Reproductive Medicine (ASRM) (2018b). Posthumous reproduction: An Ethics Committee opinion. *Fertility and Sterility, 110(1)*, 45-49. https://doi.org/10.1016/j.fertnstert.2018.04.002

Ethics Committee of the American Society for Reproductive Medicine (ASRM) (2019). Interests, obligations, and rights in gamete and embryo donation: An Ethics Committee opinion. *Fertility and Sterility, 111*(4), 664-670. https://doi.org/10.1016/j.fertnstert.2019.01.018

Ethics Committee of the American Society for Reproductive Medicine (ASRM) (2021a). Guidance on qualifications for fertility counselors: A committee opinion. *Fertility and Sterility, 15,* 1411–1415. https://www.asrm.org/globalassets/asrm/asrm-content/news-and-publications/practice-guidelines/for-non-members/qualifications_for_infertility_counselors.pdf

Ethics Committee of the American Society for Reproductive Medicine (ASRM) (2022a). Recommendations for practices utilizing gestational carriers: A committee opinion. *Fertility and Sterility, 118*, 65-74. https://doi.org/10.1016/j.fertnstert.2022.05.001

Ethics Committee of the American Society for Reproductive Medicine (ASRM) (2022b). Updated terminology for gamete and embryo donors: Directed (identified) to replace ‘‘known’’ and nonidentified to replace ‘‘anonymous’’: A committee opinion. *Fertility and Sterility, 118*, 75-78. https://doi.org/10.1016/j.fertnstert.2022.02.032

European Society for Human Reproduction and Embryology (ESHRE) (2001). *Guidelines for counselling in infertility: Special interest group psychology and counselling.* https://www.eshre.eu/Specialty-Groups/Special-Interest-Groups/Psychology-Counselling/Archive/Guidelines.aspx

European Society for Human Reproduction and Embryology (ESHRE) (2020). ESHRE guideline: Female fertility preservation. *Human Reproduction Open, Issue 4*, hoaa052. https://doi.org/10.1093/hropen/hoaa052

European Society for Human Reproduction and Embryology. ESHRE Working Group on Reproductive Donation (2022). Good practice recommendations for information provision for those involved in reproductive donation. *Human Reproduction Open, 2022*, hoac001. https://doi.org/10.1093/hropen/hoac001

Fuchs Weizman, N., Yee, S., Kazay, A., K’Necht, E., Kuwar, A. A., Maltz, G. M., & Librach, C. L. (2023). Non-identified and directed embryo donation: A questionnaire study on donor and recipient perspectives. *Human Fertility*, 2023 Jul 27;1-12. https://doi.org/10.1080/14647273.2023.2238898 Epub ahead of print

Gameiro, S. Boivin, J., Peronace, L., & Verhaak, C. M. (2012). Why do patients discontinue fertility treatment? A systematic review of reasons and predictors of discontinuation in fertility treatment. *Human Reproduction Update, 18*(6), 652–669. https://doi.org/10.1093/humupd/dms031

Golombok, S. (2020). *Modern families. The modern transformation of parents and children*. Public Affairs.

Golombok, S. (2021). Love and truth: What really matters for children born through third-

party assisted reproduction. *Child Development Perspectives, 15*(2), 103–109. https://doi.org/10.1111/cdep.12406

Gordon, E., & Grobel, M. (2023). Counseling embryo donors and recipients. In S. N. Covington (Ed.), *Fertility counseling: Clinical guide* (2nd ed., pp. 115-124).

Green, D., Tarasoff, L. A., & Epstein, R. (2012). *Meeting the assisted human reproduction (AHR) needs of lesbian, gay, bisexual, trans and queer (LGBTQ) people in Canada: A fact sheet for AHR service providers*. https://www.rainbowhealthontario.ca/resource-library/meeting-the-assisted-human-reproduction-ahr-needs-of-lesbian-gay-bisexual-trans-and-queer-lgbtq-people-in-canada-a-fact-sheet-for-ahr-service-providers/

Hammer Burns, L., Redlinger-Grosse, K., & Schoonveld, C. (2006). Genetic counselling and the infertile patient. In S. N. Covington, & L. Hammer Burns (Eds.), *Infertility counselling: A comprehensive handbook for clinicians* (2nd ed., pp 258-289). Cambridge University Press.

Holley, S., & Pasch, L. (2023). Counseling lesbian, gay, bisexual and queer fertility patients. In S. N. Covington (Ed.), *Fertility counseling: Clinical guide* (2nd ed., pp. 162-171). Cambridge University Press.

Inhorn, M. C., Birenbaum-Carmeli, D., & Patrizio, P. (2019). Elective egg freezing and male support: A qualitative study of men's hidden roles in women's fertility preservation. *Fertility and Sterility, 112*(3), e95. https://doi.org/10.1016/j.fertnstert.2019.07.369

Jadva, V., Freeman, T., Kramer, W., & Golombok, S. (2009). The experiences of adolescents and adults conceived by sperm donation: Comparison by age of disclosure and family type. *Human Reproduction, 24*(8), 1909-1919. https://doi.org/10.1093/humrep/dep110

Joseph, J., Reese, T., & Moravek, M. (2023). Transgender assisted reproductive technology. In S. N. Covington (Ed.), *Fertility counseling: Clinical guide* (2nd ed., pp. 172-182). Cambridge University Press.

Kim, H. H. (2020). Selecting the optimal gestational carrier: Medical, reproductive, and ethical considerations. Fertility and Sterility, 113, 892–6. https://doi.org/10.1016/j.fertnstert.2020.03.024

Koert, E., Malling, G. M. H., Sylvest, R., Krog, M. C., Kolte, A. M., Schmidt, L., & Nielsen, H. S. (2019). Recurrent pregnancy loss: Couples' perspectives on their need for treatment, support and follow up. *Human Reproduction, 34*(2), 291–296. https://doi.org/10.1093/humrep/dey362

Kuek, C. Y., Gurmukh Singh, S. K. A., & Tay, P. S. (2021). Conception of saviour siblings: Ethical perceptions of selected stakeholders in Malaysia. *Asian Bioethics Review, 13*(2), 167–178. https://doi.org/10.1007/s41649-021-00166-2

Lycett, E., Daniels, K., Curson, R., & Golombok, S. (2004). Offspring created as a result of donor insemination: A study of family relationships, child adjustments, and disclosure. *Fertility and Sterility, 82*, 172-179. https://doi.org/10.1016/j.fertnstert.2003.11.039

Practice Committee of the American Society for Reproductive Medicine (ASRM) (2021b). Guidance regarding gamete and embryo donation. *Fertility and Sterility, 115*(6), 1395-1410. https://doi.org/10.1016/j.fertnstert.2021.01.045

Sachs, P. L., & Hammer Burns, L. (2006). Recipient counseling for oocyte donation. In

S. N. Covington & L. Hammer Burns (Eds.), *Infertility counselling: A comprehensive handbook for clinicians* (2nd ed., pp. 319-338) Cambridge University Press.

Takefman, J. E. (2006). Ending treatment. In S. N. Covington, & L. Hammer Burns (Eds.), *Infertility counselling: A comprehensive handbook for clinicians* (2nd ed., pp. 429-439). Cambridge University Press.

Yee, S., Abrol, K., McDonald, M., Tonelli, M., & Liu, K. E. (2012) Addressing oncofertility needs: Views of female cancer patients in fertility preservation. *Journal of Psychosocial Oncology, 30*(3), 331-346. https://doi.org/10.1080/07347332.2012.664257

Yee, S., Goodman, C. V., Fu, V., Lipton, N. J., & Librach, C. (2021). Parenthood desire, childbearing plans and oocyte utilization among women who previously underwent planned oocyte cryopreservation. *Reproductive BioMedicine Online, 42*(2), 442-450. https://doi.org/10.1016/j.rbmo.2020.10.004

## APPENDIX A: TAKING A PSYCHOSOCIAL HISTORY FOR THE PURPOSE OF FERTILITY COUNSELLING

It is recommended that fertility counsellors include the following items when taking a psychosocial history. If the session includes more than one person, information will be collected for each person. Documentation should be in accordance with the counsellor's professional standards of practice. If working in a medical setting, counsellors may need to follow any additional clinic requirements for record keeping. Counsellors will obtain prior informed consent for participation in counselling and for the collection and use of personal information, according to their code of ethics and standards of practice in their field.

A psychosocial history may include, but not be limited to, the following:

| ✓ | TOPICS |
|---|---|
| | Demographic information |
| | • Name (legal and preferred names) and address |
| | • Birth date, age |
| | • Sex, gender |
| | • Education, occupation |
| | • Relationship status |
| | Reproductive history |
| | • Number and ages of children, if applicable |
| | • Months/years trying to conceive (i.e., see Continuum of Fertility Counselling) |
| | • Does patient have a diagnosis of infertility? If yes, describe |
| | • Is patient attending a fertility clinic? |
| | • History with assisted human reproduction |
| | • History with third-party reproduction? If yes, describe |
| | • Current plans for conception |
| | • History of pregnancy, reproductive loss |
| | Mental health history |
| | • History of mental health diagnoses or concerns |
| | • History of perinatal mood and anxiety disorders (PMADs) |
| | • History of psychological treatment/therapy |
| | • Current mental health status |
| | • Medications (i.e., that relate to mood, sleep, fertility, coping, etc.) |
| | Social support |
| | • Access to a support network |
| | • Level of perceived support |
| | • Impact of infertility/AHR treatment on relationships with others |
| | • Perceived pressure from others/society/culture/community to conceive |
| | • Cultural, religious, or community influences that may play a role |
| | Intrapersonal |
| | • Impact of infertility/AHR treatment on self-esteem, self-image |
| | • Strengths & vulnerabilities |
| | • Stressors, perceived level of stress along with preferred coping strategies |
| | Plan & recommendations |

## APPENDIX B: TAKING A PSYCHOSOCIAL HISTORY FOR THE PURPOSE OF THIRD-PARTY REPRODUCTION COUNSELLING

In third-party reproduction counselling sessions, it is recommended to follow the recommendations described in Section I, Section II, and Section III, and in Appendix A.

In addition, a third-party reproduction counselling session may include, but not be limited to, the following:

| ✓ | TOPICS |
|---|---|
| | Further exploration regarding personal and family history of: |
| | • Psychological diagnoses, personality disorders (some organizations/agencies/cryobanks may request psychological testing)<br>• Current use of psychotropic medications (if relevant)<br>• Past and current substance use, abuse, or dependency<br>• Support from family, partner, friends; Access to professional support<br>• Current sexual relationship(s)/behaviours<br>• Relevant religious or cultural influences<br>• Parenting relationship with existing children<br>• Criminal record/activity (if requested by organizations/agencies/cryobanks) |
| | Implications counselling |
| | Psychosocial implications |
| | • Plans for disclosure to future child and to others<br>• Plans for contact with identified/known donor or surrogate<br>• Awareness of types of non-identified cryobank donation (closed, open)<br>• Grieving the loss of a genetic and/or gestational connection<br>• Motivations for participation<br>• Expectations regarding roles, boundaries, relationships with known parties<br>• Ability to communicate between known parties |
| | Ethical implications |
| | • Assessment of possible coercion, obligation<br>• Beliefs related to prenatal testing and procedures, disposition of embryos, etc. |
| | Legal implications |
| | • Sharing resources where patients can access information on laws and regulations related to assisted human reproduction (e.g., non-payment of donors and surrogates in Canada) and families |
| | Medical implications |
| | • Practical aspects involved in having the time and ability to complete treatment and follow instructions (e.g., medications, appointments, protocols)<br>• Expectations towards success rates of treatment<br>• Exploring any issues regarding fear of procedures, needles, etc. |
| | Psychological capacity to provide informed consent |
| | • Provision of any other relevant resources to facilitate an informed choice, including the Starting Conversations: Donor Conception Resource List (CFAS, 2020b) |
| | Plan & recommendations |
| | • Report sent to clinic (with appropriate consent) to summarize topics discussed and to provide any recommendations |


CFAS.CA