LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON JUSTICE AND COMMUNITY SAFETY
Mr Peter Cain MLA (Chair), Dr Marisa Paterson (Deputy Chair), Mr Andrew Braddock MLA

Submission Cover Sheet

Inquiry into Parentage (Surrogacy) Amendment Bill 2023

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Legislative Assembly for the Australian Capital Territory
Inquiry into the Parentage (Surrogacy) Amendment Bill 2023

Submission from:
ANZICA (Australia and New Zealand Infertility Counsellors Association)

Authors of Submission:

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ANZICA (Australia and New Zealand Infertility Counsellors Association) is the peak professional Australian and New Zealand counselling organisation dedicated to promoting the psychological and social wellbeing of individuals and couples undergoing fertility treatment. Consideration of the best interests of the child to be born from all ART techniques as well as the long-term health and psychological welfare of all involved are paramount and are fundamental principles guiding both counselling practice and process.

Historically, ANZICA counsellors have been active in supporting those undertaking surrogacy since it first commenced in the Australian Capital Territory in the 1990s. Our organisational strengths lie in our comprehensive and longstanding experience with counselling practice across Australia and across diverse surrogacy programmes.

With the principle aim of stakeholder wellbeing and to ensure informed consent and harm minimisation, we contend that expert fertility counselling is required across all key stages of the surrogacy arrangement. Key stages comprise pre-treatment implications counselling and assessment of all stakeholders (i.e. intended parent(s) and surrogate and partner (if applicable); information and emotional support as required during the surrogacy pregnancy; and relinquishment counselling of surrogate and partner (if she has one); and post birth-counselling of all parties to the surrogacy, prior to a parentage order and issuance of a new birth certificate for the offspring conceived via surrogacy arrangements.

To illustrate the expertise and professionalism of ANZICA counsellors in the area of surrogacy related counselling, we have attached four documents to this submission (see addendum):

- ANZICA Surrogacy Guidelines October 2022
- ANZICA Surrogacy Guidelines Addendum June 2022
- Qualifications of Independent Counsellor, Miranda Montrone, August 2023
- Peer review publication journal in Fertility and Sterility involving ANZICA members Montrone and Rodino

ANZICA Recommendations: Proposed Amendments

Firstly, we acknowledge the positive steps forward that have enabled this review of surrogacy legislation in the A.C.T. but we have concerns related to several sections of the Bill. In our submission we wish to comment specifically on the following limitations:

1. Section 28 Counselling

Surrogacy counselling is the most complex form of fertility counselling requiring specialised, detailed knowledge and experience. Applications of fertility counselling include implications counselling, decision making and psychosocial assessment as applied in individual, couple and group format depending upon the specific nature of the surrogacy arrangement. It requires the expertise of counsellors with specific tertiary counselling qualifications, who demonstrate working knowledge of and compliance with regulatory processes in ART, and includes mental health care providers with detailed contemporary knowledge of the medical and scientific processes involved in third party reproduction.

Relevant to harm minimisation, we note that the Parentage (Surrogacy) Amendment Bill 2023 fails to consider a required level of counsellor expertise essential to safeguard clinical practice. We believe this omission poses risks to a surrogacy arrangement and needs to be amended. We recommend there be a requirement that an independent counsellor who is undertaking surrogacy related counselling should have the qualifications and experience that would permit them to become full members of ANZICA, as is required by most jurisdictions in Australia.

From the experience of more than 35 years of surrogacy related counselling by ANZICA members we **do not agree** with sections of Section 28 of the Act particularly 28(2), 28(3) and 28(4). The recommendation of Section 28 (2) "that intended parent/s must receive counselling from a counselling service that is different to the counselling service for which the birth parent and their partner, if any, receive the counselling", is contrary to best practice guidelines and experience of our members. This is misaligned with all other forms of third-party reproduction counselling relevant to surrogacy (e.g. donor sperm, donor eggs, donor embryos, gestational and genetic surrogacy). And the statement in 28(2) that the parties may receive counselling separately from their partner, is contrary to all current third party assisted reproduction counselling recommended in other jurisdictions in Australia.

The only jurisdiction in Australia and New Zealand where there was ever a requirement for pre-surrogacy counselling for parties by separate counsellors prior to a surrogacy arrangement was South Australia. After a review of some cases with significant post surrogacy birth related interpersonal concerns, the legislation was amended to ensure that pre-surrogacy counselling of parties to a surrogacy arrangement is undertaken by one experienced counsellor. And in a 2018 South Australian Law Reform Commission Review of surrogacy legislation (Surrogacy A Legislative Framework page 233) it was stated *"previous counselling requirements"* of *"three separate counsellors were unworkable."*
https://law.adelaide.edu.au/ua/media/749/salri_surrogacy_report_oct_2018_0.pdf

From the experience of ANZICA counsellors since the late 1970s, third party reproduction with parties who are known to each other, such as occurs in altruistic surrogacy arrangements in Australia, is a complex interpersonal process involving intended parent/s, and birth parents and partners, and sometimes gamete/embryo donors, who often have long term relationships, before and after a surrogacy birth. These relationships may include current offspring, and will also include offspring of the proposed surrogacy arrangement who may have a genetic connection to the birth parent and/or donor/s.

We further note that there is no requirement in the Amendment to the Parentage (Surrogacy) Act 2023 for post birth counselling of parties undergoing a surrogacy arrangement. This period is extremely critical in terms of ongoing relationships and psychological wellbeing. The intended parent/s are understandably very preoccupied with caring for their much longed for child/ren, and the birth parent is physiologically and emotionally still impacted by the gestation and birth for the surrogacy. We note that even with the good will and best intentions of all parties to a surrogacy arrangement and previous pre-surrogacy implications and assessment counselling, ANZICA members have found that there may on occasions be post birth interpersonal problems which can be mitigated with professional post-birth counselling.

Surrogacy is not an insignificant or minimal psychosocial or medical situation. It is a procedure that represents the only opportunity for intending parent(s) to have a child and should never be used as a means for social convenience or financial gain. It requires one person (birth parent) to offer their assistance through assisted conception, pregnancy, gestation and birth, with concomitant significant related medical, physiological and psychosocial implications for herself and her family as well as for the intended parent/s and offspring of the surrogacy. From the experience of ANZICA members we would recommend that there be the addition of a requirement for there to be post-birth relinquishment counselling for the birth parent and her partner, as well as parentage order counselling for all parties to the surrogacy arrangement and the offspring prior to the granting of the parentage order.

In summary, our suggestions for amendments to Section 28 of the Act include:

- Pre-surrogacy counselling of all parties to a surrogacy arrangement, should be undertaken by a counsellor with qualifications and experience that would permit them to be full members of the peak professional fertility counselling organisation - ANZICA. This implications and assessment counselling should include individual, couple and group counselling, and production of a detailed report on the pre-surrogacy counselling made available to all parties.

- Post surrogacy counselling, which is not currently included in the Amendment to the Parentage (Surrogacy) Bill 2023. This requirement is recommended for inclusion for all parties to a surrogacy arrangement. This counselling would include separate post birth relinquishment counselling for the birth parent and her partner if she has one; as well as post birth counselling of all parties to the surrogacy arrangement with the child/ren born of the surrogacy, prior to the issuance of a parentage order.

2. **Section 31B Parentage Order – commercial arrangement made, and child born before commencement day; and other Sections of the Parentage (Surrogacy) Amendment 2023 relating to Commercial Surrogacy arrangements overseas.**

In 2015 and 2016 ANZICA members, together with many other professionals working with surrogacy arrangements (legal, medical, immigration department etc) made submissions and were included in a Roundtable discussion, as part of a Federal Government Inquiry into Surrogacy. In May 2016 the Report on the Inquiry was tabled in the Federal Parliament, with the Inquiry Report being available on the Federal Government website:
"Surrogacy Matters: Inquiry into the Regulatory Aspects of International and Domestic Surrogacy Arrangements" May 2016:
https://www.aph.gov.au/Parliamentary_Business/Committees/House/Social_Policy_and_Legal_Affairs/Inquiry_into_surrogacy/Report

Unfortunately, there have been no Federal Government legislative changes following this Inquiry and Report, but many of the recommendations in "Surrogacy Matters" addressed important issues relating to international commercial surrogacy arrangements. We are pleased that the A.C.T. legislation is addressing a problem area of surrogacy, and we would suggest incorporating some of the "Surrogacy Matters" recommendations in the Parentage (Surrogacy) Amendment Bill 2023. For example, Recommendation 2 *"that sufficient regulatory protections are in place to protect the surrogate mother from exploitation"*; and Recommendation 3 *"the need for mandatory, independent and in-person counselling for all parties before entering into a surrogacy arrangement, during pregnancy, and after the birth, and at relinquishment".*

Further, we would suggest that, prior to the issuance of a parentage order in the A.C.T., that there be a mandatory requirement for written evidence that professional counselling was included as part of a commercial surrogacy arrangement. Such professional comprehensive biopsychosocial counselling, with interpreters, if necessary, should include thorough counselling of all parties: intended parent/s, birth parent/surrogate and her partner if she has one, and donors of gametes if used. Whilst this information may not be available for historical surrogacy cases it could be noted as a requirement for future commercial surrogacy arrangements overseas.

3. **Surrogacy Regulation 2023 Section 4 Reasonable Expenses**

Although surrogacy is altruistic in Australia, and we agree should remain altruistic, there are significant costs for the legal, counselling and medical processes related to a surrogacy pregnancy conception and birth. Discussion of money between friends and family can be problematic at the best of times, and from our experience it is not uncommon for a birth parent to find it awkward to request reimbursement of surrogacy related costs from the intended parent/s. As costs mount up during a surrogacy it can also become difficult for the intended parent/s to find the money to pay for all the incidental items that relate to the surrogacy arrangement. Our counsellors have found that the management of reimbursement of money can be problematic, even with the best will and intention of parties to a surrogacy arrangement.

We support the detail about expenses in this Surrogacy Regulation, although we wonder if there may be unmet needs not covered by Regulation 4. These include incidental expenses related to the pregnancy such as maternity clothes, creams/oils for the pregnancy, parking/travel expenses related to counselling provision, and the loss of income and penalty rates during maternity leave.

4. Reason for Surrogacy

Finally, and importantly, we are unable to discern any information in the Parentage (Surrogacy) Amendment Bill 2023 related to the reason for a surrogacy arrangement taking place. This could potentially leave it open to people deciding on surrogacy because of an inconvenience without an essential need for surrogacy for them to have their child/ren. We recommend clarity on this matter and suggest that it be specified in the Bill that this process is the best or only opportunity for intended parents to have a child, and none of the parties to the surrogacy are using the procedures for social or financial gain. Examples of reasons for surrogacy include: an intended mother was born without a uterus, or has had her uterus removed for medical reasons; or where pregnancy is contraindicated on health grounds; or when the need for surrogacy occurs for a single man, or a male couple, who wish to become parent/s but are unable physically to carry a baby, without a uterus.

We thank you for the opportunity to make this submission and would be available to speak to the Inquiry Committee about our submission, if it were to be requested.

Kind regards,

Rebecca Kerner, Iolanda Rodino, and Miranda Montrone
On behalf of the ANZICA Executive
4 December 2023

Addendum: Background information illustrating surrogacy expertise of ANZICA members

ADDENDUM

We have attached documents which exemplify the expertise of ANZICA members in surrogacy related counselling and which support our submission:

- Attachment 1 - **ANZICA Surrogacy Guidelines 2022**: details the requirements for surrogacy related counselling before and after a surrogacy related birth, which may be using the eggs of the birth parent (known as genetic, traditional or insemination surrogacy) or gestational surrogacy (using the gametes of the intended parent/s and/or donor eggs/sperm). Note that counselling may not only be required before a surrogacy conception, but also after a birth of offspring from the surrogacy arrangement and before the granting of a parentage order and issuance of a new birth certificate.

- Attachment 2 – **ANZICA Surrogacy Guidelines Addendum June 2022**: details the requirements for surrogacy related counselling in all jurisdictions in Australia and New Zealand. All jurisdictions require counselling before a surrogacy conception, which includes implications and assessment counselling, as well as information and support counselling. Some jurisdictions require counselling after a surrogacy birth, and counsellors in all jurisdictions would provide supportive counselling during a surrogacy pregnancy and birth if requested by any or all parties to a surrogacy arrangement. Most jurisdictions, require that the counsellor be able to demonstrate that they have the qualifications and experience to be able to undertake surrogacy counselling.

- Attachment 3 – Qualifications of Independent Counsellor, Miranda Montrone, an ANZICA counsellor from New South Wales, and a signatory to this submission, who has significant surrogacy related counselling experience since the late 1990s. This surrogacy counselling with people in more than 300 surrogacy arrangements, includes counselling before, during and after a surrogacy birth, and includes counselling for surrogacy arrangements of people in the A.C.T.

- Attachment 4 – Peer Reviewed Research Publication: **Montrone** M, Sherman KA, Avery J, **Rodino** I.S. A comparison of sociodemographic and psychological characteristics among intended parents, surrogates, and partners involved in Australian altruistic surrogacy arrangements. Fertility and Sterility 2020; Vol 113 (3), p642-652. Objective of study: To characterize the sociodemographic and psychological profiles of participant groups involved in altruistic surrogacy in Australia. https://www.fertstert.org/article/S0015-0282(19)32530-0/fulltext

ANZICA SURROGACY GUIDELINES

October 2022

1. Mission Statement:

ANZICA (Australia and New Zealand Infertility Counsellors' Association) is the peak professional Australian and New Zealand counselling organisation dedicated to promoting the psychological and social wellbeing of individuals and couples undergoing fertility treatment. Consideration of the best interests of the child to be born from ART techniques, including through surrogacy, is paramount and is a fundamental principle guiding both counselling practice and process.

2. Background

Family formation through the process of surrogacy is considered both a complex psychological and social process. A surrogacy arrangement is one in which before the child is conceived, the intended parent/s and the surrogate (and their partner, if she has one) agree that the surrogate will become pregnant with the intention that the child will, at birth, be given into the care of the intended parent/s to raise as their own. The most common reasons for surrogacy are absence of the uterus (such as after surgery for women, or for men who may be in a same sex relationship or may be single), congenital malformation of the uterus, or a medical condition that compromises pregnancy making it unsafe for the woman or her prospective baby.

Potentially, there are a number of situations that could be encompassed within the definition of surrogacy. A surrogate conception may occur where the genetic material is provided by both intended parents or by one only of them, by both of the surrogate parents, or by one only of them, or by third-party donors who are not involved in the actual surrogacy arrangement. It follows that conception in a surrogacy arrangement has the potential to come about naturally, through assisted reproductive technology, or through the surrogate's self-insemination. Surrogacy as practised in Assisted Reproductive Technology (ART) clinics is primarily IVF or gestational surrogacy, which does not involve any genetic material of the surrogate or their partner; with insemination surrogacy (also known as traditional or partial) being less common; and natural conception surrogacy being extremely rare.

There is significant variation in the laws that govern the practice of surrogacy across the Australian states and territories and New Zealand. Counsellors should therefore have a thorough knowledge of the relevant legislation in their own jurisdiction including knowledge of the assisted reproductive

treatment and psychosocial implications associated with the differing forms of a surrogacy conception arrangement.

Information about the legislated requirements for surrogacy counselling in each jurisdiction is included in an addendum to these guidelines – (see Addendum: Surrogacy Legislation in each state or territory of Australia, and in New Zealand, and requirements for counselling related to surrogacy arrangements.) This information includes the counselling requirements before, during and after a surrogacy birth, in addition to the requirements for the qualifications of counsellors who undertake surrogacy related counselling.

In Australia in May 2016, a report was released following an Inquiry by the House of Representatives, Standing Committee on Social Policy and Legal Affairs, entitled: "Surrogacy Matters: Inquiry into the regulatory and legislative aspects of international and domestic surrogacy arrangements.[1] In the Foreword to this report it was stated *"The Committee recommends that the practice of commercial surrogacy remain illegal in Australia."* The Committee also made recommendations in an attempt to improve the processes related to Australian children born through overseas surrogacy arrangements. The Committee supported altruistic surrogacy in Australia and recommended the development of a nationally consistent legal framework in Australia to be based on:

"Four key principles:

- ***the best interests of the child,***
- ***the surrogate's ability to make free and informed decisions,***
- ***ensuring the surrogate is free from exploitation, and***
- ***legal clarity about the resulting parent-child relationships."***

To date, no nationally consistent framework has been implemented. These counselling guidelines have been written in the context of the Committee's recommendations particularly in regard to the counselling in surrogacy arrangements.

3. Pre-Surrogacy Counselling

The provision of client/patient centred counselling is an indispensable part of the preparation of those wishing to access surrogacy treatment. It should be provided by appropriately qualified and trained practitioners, who are full members of ANZICA. It should also be integral to clinic protocol for surrogacy treatment which might also include consultations with: one or more medical specialists (including an independent gynaecologist); one or two legal practitioners; possibly a psychiatrist; as well as counselling by the clinic counsellor and an assessment by an independent psychologist/counsellor.

[1] (http://www.aph.gov.au/Parliamentary_Business/Committees/House/Social_Policy_and_Legal_Affairs/Inquiry_into_surrogacy/Report)

The current status of surrogacy counselling by ART clinic counsellors varies from little or no surrogacy counselling (where all such counselling is left up to the independent counsellor) to much more intensive clinic counselling where there are multiple contacts by the clinic counsellor with all parties to a surrogacy arrangement over a number of months. Irrespective of how it is organised, pre-treatment counselling needs to be respectful of the needs of all involved in the surrogacy proposal, including the intended parent/s, the surrogate and partner if she has one, and any children of the intended parent/s or of the surrogate, and of potential unborn offspring of the surrogacy treatment.

A comprehensive biopsychosocial evaluation of a surrogacy proposal, often done by an independent counsellor, includes a personality assessment to exclude psychopathology, consideration of the connections between the parties to the proposal, reproductive history and any history of trauma or loss, possible coercion or financial inducement (explicit or implicit) and expectations of a surrogacy pregnancy and delivery and the implications of medical or psychological complications.

The pre-surrogacy treatment counselling process must give time and space for a thorough consideration of the implications of the proposed treatment and the opportunity for a change of mind, -thus minimising possible rupture of relationships (which may be longstanding). Comprehensive pre-surrogacy counselling is an integral part of ensuring full informed consent as well as assessing surrogacy suitability.

4. Counselling Roles in Surrogacy Counselling

a. Clinic Counsellor:

The role of the clinic counsellor in providing counselling is different from that of a practitioner providing independent psychological assessment and/or advice and guidance. Although it is inevitable that clinic counsellors working with participants to a surrogacy arrangement will note the personality characteristics and functioning of their clients, it is essential that the work of such a counsellor not be confused with that of an independent psychologist/counsellor who has been commissioned to provide surrogacy advice and guidance or a formal assessment on these matters, including participants' suitability for the proposed treatment.

At the pre-surrogacy stage this role varies according to the jurisdiction in which the surrogacy arrangement is to take place. In some jurisdictions the independent counsellor's role is to provide a detailed psychosocial assessment including psychometric testing. In others it may be more focussed on implications counselling and decision making, and it may or may not require a comprehensive report. In other jurisdictions the independent counsellor is not required to do any implications or decision making counselling but has a role restricted solely to assessment of the parties for the purposes of treatment suitability.

During the pre-surrogacy assessment stage, the impact on children, (including those of the surrogate), must further be considered as part of the overall assessment - in some jurisdictions it is a mandatory requirement that children be seen as part of the assessment. Whilst pre-surrogacy counselling addresses many of the issues which may have been raised in implications counselling by a clinic counsellor the primary purpose of an independent assessment is to provide the treating clinic with an objective, succinct, accurate description of the emotional and psychological preparedness of the

participants to the surrogacy proposal. It is not intended for on-going supportive counselling, crisis counselling or psychotherapy.

Subject to legislative requirements a clinic counsellor's report might be requested by clinic management prior to the surrogacy arrangement proceeding. This should be written using a descriptive framework – summarizing the issues that have been discussed. A clinic counsellor would typically focus on current issues including: communication and relationships between all parties, strategies for managing conflict, recommended surrogacy preparations, life priorities, and expectations of treatment. The counsellor should ensure that the best interests of children are paramount - this includes the children of all parties.

b. Independent Counsellor:

In a number of jurisdictions there is a requirement for there to be assessment and counselling conducted by a counsellor who is independent of the treating fertility clinic. This counsellor may be involved at various stages throughout the surrogacy arrangement including: the pre-surrogacy or post-birth stage of a surrogacy arrangement or at times, both. This is consistent with recommendation 3 from the Australian Federal Government Inquiry Surrogacy Matters which stipulates: "The need for mandatory, **independent** and in-person counselling for all parties before entering into a surrogacy arrangement, during pregnancy, after the birth, and at relinquishment." Pre-surrogacy assessment is a requirement mandated by many legislations and a number of treating clinics and would usually include psychometric testing which must be provided by an appropriately qualified professional.

Assessment counselling requires a formal structured counselling process to gather and assess relevant information about the functioning and motivation of all involved in the surrogacy proposal. The assessment process includes structured clinical interviews of all involved (as individuals, as couples and as a group) and often the use of an objective measure of psychopathology as part of the psychosocial screening process. In some jurisdictions there is a legislated requirement for the assessment counsellor to give their written opinion as to the suitability of the parties to participate in a surrogacy arrangement.

Assessment counselling requires there to be at least one occasion in which all the parties to the surrogacy arrangement are seen in person by the mental health practitioner who is undertaking the psychosocial assessment prior to the surrogacy arrangement. This is also required by the guidelines issued by the Family Court of Australia for assessment: Australian Standards of Practice for Family Assessments and Reporting February 2015 [2] where it is stated in Section 14 (page 17):

- Family assessors should conduct at least one in-person interview with each parent and other adults who perform a caretaking role with the children.
- Telephone or video interviews can be used as a supplementary means of interview with adults

[2] (http://www.familycourt.gov.au/wps/wcm/connect/fcoaweb/about/policies-and- procedures/asp-family-assessments-reporting

- Where there is no alternative but to interview an adult by telephone, this must be noted as a significant limitation of the assessment, and the reasons for undertaking a phone interview articulated.

ANZICA acknowledges some of the complexities of providing face-to-face assessments created through fluctuating public health safety directions and clinic rules during the era of the COVID-19 pandemic. Therefore it may be appropriate that surrogacy counselling be carried out via telehealth during the COVID-19 pandemic restrictions only. Importantly, where psychometric assessment is undertaken remotely, this is at the discretion of that particular counsellor and they should follow the current guidelines of their professional association.

Issues that may need consideration in pre-surrogacy counselling:

Psychological Wellbeing:

- Reproductive and infertility history, how these have been coped with.
- Consideration of the emotional challenges to and capacity of the intended mother to manage the challenges of another woman carrying her baby.
- Mental health history and current psychological state.
- Psychological Entitlement – the sense that the world owes them.
- Any other stress factors – major upheavals or transitions.

Relationships:

- How discussions about the surrogacy arrangement with the surrogate first came about.
- Relationship between the individuals involved and implications of surrogacy (capacity to make independent decisions – financial or emotional dependence issues.)
- Relationship stability of all parties to the surrogacy arrangement.
- Commitment to and motivation for surrogacy and its unique demands, potential benefits and cost to the surrogate and her family.
- Implications for any existing partner and risk factors (i.e. partner support)
- Implications for any existing children and risk factors such as any loss issues and how parents intend to deal with them. (Some jurisdictions require for children between 4 and 18 years to be counselled in an age appropriate manner. Most legislations do not require that the children be seen, but that the issues of the children be considered in the counselling.)
- Differences in parenting styles.
- Possible complications that may affect a couple or individual, e.g. relationship breakdown, medical problems, even death.
- Contraceptive measures used by all parties and the psychosocial implications if a spontaneous pregnancy were to occur during surrogacy treatment.
- Expectations regarding ongoing relationships and the role of the surrogate with the future child.

Gametes/Embryos:

- If donor gametes or embryos are to be used - the implications and understanding of all parties to the surrogacy arrangement.
- If the intended parents are a same sex couple, decision making around whose sperm is to be used to form the embryos in the surrogacy arrangement.
- Decision making about number of embryos to be transferred.
- Intentions re disclosure and explanation to others.
- The availability of a permanent, accurate record of conception, gestation and birth for the child born of surrogacy.
- Decision making regarding additional embryos and any plans for another child.

Surrogacy Treatment:

- The amount of perceived control that the intended parent/s have over the surrogate's behaviour during the pregnancy and whether this is a concern.
- Lifestyle factors that may be of concern during a surrogacy pregnancy.
- Pregnancy risk factors: pre-eclampsia, gestational diabetes, risk of death of surrogate
- The possibility of a multiple birth, and positions of all parties.
- Attitudes to pre-natal screening and termination of pregnancy.
- The possibility of legal termination of a pregnancy if a child is diagnosed before birth with a disability or abnormality.
- The possibility of the surrogate deciding against a termination in the above situation and subsequent care of the child.

Legal/Process:

- Forensic history of all parties.
- Awareness and acceptance of legal ramifications, and informed consent issues.
- Information on research outcomes in ea.
- Change of mind by a party before or during the process.
- The possibility of a breakdown in the arrangement, such that the surrogate refuses to relinquish the child to the intended parents and/or wishes to keep the baby.
- The possibility of a breakdown in the arrangement, such that the intended parent/s refuse to accept and patent a child born with a disability.
- The need for the parties to agree on a process for resolving disputes if there is any conflict or significant difference of opinion over issues such as treatment decisions, The reimbursement of expenses, or post-delivery issues.

Summary: ANZICA Counselling Pre-Treatment Practice Standards

Based on the aforementioned, the following are best practice minimum standards psychosocial/counselling guidelines recommended by consensus by the ANZICA Executive Committee.

It is recognised that legislative requirements and clinic policy may override these ANZICA counselling guidelines.

ANZICA recommends that:

- Counselling is only undertaken by a counsellor eligible for full membership of ANZICA.
- All parties and their partners must have separate interviews with a minimum of 2 interviews for each party; and a joint session with all parties.
- All counselling should be undertaken with sufficient time between sessions for all parties to consider and reflect on the gravitas and complexities of the arrangement as well as to have relevant discussions with each other as needed.
- Counselling with all parties in the arrangement must not be completed in one day.
- A further joint counselling session after a 3 month cooling off period before the arrangement is allowed to proceed. This process may vary between clinics and jurisdictions but will usually include an independent counsellor and a psychological assessment of all parties.
- Ideally, the youngest child of the surrogate is at least 12 months old before the surrogacy arrangement is allowed to proceed.
- Given the complexities involved in surrogacy, it is recommended that face-to-face counselling is the optimal mode of conducting the pre-surrogacy counselling sessions and psychometric testing. The providers of online counselling and online psychometric assessments must take responsibility for their own practice decisions and outcomes and test standardization and security should always remain paramount.

5. Counselling during ART treatment and surrogacy pregnancy

Counselling requirements, if any, including mode of counselling, frequency of counselling and provider of counselling are determined by specific legislation in each jurisdiction. (See Addendum) Even if not legislated there may arise a need for counselling during treatment or after a pregnancy (but before delivery of the baby).

Supportive counselling would be provided at this stage though sometimes issues may arise between the parties to the surrogacy arrangement which can call for intensive implications and relationship counselling. Counselling can also include discussion of plans for the delivery and handover of a baby, and discussion of planned post-delivery contact.

Counselling at this stage tends more often to be completed by the clinic counsellor, but there may also be contact with an independent counsellor, depending on the preferences of the parties to the surrogacy arrangement. In this latter situation it may necessitate a review of the external counselling implicit 'contract' to move from an assessment role to a supportive or therapeutic counselling role. Follow up counselling after treatment, whether there is a pregnancy or not, is however highly recommended and should be available to all parties to a surrogacy arrangement. It is however not common for there to be a legislated requirement for surrogacy pregnancy counselling before delivery of a child/ren conceived through a surrogacy arrangement or if there is a miscarriage. (See Addendum for guidance on legislation for each jurisdiction)

6. Post Surrogacy Birth counselling:

Follow up counselling of the surrogate and her partner after delivery of a surrogacy baby is highly recommended and should be available to all participants. In some jurisdictions, there is a formal requirement for counselling post-delivery which may be provided by either the clinic counsellor or the independent counsellor. This professional may or may not be the same person who has completed the pre- surrogacy assessment counselling.

And in some jurisdictions a post surrogacy birth report, for use in an application for a parentage order, must be prepared by an independent and appropriately qualified counsellor with there being a legislated requirement for this to be an independent counsellor other than the counsellor who did the pre-surrogacy counselling. Therefore there are two different forms of counselling required after delivery of a child/ren conceived through a surrogacy arrangement:

a. Relinquishment Counselling, of surrogate and her partner:

The focus of this counselling is on the needs of the surrogate and her family after the delivery of a baby through a surrogacy arrangement.

Issues that may need consideration in relinquishment counselling:

- The surrogacy pregnancy and how it was the same and different from the
- surrogate's own previous pregnancy/s;
- The delivery and handover of the baby – how it proceeded, who was present, and reactions of all parties during delivery and afterwards;
- Emotional and physical reactions of the surrogate before, during and after delivery of the baby;
- Effects on the surrogate's partner and family;
- Post birth contact of the surrogate with the baby and the intended parents;
- A review of the overall impact of the surrogacy experience compared with expectations and how any differences have been experienced and dealt with, as well as plans for the future.

b. Parentage Order Counselling:

In counselling for parentage order reports the focus of the counselling is on the best interests of the child/ren born of the surrogacy arrangement.

Implications for pre-existing children of the surrogate should also be considered. Sometimes a report for the court is required following this counselling, in other situations there may only be a requirement for the counsellor to sign a certificate confirming that the counselling has occurred.

Issues that may need consideration in parentage order counselling:

- The understanding of all parties involved in the surrogacy arrangement of the social and psychological implications of the making of a parentage order (both in relation to the child and to any affected parties);
- Each party's understanding of the principle that openness and honesty about a child's birth parentage is in the best interests of the child/ren;
- The care arrangements proposed by the intended parent/s in relation to the child/ren;
- Any contact arrangements proposed in relation to the child/ren and the intended parent/s with his or her birth parent or parents or biological parent or parents;
- The parenting capacity of the intended parent/s;
- Whether any consent given by the birth parent or parents to the parentage order is informed consent, freely and voluntarily given;
- The wishes of the child/ren, if the counsellor is of the opinion that the child is of sufficient maturity to express his or her wishes.
- Consideration of whether the making of a parentage order would be for the wellbeing and in the best interests of the child/ren.

7. Conclusion

The counselling role varies depending upon the stage of the surrogacy arrangement and legislative requirements. Each counsellor must ascertain the specific requirements of practice in their particular situation to ensure that the counselling protocol fits the regulatory requirements. (See Addendum) Whilst there are differing legislative situations in each state of Australia and in New Zealand which outline the counselling before, during and after a surrogacy pregnancy and delivery, the key aspects of surrogacy counselling remain as outlined in these guidelines.

Differences in whether the counselling is done in-clinic or by a practitioner independent of the clinic or by a combination of both depend on the requirements of differing jurisdictions (See Addendum to these guidelines) as well as the approaches of individual ART clinics. It is however the responsibility of any counsellor undertaking any part of surrogacy related counselling, to ensure that the issues listed in these guidelines are covered, either by themselves or by another counsellor/s involved in the surrogacy case.

8. Addendum to Surrogacy Guidelines

Surrogacy legislation and corresponding counselling requirements varies according to state or country of counselling practice. For further information ANZICA members are directed to the document called *Addendum: Surrogacy Legislation in each state or territory of Australia, and in New Zealand, and requirements for counselling related to surrogacy arrangements August 2016" located in the ANZICA members resource section of the FSANZ website.*

Addendum to ANZICA Surrogacy Guidelines - Surrogacy Legislation in New Zealand and each Australian state or territory of Australia, and requirements for counselling related to surrogacy arrangements V5-June 2022

Legislation	Counselling Requirements	Counsellor Eligibility

Australian Capital Territory

This is summary information.
It is recommended that the relevant Act/s be read before undertaking counselling.

Legislation	Eligibility criteria	Pre Surrogacy	During Treatment/ Pregnancy	Post Birth	Counsellor/s
Surrogacy Act 2004 **Key Issues:** Conception must occur in ACT Traditional surrogacy prohibited. At least one IP must be genetic parent Surrogacy agreement can be oral. Surrogate and partner legal parents at birth. IPs apply to Supreme Court for Parentage Order when child is 6 weeks - 6 months age. Commercial surrogacy prohibited, payments to surrogate strictly to reimburse expenses connected to surrogate pregnancy. Illegal to advertise for surrogacy Illegal to undertake a commercial surrogacy arrangement overseas	IP: - min age 25 - married or defacto couple - resident of ACT Surrogate: - min age 18 - in a couple relationship. - must have birthed own child	In clinic and external counselling required. * Purpose of the surrogacy report S26.3.e "whether both birth parents and both substitute parents have received appropriate counselling and assessment from an independent counselling service". 2 ACT clinics offer surrogacy. Information from Canberra Fertility Centre (CFC) below is an indication of requirements: *Assessment by external counsellor eligible for registration with AASW, ANZICA or APS. Assessment must attend to required "questions" in CFC booklet. Personality testing at counsellor discretion. External counsellor makes recommendations for counselling during pregnancy and post-delivery. *Clinic counsellor sees patients before treatment, repeating surrogacy "questions". *'Cool-off' period before treatment.	No legislative requirements. CFC: Counselling recommended, but not a requirement of the clinic	No legislative requirements. CFC: Counselling recommended, but not a requirement of the clinic.	Definition of Appropriate Counsellor: S26.5 "a counselling service is not independent if it is connected with— (a) the doctor who carried out the procedure that resulted in the birth of the relevant child; or (b) the institution where the procedure was carried out; or (c) another entity involved in carrying out the procedure. Pre-surrogacy assessment done by external counsellor who is registered or eligible for registration of AASW, ANZICA, APS.

Addendum to ANZICA Surrogacy Guidelines - Surrogacy Legislation in New Zealand and each Australian state or territory of Australia, and requirements for counselling related to surrogacy arrangements V5-June 2022

Legislation		Counselling Requirements			Counsellor Eligibility
New South Wales		**This is summary information. It is recommended that the relevant Act/s be read before undertaking counselling.**			
Legislation	**Eligibility criteria**	**Pre Surrogacy**	**During Treatment/ Pregnancy**	**Post Birth**	**Counsellor/s**
Surrogacy Act 2010 No 102 Vs 7/6/2011 **Surrogacy Regulation 2016 Vs 29/7/2016** **Assisted Reproductive Technology Act 2007 No 69 Vs 8/1/2019** **Assisted Reproductive Technology Regulation 2014 vs 24/7/2020** **Key issues:** Medical or social need for surrogacy required. Traditional surrogacy is permitted. No restrictions on gametes used. Must have written surrogacy agreement Reimbursement of birth mother costs is enforceable	IP: - Min age 18 years BUT assessment of maturity for anyone under 25 years - any single person or couple. - resident of NSW Surrogate: - min age 25 years - does not have to birthed own child	**Surrogacy Act S35 (1)** Each party must have received counselling from an independent qualified counsellor about the surrogacy arrangement and its social and psychological implications before entering into a surrogacy arrangement. Independent counsellor must assess the parties for suitability to participate in a surrogacy arrangement and for the IPs to be parents. **AND** **A.R.T Act 2007 amendments 2010 S15A** Before treatment a medical practitioner must receive assessment report from qualified counsellor, providing opinion as to whether the parties suitable persons to enter into surrogacy arrangement. Report also required by legal practitioners for the court if there is a surrogacy birth. **Clinic Counselling** Some clinics also provide counselling on the issues listed in the ANZICA guidelines, as well as providing supportive counselling.	No legislative requirements though some clinics do provide counselling support and implications counselling as part of their processes; and when it is required for a surrogacy arrangement.	**Surrogacy Act S35 (2)** The birth mother and the birth mother's partner must have received further counselling from a qualified counsellor about the surrogacy arrangement and its social and psychological implications after the birth of the child and before consenting to the parentage order. **Surrogacy Act S 17** Application for parentage order must be supported by a report prepared by another independent counsellor. Section 17 outlines the issues to be considered by the counsellor for the writing of the parentage order counselling report. **ART Act 2007 and ART Regulation 2014–** Information related to the	**Surrogacy Act S 4** No formal accreditation process for counsellors. "Qualified counsellor": person who has the experience or qualifications required by the regulations to exercise the functions of a counsellor under the Act **AND** **Surrogacy Regulation S 6** "Qualified counsellor" must be eligible as member of ANZICA, and familiar with relevant guidelines. **Surrogacy Act S17 (7)** An independent counsellor cannot be a clinic counsellor and/or cannot be connected with a medical practitioner who did the surrogacy treatment AND must be a qualified psychologist, psychiatrist or social worker, with specialist knowledge.

Commercial surrogacy prohibited, payments to surrogate strictly to reimburse expenses connected the surrogate pregnancy. Surrogate and partner recognized as birth parents. IPs can apply to Supreme Court for a Parentage Order any time following birth, before the child turns 18. Permitted to advertise for surrogacy Illegal to undertake a commercial surrogacy arrangement overseas				conception and birth of offspring of surrogacy arrangements is held in NSW Central Register. For contact there may be requirement for a psychological report under Section 23A of the ART Regulation 2014	

Addendum to ANZICA Surrogacy Guidelines - Surrogacy Legislation in New Zealand and each Australian state or territory of Australia, and requirements for counselling related to surrogacy arrangements V5-June 2022

Legislation	Counselling Requirements	Counsellor Eligibility
New Zealand	**This is summary information. It is recommended that the relevant Act/s be read before undertaking counselling.**	

Legislation	Eligibility criteria	Pre Surrogacy	During Treatment/ Pregnancy	Post Birth	Counsellor/s
HART Act 2004 **Adoption Act 1955** **Status of Children Amendment Act 2004** **The Hague Convention** **ACART** **Advice to ECART** **ECART issues and guidelines** **Key Issues:** Ethics Committee approval required Prior approval for adoption via surrogacy must be sought by IPs from Oranga Tamariki. Illegal to take parental responsibility until sanctioned All parties must receive independent legal advice and medical consultation. Additional medical specialist reports may be required Legislation only applicable to surrogacy involving fertility	IPs: - Heterosexual or homosexual couples, single women Surrogate: - min age 20. If over 45, usually require obstetric physician review	Independent pre-surrogacy psychology report required as an addition to counselling if parties have a history of mental health issues. All parties must have counselling from an ANZICA counsellor independent of each other and together	Clinic counsellors provide follow up and counselling if needed	Oranga Tamariki give consent to baby being in care of IPs (or baby cannot be in their care until consent to adoption signed 10 days postbirth) Interim adoption order and Final adoption order applied for by IPs' lawyer Clinic ANZICA counsellor follow up	Each party must have a different counsellor who is an ANZICA member Independent psychological assessment or psychiatric assessment sometimes required.

providers. All fertility providers must apply to ECART Surrogate (and partner) legal parents at birth. Consent to relinquishing parental rights must be signed by surrogate >10 days post birth Surrogate has all legal rights about the pregnancy No payment for loss of earnings- only medical and some legal expenses Traditional surrogacy permitted					

Addendum to ANZICA Surrogacy Guidelines - Surrogacy Legislation in New Zealand and each Australian state or territory of Australia, and requirements for counselling related to surrogacy arrangements V5-June 2022

Legislation	Counselling Requirements				Counsellor Eligibility
Northern Territory	**This is summary information. It is recommended that the relevant Act/s be read before undertaking counselling.**				
Legislation	**Eligibility criteria**	**Pre Surrogacy**	**During Treatment/ Pregnancy**	**Post Birth**	**Counsellor/s**
Surrogacy Act 2022 Explanatory Statement, Surrogacy Bill 2022 **Key issues:** S5. The paramount consideration in respect of the administration and operation of this Act is the best interests of the child born under a surrogacy arrangement. S10. A surrogate mother has the same rights to manage her pregnancy and birth as any other pregnant woman. S12 Reimbursement of reasonable costs to the surrogate mother is enforceable. S14. The surrogacy arrangement must be in writing. S15. Surrogacy arrangement	**Intended Parent/s** - Minimum age 25 years BUT can be exception if assessment of maturity for anyone under 25 years - any single person or couple. - must be Australian citizen/s or permanent resident/s. **Surrogate:** - min age 25 years BUT can be exception if assessment of maturity for anyone under 25 years Australian citizen or permanent resident. No requirement to have birthed own child.	**Surrogacy Act S22(1-3)** Each party to the surrogacy arrangement must undertake counselling about the surrogacy arrangement and its implications before entering into the surrogacy arrangement. The counselling may be provided by more than one counsellor. The counsellor must prepare a certificate on the counselling and give it to the person counselled. **Surrogacy Act S22 (4)** The certificate must certify the following matters: The qualifications of the counsellor; that the counsellor is independent of any business providing fertility services; the names of the persons who were counselled; the dates of the counselling; that counselling on the required matters was provided; in the case of a surrogate mother under 25 years – that exceptional circumstances exist to justify her entering into the surrogacy arrangement; in the case of an intended parent under 25 years – that the intended parent is sufficiently mature to understand the	No legislative requirements	**Surrogacy Act S23** The surrogate mother, her partner, if any, and any other birth parent must undertake counselling about the surrogacy arrangement and its social and psychological implications after the birth of the child and before consenting to the parentage order. The counselling may be provided by the same counsellor that provided counselling before the surrogacy arrangement. **Surrogacy Act S24**(1) Each party and any birth parent of the child who is not a party to the surrogacy arrangement must have counselling for the purpose of a **Report for**	**Surrogacy Act S 25** A Requirements related to counsellors: A counsellor must be a member, or a person eligible for full membership, of ANZICA; or a person with other qualifications prescribed by regulation; and must be independent of any business providing fertility services. The counselling must be consistent with any guidelines relevant to surrogacy, in effect as of the time of the counselling, issued by ANZICA and the NHMRC.

must be entered into before surrogate mother becomes pregnant with the child of the surrogacy arrangement. S19. Medical or social need for surrogacy required. No restrictions on gametes used or form of conception. Surrogate and partner recognized as birth parents. S26. Application for parentage order must be made no earlier than 30 days after the birth of the child; and no later than 180 days, unless the Local Court is satisfied there are exceptional circumstances. S33 A parentage order must not be made unless each applicant resides in the Territory at the time of the hearing of the application. Commercial surrogacy prohibited S34, S48, and it is an offence to S49 facilitate a surrogacy or S50 advertise.		implications of the surrogacy arrangement.		**the Local Court** (2) before an application for a Parentage Order. (5) The counsellor must not have provided any previous counselling to the parties. (3 and 4) Local Court Report requirements include the counsellor's opinion on the bests interests of the child born from the surrogacy arrangement and grounds for the opinion. (For full details see the Act) (6) A copy of the report must be given to each person interviewed before an application is made for a parentage order.	

Addendum to ANZICA Surrogacy Guidelines - Surrogacy Legislation in New Zealand and each Australian state or territory of Australia, and requirements for counselling related to surrogacy arrangements V5-June 2022

Legislation	Counselling Requirements	Counsellor Eligibility
Queensland	**This is summary information. It is recommended that the relevant Act/s be read before undertaking counselling.**	

Legislation	Eligibility criteria	Pre Surrogacy	During Treatment/ Pregnancy	Post Birth	Counsellor/s
QLD Surrogacy ACT Status of Children Act **Key issues:** Must be medical or social need for surrogacy Must have written surrogacy agreement and receive legal advice Can be traditional surrogacy or dual donor Commercial surrogacy prohibited, any payment to surrogate strictly to reimburse for expenses connected the surrogate pregnancy. Surrogate (and partner) legal parents at birth. IPs can apply to Supreme Court for Parentage Order 28 days - 6 months following birth.	IPs: - min age 25 - can be heterosexual or same sex; single or couple - must be QLD resident Surrogate: - Min age 25 - can be single	Prior to conception and signing of a surrogacy arrangement all parties, IPs, surrogate (and partner), must attend counselling with an experienced counsellor regarding the potential surrogacy. Routine for assessment counselling to include personality and mental health assessment using standard testing procedures, but not a legal requirement. **31 Initial counsellor's Affidavit:** The affidavit sworn by the appropriately qualified counsellor who gave counselling to the birth mother, the birth mother's spouse (if any) and the intended parents (the relevant persons) must verify a report prepared by the counsellor addressing the matter mentioned in section 22(2)(e)(ii), including by stating— (a)the reasons the counsellor is an appropriately qualified counsellor; and (b) that counselling about the	Nil legal or clinic requirements. Recommended follow-up by counsellor	Surrogacy Guidance report to be completed by independent counsellor post birth. Content and qualifications, and independence defined under the Act,. Must NOT be the initial counsellor, or any counsellor associated with the treating doctor/clinic Relevant section of the legislation: **32 Surrogacy guidance report** A surrogacy guidance report must be prepared by an independent and appropriately qualified counsellor and state the following matters— (a) the reasons the counsellor is an independent and appropriately qualified counsellor; (b) that, for the application, the counsellor interviewed the birth mother, the birth mother's spouse (if any), another birth parent (if any) and the applicant, or joint applicants, (the relevant persons); (c) the date or dates of the interviews; (d) the counsellor's opinion formed	**S19 Appropriately qualified** means: one of the following— (A) a member of the Australian and New Zealand Infertility Counsellors Association; (B) a psychiatrist who is a member of the Royal Australian and New Zealand College of Psychiatrists; (C) a psychologist who is a member of the Australian Psychological Society; Chapter 3 Parentage orders (D) a social worker who is a member of the Australian Association of Social Workers; and (ii) has the experience, skills or knowledge appropriate to prepare the report; or (b) for a medical practitioner swearing an affidavit mentioned in section25(1)(j), a medical practitioner who has the qualifications, experience, skills or knowledge appropriate to prepare the report. **Independent counsellor**: (a) did not give counselling about the surrogacy arrangement to the birth mother, the birth mother's spouse (if

Illegal to advertise for surrogacy Illegal to undertake a commercial surrogacy arrangement overseas		surrogacy arrangement and its social and psychological implications was given to the relevant persons before the surrogacy arrangement was made.		as a result of the interviews relevant to the application for a parentage order including, for example, about the following matters (i) each relevant person's understanding of— (A) the social and psychological implications of the making of a parentage order on the child and relevant persons; (B) openness and honesty about the child's birth parentage being for the wellbeing, and in the best interests, of the child; (ii) the care arrangements that the applicant, or joint applicants, have proposed for the child; (iii) whether the making of a parentage order would be for the wellbeing, and in the best interests, of the child.	any) or an intended parent; and (b) is not, and has not been, directly connected with a medical practitioner who carried out a procedure that resulted in the birth of the child. All fertility groups in QLD recognize that the counsellor should be an ANZICA member, as well as being a psychologist or a social worker, but not a legislative requirement.

Addendum to ANZICA Surrogacy Guidelines - Surrogacy Legislation in New Zealand and each Australian state or territory of Australia, and requirements for counselling related to surrogacy arrangements V5-June 2022

Legislation		Counselling Requirements			Counsellor Eligibility
South Australia		**This is summary information. It is recommended that the relevant Act/s be read before undertaking counselling.**			
Legislation	**Eligibility criteria**	**Pre Surrogacy**	**During Treatment/ Pregnancy**	**Post Birth**	**Counsellor/s**
Family Relationships Act 1975 Assisted Reproductive Treatment Act 1988 Statutes Amendment Act 2009 Family Relations Surrogacy Amendment Act 2015 Surrogacy Act 2019 Surrogacy Regulations 2020 **Key issues:** IP(s) **must** be an Au citizen or permanent resident. Surrogate **must** be an Au citizen or permanent resident. At least one IP must be domiciled in SA at the time of the Surrogacy arrangement. Traditional Surrogacy permitted Must have written agreement	IPs: - married or de facto couples, single women - SA residents - Min age 25 Surrogate: - Min age 25	IPs, Surrogate (and partner) must attend individual and joint counselling. All counselling should be provided by one counsellor. Counselling must be consistent with ANZICA and NHMRC guidelines. Counselling Certificate issued by an accredited counselling service stating: all parties received counselling about personal and psychological issues that may arise in connection with a surrogacy arrangement AND in the opinion of the counsellor, the proposed surrogacy agreement would not jeopardise the welfare of any child born as a result of the agreement.	No legislative requirement	IPs must ensure surrogate (and partner) are offered counselling after the birth (including still birth) at no cost to Surrogate (or partner).	Counselling must be provided by an accredited counselling service. Counselling must be consistent with ANZICA and NHMRC guidelines.

Each of the parties is expected to provide the other with a criminal history report provided by SA Police or Australian Crime Commission within 12 months prior to the lawful Surrogacy agreement. IVF treatment prior to the surrogacy agreement can take place outside of SA Commercial surrogacy prohibited, however reimbursement of costs for surrogate in lost income is permitted. Surrogate (and partner) legal parents at birth. IPs can apply to Supreme Court for Parentage Order 30days – 12 months following birth. Permitted to advertise for surrogacy					

Addendum to ANZICA Surrogacy Guidelines - Surrogacy Legislation in New Zealand and each Australian state or territory of Australia, and requirements for counselling related to surrogacy arrangements V5-June 2022

Legislation	Counselling Requirements	Counsellor Eligibility

Tasmania

This is summary information.
It is recommended that the relevant Act/s be read before undertaking counselling.

Legislation	Eligibility criteria	Pre Surrogacy	During Treatment/ Pregnancy	Post Birth	Counsellor/s
Surrogacy Act 2012 **Key Issues:** Must have written agreement Commercial surrogacy prohibited, any payment to surrogate strictly to reimburse expenses connected the surrogate pregnancy. Only gestational surrogacy arrangements are permitted All parties must seek independent legal advice and counselling prior to making arrangement. Illegal to advertise for surrogacy Surrogate (and partner) legal parents at birth. IPs apply to Supreme Court for Parentage Order 30 days - 6 months following birth.	IPs: - min age 25 - Heterosexual or homosexual couple or single women - Tas resident Surrogate: - Min age 25 - must have birthed own live child - Tas resident	Parties must receive counselling from accredited counsellor prior to entering into an arrangement.	No requirements	After the birth counselling is to be used to ensure that all parties are still comfortable with the arrangement. No detailed written report is required here unless requested by court but a certificate needs to be signed stating that the counselling has occurred.	Accreditation of counsellors through Department of Justice (Births, Deaths and Marriages). "Appropriate experience" for accreditation, counsellor must be: registered psychologist, OR have level 2 Membership of the Australian Counselling Association OR be registered with Psychotherapy and Counselling Federation of Australia. No specific fertility experience required

Addendum to ANZICA Surrogacy Guidelines - Surrogacy Legislation in New Zealand and each Australian state or territory of Australia, and requirements for counselling related to surrogacy arrangements V5-June 2022

Legislation	Counselling Requirements	Counsellor Eligibility

Victoria

This is summary information.
It is recommended that the relevant Act/s be read before undertaking counselling.

Legislation	Eligibility criteria	Pre Surrogacy	During Treatment/ Pregnancy	Post Birth	Counsellor/s
Assisted Reproductive Treatment Act 2008 **Key issues:** Surrogacy must be pre-approved by Patient Review Panel Commercial surrogacy prohibited; IPs may reimburse surrogate for costs connected to the surrogate pregnancy Can be dual donor May have Oral agreement Illegal to advertise for surrogacy Surrogate and partner legal parents at birth. IP apply to the Supreme Court for Parentage Order 28 days - 6 months following birth.	IP: - min age 18 - heterosexual, same sex couples, single women - Vic residents Surrogate: - min age 25 - Surrogate can be single - must have birthed own live child	**S40(1)(c)-** Patient Review Panel may only approve a surrogacy arrangement if the commissioning parent/s, surrogate mother and surrogate mother's partner have received counselling **S 41 Part 4—Surrogacy Assisted Reproductive Treatment Act 2008** (a) undergo counselling, by a counsellor providing services on behalf of a registered ART provider, about the social and psychological implications of entering into the arrangement, including counselling about the prescribed matters; and (b) undergo counselling about the implications of the relinquishment of the child and the relationship between the surrogate mother and the child once it is born; and (c) obtain information about the legal consequences of entering into the arrangement.**S43**(a) and (b) the counselling must address the social and psychological implications of entering into the arrangement and implications of relinquishing the child and the relationship between the surrogate mother and the child once it is born.	None legally required. Some clinics offer supportive counselling throughout entire journey including pregnancy and post birth.	None legally required. Some clinics offer supportive counselling throughout entire journey including pregnancy and post birth. If any parties are not living in Victoria they may be required to have further counselling.	**S43(a)-** aforementioned parties must be counselled by a counsellor providing services on behalf of a registered ART provider **S3**- registered ART provider is a person/body registered under Part 8 of the Act Clinic counsellor required to complete the pre-treatment counselling. The PRP must approve all surrogacy applications, also require independent psychological assessment done external to the clinic (although this is not a legal requirement).

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Legislation	Counselling Requirements	Counsellor Eligibility

Western Australia

This is summary information.
It is recommended that the relevant Act/s be read before undertaking counselling.

Legislation	Eligibility criteria	Pre Surrogacy	During Treatment/ Pregnancy	Post Birth	Counsellor/s
Surrogacy Act 2008 Surrogacy Regulations 2009 **Key Issues:** Parentage orders cannot be made unless surrogacy agreement approved by the WA Reproductive Council. Commercial surrogacy prohibited, payments to surrogate strictly to reimburse for expenses connected the surrogate pregnancy. Written agreement required; Permitted to advertise Traditional surrogacy permitted. Surrogate and partner legal parents at birth. IPs can apply to Supreme Court for Parentage Order 28 days - six months following birth.	IP: - min age 18 - Heterosexual couples, single women - WA resident Surrogate: - min age 25 - must have birthed own live child	**S 17 c (i)** 1. Counselling about the implications of the surrogacy arrangement. Counsellor must prepare a written certificate regarding the counselling and any concerns. 2. Assessment by a clinical psychologist, with a written report.	**Surrogacy Regulations (2009)S 12**: Ongoing counselling and support throughout treatment including counselling at a time where there is a decision by participants to discontinue the surrogacy process. **S13:** Counselling requirements during pregnancy by an approved counsellor for both surrogates and intended parents at 20 and 34 weeks after the beginning of a pregnancy and at 14 days after either a miscarriage or live birth.	**Surrogacy Regulations S 6:** Appropriate counselling for the purposes of **S21 (2)(b)**: counselling about the proposed order provided by an approved counsellor following the birth of a child. Done by Approved Counsellor, usually the clinic counsellor, not the independent psychologist. Presumed that all parties to the arrangement will attend. Unlike the implications counselling section in S4, not defined what is covered in post order counselling nor surrogate relinquishment. Must be consideration of "whether the making of a parentage order would be for the wellbeing, and in the best interests of the child."	Two different counsellors: 1 "Approved Counsellor": clinic counsellor who conducts the implications counselling, then writes certificate indicating dates patients were counselled with final statement highlighting any concerns. Must be qualified and experienced counsellors, who possess significant knowledge of the issues associated with fertility and infertility, and demonstrate evidence of keeping up to date with technological developments including fertility specific professional development. To become formally recognised as an "Approved Counsellor" under the HRT Act 1991 a counsellor must apply to the RTC for formal recognition. Approved counsellors must be ANZICA eligible. 2 Independent psychosocial assessment by a clinical psychologist who completes psychological report.

Miranda MONTRONE

Psychologist ***Family Therapist*** ***Infertility Counsellor***

BA MA MAPS MCOHP MANZICA

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QUALIFICATIONS OF INDEPENDENT COUNSELLOR

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As required by the New South Wales (NSW) Surrogacy Act 2010, I hereby state that I am a qualified counsellor with the experience and qualifications of a kind required by the Regulations to exercise the functions of a Counsellor under the Act. Having qualified with a B.A. (Macq.) in 1976, and a M.A. (Syd.) 1990, I have been registered as a psychologist since 1991 (PSY0001138165) (now Health Psychology endorsed). I have relationship therapy (couple and family) training (1990, 1991) and I am a Clinical Member of the Australian Association of Family Therapists. I have been a member of the Fertility Society of Australia (FSA) now Fertility Society of Australia and New Zealand (FSANZ) since 1991 (Member No 183), as also a member of ANZICA (Australia and New Zealand Infertility Counsellors' Association), which is now a sub- group of the FSANZ. I am familiar with the ANZICA Surrogacy Guidelines (September 2016 and 2022) and the NHMRC Ethical Guidelines on the Use of Assisted Reproductive Technology in Clinical Practice and Research (2007).

I have worked in the areas of infertility and assisted reproduction for more than thirty years. For nine of those years (1992-2001) I worked as Infertility Counsellor at the then City West IVF (now IVF Australia, Western Sydney). Since 2001 I have worked solely in private practice in Glebe, Sydney, with more than 50% of my work being related to infertility and assisted reproduction. This work includes the independent psychological assessment of altruistic surrogacy proposals required even before surrogacy legislation, by a number of assisted reproduction clinics (in Sydney and Canberra) as part of the pre surrogacy treatment process. Since 2010 I have also done post surrogacy birth relinquishment counselling and the counselling required for parentage order applications. Over more than 30 years I have counselled in more than 300 altruistic surrogacy cases, including before surrogacy treatment and/or conception and after the birth of a child conceived through surrogacy.

As an illustration of my professional background, I list here a sample of the papers/presentations which I have given at professional conferences or had published:

- Secrets in Families, Fertility Society of Australia Conference, Adelaide 1992
- Ethical Considerations in ART – A Baby at any price? – Psycho-Social Implications. International Meeting of Consumers and Physicians (IFIPA) Sydney 1996
- Assisted Reproduction & Long-Term Family Issues. Family Court Judges' Conf., Sydney 2001
- A Voluntary Contact Register: Stakeholders, Values, Processes, Dilemmas. FSA, Perth 2003

- The Role of Assessment in Preparation for Surrogacy. ANZICA Workshop. FSA Sydney 2006
- Gestational Surrogates. ANZICA Workshop, FSA Annual Conference, Brisbane 2008
- Pre-Surrogacy Assessment, ANZICA Workshop, Sydney May 2011
- Information Dissemination as an integral part of assessment and decision making in surrogacy, APS Health Psychology Conference, Sydney April 2015
- Pre-Surrogacy Assessment Counselling – A Review of 120 cases; and Use of the PAI in Pre-Surrogacy Assessment, FSA Conference, Canberra September 2015
- Altruistic Surrogacy Relationships and Values, ASPIRE Conference, Jakarta April 2016
- Pre-Surrogacy Assessment: Positive and Negative Indicators, (Prize winning paper) FSA Perth September 2016
- Experience of Surrogates, Fertility Society of Australia Conference, Adelaide, October 2017
- What do we know about Altruistic Surrogates? Fertility Society of Australia. Conference, Hobart Oct 2019
- Podcast prepared by Bryant McKinnon Lawyers on Surrogacy, Donor and IVF, 12/2019 https://bryantmckinnon.com.au/family-matter/childrens-matters/surrogacy-ivf/
- A comparison of sociodemographic and psychological characteristics among intended parents, surrogates, and partners involved in Australian altruistic surrogacy arrangements. Vol 113, No 3, Fertility & Sterility March 2020
- Surrogacy in Australia. Journal für Reproduktionsmedizin und Endokrionologie (Reproductive Medicine and Endocrinology) Vol 17 (2020) No 5
- Surrogacy: Implications & Assessment Counselling. Australian Psychological Society Webinar 20 July 2021 https://www.psychology.org.au/Event/22339
- American Society for Reproductive Medicine MHPG Clinical Session: Testing: A therapeutic assessment model in the psychological screening of gestational carriers. October 19 2021
- APS (Australian Psychological Society) Webinar Presentations:
    - Surrogacy Implications and Assessment Counselling (Before Conception to After Birth, July 2021
    - PIPIG Interest Group: Part 1 – Infertility and Assisted Reproduction, 5 April 2022
    - PIPIG Interest Group: Part 2 – Third Party Reproductiong 17 April 2022
- FSANZ (Fertility Society of Australia and New Zealand) pre-Conference ANZICA Workshop presentation: ANZICA – The Early Years of Donor Counselling.

I made written submissions to the South Australia Legislative Council into Gestational Surrogacy (2007); to the Queensland Investigation into Altruistic Surrogacy Committee (2008), and to the NSW Investigation into Altruistic Surrogacy in NSW (2008), and was invited to appear before both the Queensland and New South Wales hearings. In 2009 I made a written response to the Proposal for a National Model to Harmonise Regulation of Surrogacy and in 2013 I wrote a submission to the NSW Inquiry into Managing Information related to Donor Conception and appeared before the Inquiry. In early 2015 I was invited to participate in a Federal Government Standing Committee Roundtable on Surrogacy and also co-wrote a submission of behalf of ANZICA (ANZ Infertility Counsellors'; Association) and appeared before the subsequent 2015 Federal Inquiry into Surrogacy.

All submissions were based on experience in supportive, implications and assessment counselling of patients during donor and surrogacy treatment at the then City West IVF, as well as extensive experience in independent psychological assessment of patients before clinic approval for altruistic surrogacy treatment, counselling a number of people during a surrogacy pregnancy, assessment counselling related to several planned home surrogacy arrangements, counselling after the birth and handover of a baby. Since the introduction of the NSW Surrogacy Act in 2010 I have also completed approximately 50 post surrogacy birth parentage order counselling assessments.

A comparison of sociodemographic and psychological characteristics among intended parents, surrogates, and partners involved in Australian altruistic surrogacy arrangements

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Objective: To characterize the sociodemographic and psychological profiles of participant groups involved in altruistic surrogacy in Australia.
Design: Cross-sectional study.
Setting: Single psychological practice in Sydney, Australia.
Patient(s): Six hundred and two individuals involved in 160 altruistic surrogacy arrangements: 143 intended mothers, 175 intended fathers (including 17 same-sex intended father couples), 160 surrogates, and 124 surrogate partners.
Intervention(s): None.
Main Outcome Measure(s): Responses to a presurrogacy sociodemographic assessment counseling protocol and the Personality Assessment Inventory (PAI).
Result(s): The surrogates were primarily sisters, sisters-in-law, mothers (48.6%), or other extended family or friends (46.3%) of the intended parents. Most participants resided in residential postcode areas within the highest socioeconomic status quintile; however, intended mothers were more likely than surrogates to live in the most advantaged residential areas, to be younger and be more educated, and to be employed in professional occupations. Most participant psychological profiles were normal. A statistically significantly elevated PAI Somatic Complaints–Health Concerns subscale for intended mothers was observed compared with other participant groups. The higher PAI Warmth scale scores of intended mothers and surrogates were statistically significantly different from their respective partners, although not different from each other.
Conclusion(s): Sociodemographic and some psychological differences between participant groups were observed that warrant exploration in pretreatment surrogacy counseling. Importantly, the higher scores on the PAI Warmth scale exhibited by intended mothers and surrogates in the context of close family and friendship relationships are likely to serve as protective mechanisms for the altruistic surrogacy outcome. (Fertil Steril® 2020;113:642-52. ©2019 by American Society for Reproductive Medicine.)
El resumen está disponible en Español al final del artículo.

Key Words: Altruistic surrogacy, intended parent, surrogate, PAI, sociodemographic index

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Altruistic surrogacy involves an arrangement by which a surrogate mother, also known in some jurisdictions as a gestational carrier, agrees to gestate a child for intended parent(s) without being financially remunerated for their reproductive effort. Medically, this form of assisted reproductive treatment has been legally practiced within Australia since the late 1990s (1, 2), with a ban on compensated surrogacy embedded within national legislation (1, 3–6). Although subtle legislative and counseling differences exist between Australian state jurisdictions, the overarching guiding principles of surrogacy and other third-party reproduction programs are characterized by [1] fundamental concepts pertaining to altruism, [2] rights for individuals born of surrogacy and donor gamete arrangements to be informed of the circumstances of their conception, including biological heritage, and [3] assurances of participant informed consent.

Integral to Australian surrogacy arrangements is the role of the mental health professional. This includes implications counseling provided by a mental health professional based in an vitro fertilization (IVF) clinic, whose role through the clinical interviews and psychoeducation is to ensure that the participants understand the potential short-term and long-term consequences of their proposed treatment for themselves, their families, and any child that is to be born of treatment (7). Furthermore, a second line of counseling and assessment involving administration of validated standardized measures is also conducted by psychologists who work independently of the fertility clinic. These psychological tests are used to screen for psychopathology, personality traits, and problematic interpersonal styles.

Both forms of psychological evaluations include aspects of ethical gatekeeping, with consideration of issues such as coercion, financial inducement, and informed consent (8). These are deemed essential in regards to providing recommendations about suitability for treatment and/or the need for adjunct supportive counseling care. Knowledge obtained through implications counseling in conjunction with objective psychological evaluations can be used to preempt targets for psychotherapeutic care and to highlight potentially risky relationship dynamics, coercion, or legal issues that can emerge between the participants who are contemplating surrogacy because these aspects have relevance to treatment and psychological outcomes (9, 10).

Ruiz-Robledillo and Moya-Albiol (11) concur that part of good clinical practice is the clear need for psychological assessment of everyone involved at each stage of the surrogacy process. This is a means of mitigating the relationship and emotional stresses that could emerge throughout the evolving stages of the surrogacy arrangement. Worldwide, however, counseling practices pertaining to surrogacy are diverse (12–15); they are shaped by contextual factors including the presence or absence of legislation, statutory guidelines, and guidance by expert mental health professional organizations associated with reproductive medicine (see, for example, the International Infertility Counseling Organisation at http://www.iico-infertilitycounseling.org/1216-2/).

Across Australia, pretreatment psychological assessment by an independent psychologist and additional implications counseling are legally mandated for all parties to a surrogacy arrangement, inclusive of intended parents, surrogates, and their partners (16). This differs from jurisdictions within the United States where psychological assessment is routine for gestational carriers although only recommended for the intended parents in circumstances where family members are used as surrogates. In these situations, counseling by an independent mental health professional is strongly recommended (9, 12, 17). Moreover, Australian presurrogacy counseling practice differs from that of the United Kingdom, where psychosocial assessment is not mandated by legislation unless there are specific concerns as to the mental health capacity of the surrogate. In clinical practice, however, routine implications counseling and/or screening protocols of all parties appear to be used (13, 14). In New Zealand there are legislative requirements pertaining to presurrogacy implications counseling, although there is no mandated requirement for formal psychological assessment of any participant contemplating an altruistic arrangement (18).

From a medical perspective, the success of a surrogacy arrangement is the birth of a baby. Psychologically, success can be more complex, being in part determined by the participants' preexisting mental health, the intended parents' relationship with the surrogate, everyone's attitudes toward the surrogate's pregnancy, the successful relinquishment of the child, and no long-term negative impact on the health or mental well-being of any of the parties involved. To date, most studies that have investigated surrogate psychological profiles have been conducted with the patients undergoing treatment in compensated surrogacy systems (19–22).

Findings reported from compensated surrogacy studies may not be generalizable to those participating in altruistic surrogacy arrangements. Although retrospective studies of altruistic surrogacy (23–25) have found minimal problems for surrogates, many of these studies have had limitations, including small sample size, concerns about the representativeness of the participants, low survey response rates, and omission of important psychological characteristics of the intended mothers, intended fathers, surrogates, and partners of surrogates collected as part of presurrogacy counseling (26–29). Consequently, the overarching aim of our study is to extend knowledge about altruistic surrogacy arrangements in Australia by undertaking an analysis of a large sample of presurrogacy counseling cases (N = 160), evaluating parameters for all parties involved and using data related to the sociodemographic and psychological characteristics of intended mothers, intended fathers, surrogates, and partners of surrogates.

MATERIALS AND METHODS

Participants

Participants in this cross-sectional study were adult and mostly Australian-born parties to an altruistic surrogacy arrangement (Tables 1 and 2). In total, 602 participants were interviewed in the presurrogacy counseling program. These included 143 intended mothers (of whom two were single), 175 intended fathers (including 34 men in 17 same-sex

TABLE 1

Sociodemographic characteristics of surrogacy participants (N = 602).

	Intended parents		Surrogates and partners		
Characteristics	**Mothers (n = 143)**	**Fathers (n = 175)**	**Surrogates (n = 160)**	**Partners (n = 124)**	***P* value**
Age (mean, SD)	35.42 (5.77)	36.66 (5.92)	37.35 (6.44)	39.95 (7.82)	< .0001
Education					< .005
School certificate (y 10) or lower completed	20 (13.99)	17 (9.71)	51 (31.88)	32 (25.81)	
Higher school certificate (y 12) completed	17 (11.89)	22 (12.57)	26 (16.25)	10 (8.06)	
Trade certificate or diploma/ university start/advanced diploma	33 (23.08)	64 (36.57)	43 (26.88)	53 (42.74)	
Completed bachelor's degree or postgraduate study	73 (51.05)	72 (41.14)	40 (25.00)	29 (23.39)	
Occupation					< .005
Managers and professionals	76 (53.15)	86 (49.14)	44 (27.67)	36 (29.03)	
Associate professionals, skilled trades, advanced clerical, sales, service workers	35 (24.48)	67 (38.29)	51 (32.08)	55 (44.35	
Intermediate sales, service, production workers	25 (17.48)	16 (9.14)	35 (22.01)	17 (13.71)	
Elementary clerical, sales, laborers	7 (4.90)	6 (3.43)	29 (18.24)	16 (12.90)	
Country of birth					.031
Australia	122 (85.31)	147 (84.00)	144 (90.00)	110 (88.71)	
United Kingdom/Ireland	1 (0.70)[a]	10 (5.71)	1 (0.63)[a]	4 (3.23)[a]	
Other	20 (13.99)	18 (1029)	15 (9.38)	10 (8.06)	
Ethnicity					.159
Caucasian	123 (86.01)	155 (88.57)	148 (92.50)	111 (89.52)	
African American	2 (1.40)[a]	1 (0.57)[a]	1 (0.63)[a]	0 (0.00)	
Asian/Pacific Islander including Maori	7 (4.90)	4 (2.29)[a]	6 (3.75)	10 (8.06)	
Hispanic (including Portuguese and South American)	2 (1.40)[a]	5 (2.86)	0 (0.00)[a]	0 (0.00)[a]	
Indian Pakistani and Bangladeshi	6 (4.20)[a]	5 (2.86)	3 (1.88)[a]	1 (0.81)[a]	
Turkish, Arabic, Lebanese	3 (2.10)[a]	5 (2.86)	2 (1.25)[a]	2 (1.61)[a]	
SEIFA quintile (IRSD)					.084
Lowest quintile	16 (11.19)	18 (10.29)	30 (18.75)	27 (21.77)	
Low quintile	20 (13.99)	17 (9.71)	17 (10.63)	13 (10.48)	
Middle quintile	24 (16.78)	30 (17.14)	38 (23.75)	24 (19.35)	
High quintile	23 (16.08)	33 (18.86)	20 (12.50)	14 (11.29)	
Highest quintile	60 (41.96)	77 (44.00)	55 (34.38)	46 (37.10)	
Totals	143 (23.75)	175 (29.07)	160 (26.58)	124 (20.60)	602 (100.00)

Note: Values are n (%). Statistical tests: chi-square test $P < .05$. IRSD = Index of Relative Socioeconomic Disadvantage; SD = standard deviation; SEIFA = Socioeconomic Index for Areas.
[a] Cell sizes (<5) too small for statistical tests.

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male relationships), 160 surrogates, and 124 men who were partners of surrogates.

Clinical Interview

All participants were interviewed by the first author (M.M.) with an assessment protocol originally formulated from guidelines available in the literature (2, 30, 31). The protocol, which paid due regard to the participants' capacity to give informed consent and considerations of the welfare of the child to be born (7), addressed issues relating to psychological well-being, relationships, fertility history, proposed surrogacy and obstetric treatment, and legal ramifications. The comprehensive clinical case notes were used to obtain the sociodemographic information for this study (see Tables 1 and 2). A personality assessment measure was used to objectively evaluate each participant's overall psychological profile, gauge interpersonal style, identify potential mental health problems, and if indicated to plan adjunct psychosocial interventions. Details of this altruistic surrogacy protocol have been endorsed by the Australia and New Zealand Infertility Counsellors' Association (ANZICA) and are embedded within the current ANZICA guidelines (32).

Personality Assessment Inventory

The Personality Assessment Inventory (PAI) (33, 34) is a widely used self-administered inventory of adult personality designed to provide information relevant to mental health clinical diagnosis, treatment planning, and screening for psychopathology. The PAI contains 344 items which comprise 11

TABLE 2

Treatment and relationship characteristics of surrogacy participants (N = 602).

Surrogacy assessment	n (%)
Reason for surrogacy	
IM born without uterus or with congenital problems	98 (16.3)
IM uterus removed (e.g., postcancer, placenta accreta, postpartum hemorrhage)	151 (25.1)
Diagnosed nonfunctioning uterus of IM, multiple pregnancy losses	189 (31.4)
Health risks for IM of carrying pregnancy	103 (17.1)
Same-sex (male) relationship of intended parents	61 (10.1)
Assessment of suitability for surrogacy	
Suitable to participate in surrogacy arrangement	466 (77.4)
Suitable to participate with qualifications	97 (16.1)
Parties decided not complete counseling	14 (2.5)
Decided not to proceed, even though assessed as suitable	15 (2.5)
Deemed unsuitable for surrogacy arrangement	10 (1.7)
Relationship of surrogate with intended parents	
Sister of IM or sister of IF	170 (28.2)
Friend of IM/IF, other family (e.g., cousin), friend of friend, friend of extended family	270 (46.3)
Met through Internet forum/chat group connection	31 (5.1)
Sister-in-law of IM or IF, or mother of IM or IF	122 (20.3)

Note: IF = intended father; IM = intended mother.

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clinical scales (Somatic Complaints, Anxiety, Anxiety Related Disorders, Depression, Mania, Paranoia, Schizophrenia, Borderline Features, Antisocial Features, Alcohol Problems, and Drug Problems), where the items on the scale directly reflect the phenomenology and symptomatology of the clinical construct. There are also five treatment consideration scales (Aggression, Suicidal Ideation, Stress, Non-support, Treatment Rejection) used to gauge issues important in clinical case management and treatment planning, four validity scales (Inconsistency, Infrequency, Positive Impression, Negative Impression) that are used to assess factors that could distort the results of testing, and two interpersonal scales (Dominance, Warmth). The nine clinical scales have subscales (eight with three subscales, one with four subscales), and one treatment scale (Aggression) has three subscales (see Table 3).

The PAI scale and subscale raw scores are transformed to T-scores with a mean score of 50 (± 10 standard deviation). Clinical interpretation was made relative to a U.S. community normative sample (combined male and female norms) because there are no Australian norms for the PAI. Moderate elevations (84th percentile) are indicated by a score of 1 standard deviation above the mean, with high elevations indicated by 2 standard deviations (96th percentile) above the mean. There is variability in the cutoff for psychopathology, with elevated scores and below-mean scores having interpretive relevance as standalone scores in the context of an overall PAI. Thus, for example, a moderate elevation on the Mania-Grandiosity subscale may reflect optimism and an unwillingness to be hampered by limitations; very low Aggression scale scores could indicate very meek and unassertive persons who have difficulty standing up for themselves.

Combinations of scales can be of interest. Thus, Positive Impression scale items involve the presentation of a very favorable impression or the denial of relatively minor faults. The Treatment Rejection scale provides a measure of attributes and attitudes associated with an interest in personal changes of a psychological or emotional nature. Elevations on both scales indicate defensive responding and possible suppression of clinical scale scores. Interpersonal Style is assessed using the Dominance and Warmth scales; the Dominance scale provides a measure of the extent to which a person is controlling, submissive, or autonomous in interpersonal relationships, and the Warmth scale provides a measure of the extent to which an individual is empathic and engaging (versus withdrawing, rejecting, and distrustful) in interpersonal relationships. These aspects are of particular relevance in presurrogacy assessment—particularly the latter, given the inherent interpersonal nature of surrogacy (33, 34).

Procedure

Participants in this study were patients referred for independent presurrogacy assessment counseling by their treating IVF clinic or lawyer to the psychological private practice of the first author (M.M.) in Sydney, Australia. All parties to the surrogacy (intended mothers, intended fathers, surrogates, and surrogate partners) attended individual, couple, and group counseling sessions that were conducted over two separate occasions, totaling 6 to 8 hours of clinical interviews and testing, during which data were collected.

Before attending the first appointment, the participants were sent an e-mail outlining the counseling process. Inclusive in the consent form was a section requesting permission to use their deidentified assessment data for prospective surrogacy-related research. The participants were advised that assessment and implications counseling for the purposes of their surrogacy arrangement were mandatory, but their participation in the study was entirely voluntary. The assessment data were collected from May 2002 to January 2018. Ethics approval for retrospective review and analysis of data was provided by Macquarie University Human Research Ethics Committee (Reference No: 5201700068).

Data Analyses

Frequency tabulation and percentages were calculated for all surrogacy data, including reason for treatment, participant relationships, and sociodemographic items gauging gender, age, country of birth, ethnicity, highest education level, and occupation. The Australian Socioeconomic Index for Areas (Index of Relative Socioeconomic Disadvantage) (SEIFA) (35) was calculated for each of the residential postcodes,

TABLE 3

Personality Assessment Inventory (PAI) scores with Cronbach's alpha for surrogacy participants (N = 590).

		Intended parents		Surrogates and partners	
PAI scale	**Cronbach's α**	**Mothers (n = 141)**	**Fathers (n = 173)**	**Surrogates (n = 157)**	**Partners (n = 119)**
Validity scales					
Inconsistency		46.05 (8.00)	47.15 (7.51)	45.35 (8.58)	47.63 (8.33)
Infrequency		50.56 (7.15)	50.27 (7.85)	50.49 (8.34)	49.68 (7.78)
Negative impression		47.63 (5.18)	46.67 (4.52)	46.31 (4.36)	47.02 (5.20)
Positive impression		55.14 (7.88)	56.00 (8.61)	54.26 (7.66)	54.66 (8.00)
Clinical scales					
Somatic complaints	.763	54.79 (9.46)	45.19 (5.69)	45.41 (4.70)	46.53 (7.25)
Conversion		51.20 (9.33)	45.49 (4.29)	45.92 (4.54)	47.07 (6.68)
Somatization		49.37 (8.28)	45.88 (7.24)	44.79 (5.53)	46.14 (7.17)
Health concerns		60.84 (11.57)	45.67 (5.80)	46.87 (5.44)	47.63 (7.71)
Anxiety	.825	48.16 (6.71)	44.49 (6.60)	45.90 (5.97)	44.58 (6.47)
Cognitive		49.90 (7.91)	45.71 (7.47)	46.13 (6.50)	45.57 (7.53)
Affective		48.25 (7.47)	43.69 (7.28)	46.78 (6.96)	44.64 (6.64)
Physiological		47.18 (6.34)	45.47 (5.78)	46.18 (5.87)	45.77 (6.49)
Depression	.662	46.04 (6.19)	44.44 (6.09)	44.86 (5.66)	44.22 (7.23)
Cognitive		46.20 (6.73)	44.98 (6.38)	45.50 (5.99)	45.94 (7.38)
Affective		46.10 (5.51)	47.78 (5.81)	44.36 (5.28)	45.35 (6.53)
Physiological		47.75 (8.16)	44.26 (7.32)	47.35 (7.22)	45.30 (7.94)
Mania	.619	48.47 (9.37)	49.07 (9.48)	47.12 (7.93)	50.87 (8.67)
Activity level		49.04 (9.36)	47.50 (9.26)	48.53 (9.24)	48.78 (8.73)
Grandiosity		50.11 (9.95)	52.70 (9.56)	48.63 (8.04)	54.14 (9.30)
Irritability		47.85 (9.21)	47.57 (8.95)	46.82 (8.10)	49.06 (9.32)
Paranoia	.701	44.41 (6.70)	46.23 (7.66)	45.30 (7.20)	46.33 (7.82)
Hypervigilance		45.41 (8.28)	47.40 (8.68)	46.10 (8.43)	47.38 (8.02)
Persecution		45.01 (6.02)	46.20 (7.45)	45.12 (6.93)	46.08 (7.02)
Resentment		45.60 (7.40)	46.80 (7.84)	46.93 (7.37)	47.18 (8.50)
Borderline features	.697	46.50 (7.35)	44.35 (6.80)	46.15 (6.53)	45.86 (6.77)
Affective instability		47.14 (7.42)	45.61 (7.84)	46.25 (6.55)	46.29 (7.34)
Identity problems		48.96 (7.96)	45.72 (7.35)	46.06 (6.93)	47.27 (8.26)
Negative relationships		46.89 (7.71)	44.89 (7.11)	48.30 (8.82)	45.86 (7.60)
Self-harm		46.32 (7.18)	45.71 (7.11)	47.25 (7.01)	48.07 (8.06)
Antisocial features	.623	45.27 (6.47)	48.63 (6.78)	46.03 (6.24)	52.14 (7.90)
Antisocial behaviors		45.15 (6.70)	48.24 (7.09)	47.32 (7.44)	52.71 (8.81)
Egocentricity		47.36 (6.23)	49.50 (7.22)	46.66 (6.15)	50.57 (8.04)
Stimulus seeking		46.40 (7.62)	49.27 (7.63)	46.17 (7.10)	51.75 (9.23)
Alcohol problems		45.71 (4.86)	49.82 (7.66)	47.65 (6.28)	51.04 (8.00)
Drug problems		47.04 (5.97)	47.43 (5.86)	47.08 (5.57)	48.29 (5.96)
Treatment scales					
Aggression	.717	44.51 (7.11)	44.59 (7.69)	45.00 (6.88)	46.32 (7.87)
Aggressive attitude		42.71 (7.23)	41.91 (7.71)	43.38 (7.45)	43.18 (7.57)
Verbal aggression		49.55 (10.36)	49.18 (8.77)	48.90 (8.99)	50.36 (9.78)
Physical aggression		44.91 (4.52)	46.39 (6.25)	46.09 (5.43)	47.9 (7.02)
Suicidal ideation		46.33 (5.73)	44.63 (3.45)	45.57 (5.54)	45.46 (5.25)
Stress		44.04 (5.73)	43.03 (5.33)	44.41 (6.22)	45.63 (6.09)
Non-support		41.26 (5.05)	43.68 (6.05)	40.68 (5.37)	43.36 (7.00)
Treatment rejection		57.10 (7.03)	58.96 (7.00)	57.69 (6.47)	56.54 (7.70)
Interpersonal scales					
Dominance		52.90 (9.44)	53.74 (8.40)	51.26 (9.27)	52.88 (9.48)
Warmth		56.45 (7.89)	51.37 (8.47)	55.70 (7.09)	49.57 (9.36)

Note: Values are mean (± standard deviation). Cronbach's alpha internal consistency coefficients; n = 590 of 602, and mean indicates the mean T-scores. The results for the Anxiety Related Disorders and Schizophrenia scales were not reported because a low Cronbach α indicated item unreliability.

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and the quintiles were determined. The highest quintile represented the area of least socioeconomic disadvantage, and the lowest quintile the most disadvantaged (see Table 1).

Descriptive statistics were derived for sociodemographics, surrogacy characteristics, and PAI scales and subscales. Chi-square tests (categorical variables) and one-way analysis of variance (ANOVA, continuous data) were used to compare the sociodemographic characteristics by surrogacy participant group type (i.e., intended mothers, intended fathers, surrogates, surrogate partners) and to identify potential covariates for further analyses with the PAI scores. Between-group differences for the PAI scores were analyzed by separate univariate analyses of covariance (ANCOVA), controlling for identified covariates (age, education, occupation). When statistically significant differences were evident, post hoc paired contrasts were conducted. To reduce the

likelihood of type I error, a conservative adjusted alpha level was applied for all other PAI scale and subscale analyses (.05/45 = critical $P \leq .001$). The Anxiety Related Disorders and Schizophrenia scales and subscales were excluded owing to low Cronbach alphas ($\alpha < .60$). All other analyses applied a critical $P < .05$. All data analyses were undertaken using SPSS for Windows version 24 (IBM).

RESULTS

Of the 160 surrogacy cases, 158 were gestational and two were genetic (also referred to as traditional or partial surrogacy arrangements), where the oocyte used was that of the surrogate. There were four heterosexual intended-parent couples and 16 same-sex male couples who used donor oocytes; the remainder of the gestational surrogates used the embryos of the intended parents. As shown in Table 2, over the 15 years during which data were collected, the most common reason for the surrogacy was related to the intended mothers' reproductive complications. After legislation passed in 2010 permitting their treatment (6), the first same-sex male couple was seen in the study in 2012, after which the percentage of same-sex male intended parents over the residual timeframe of the study was 22% (i.e., n = 17 of 78 cases assessed between August 16, 2012, and January 10, 2018). Surrogates were primarily sisters or sisters-in-law, mothers, friends, or another extended family member of an intended parent. A small percentage of surrogates were recruited from Internet forum support groups.

On completion of the mandatory PAI assessment and clinical interviews, the majority of cases (95.6%) were assessed as suitable for surrogacy; the remaining persons were deemed unsuitable because of failure to complete the assessment process, current mental health/life issues, or indications of coercion. In a minority of cases assessed as suitable, there was a recommendation for adjunct interventions, including referral for further medical and/or legal advice (6 of 26 cases), a communication/surrogacy plan of action (6 of 26 cases), or supportive therapeutic counseling (most often for the intended mother) with an alternative counselor to help with the management of surrogacy-related stressors (14 of 26 cases) (11). A further 2.6% of cases who had been assessed as suitable decided not to continue with the surrogacy.

Demographic Characteristics

Sample characteristics are provided in Table 1. Overall, the majority of study participants were born in Australia and were of Caucasian ethnicity. There were no statistically significant differences between the groups (intended mothers, intended fathers, surrogates, and surrogate partners) by country of birth or ethnicity. The ages differed between the participant groups ($F_{3,598} = 11.56$, $P \leq .001$); for the women, the intended mothers were younger than the surrogates (t [302] = 97.78477.4+; $P \leq .007$). Educational attainment also differed (chi-square [9] = 60.943, $P \leq .001$), with the intended mothers more likely than the surrogates to have completed high school (year 12) (odds ratio [OR] 4.65; 95% confidence interval [CI], 2.44–8.87; $P \leq .001$) and to have attained a university qualification, a bachelor's degree, or higher degree (OR 2.38; 95% CI, 1.31–4.31; $P = .004$). The intended fathers were also more likely to have completed high school (OR 4.67; 95% CI, 2.25–9.69; $P \leq .001$), and to have attained a tertiary university degree than the surrogate partners (OR 2.06; 95% CI, 1.17–3.61; $P = .012$).

The study participants most commonly resided in postcodes within the highest Socioeconomic Index for Areas (Index of Relative Socioeconomic Disadvantage) (SEIFA IRSD) quintile (35). The between-group analysis of SEIFA (35) revealed a difference between the intended parents and surrogate couples (chi-square [9] =16.050; $P = .003$). As couples lived together and thus had the same SEIFA categorical index, a decision was made to compare the groups of women (intended mothers and surrogates). When only the women were compared, the surrogates were less likely to live in the highest SEIFA quintile (the most advantaged) than the intended mothers (OR 0.48; 95% CI, 0.24, 0.90; $P = .048$), although most resided in an Australian region of relatively high socioeconomic advantage. The comparison did not include the small number of same-sex male couples. Statistically significant differences were also evident in the level of occupation as determined by the Australia and New Zealand Standard Classification of Occupations (ANZSCO 2013) (36) across all groups (chi-square = [9] 61.52; $P \leq .001$). The surrogates were more likely than the intended mothers to have an elementary/nonprofessional occupation (OR 7.16; 95% CI, 2.9–17.7; $P \leq .001$). In the male groups, the partners of surrogates were also more likely to have an elementary occupation than the intended fathers (OR 6.37; 95% CI, 2.3–17.6; $P \leq .001$).

Psychological Characteristics—Personality Assessment Inventory (PAI)

The response rate for PAI completion was 98%, and noncompletion was due to lack of English-language proficiency or very defensive responding. The univariate ANCOVA analyses revealed several statistically significant between-group differences on the PAI scales and subscales. See Table 3 for adjusted mean T-scores based on PAI referent U.S. norms (33, 34) and Table 4 for statistically significant post hoc between-group comparisons.

Overall, most of the clinical scale means for all participant groups clustered around the lower end of the average T-score range of 45–55 with few outliers, indicating no statistically significant psychopathology. The Positive Impression validity scale was in the average range, indicating that the overall responses to test items were not distorted to give an excessively positive impression profile. As shown in Table 4, the pairwise post hoc comparisons of the PAI scores highlighted statistically significant between-group differences on a number of scales, although the scores were mostly in the normal range.

On the Clinical Scales, the mean Somatic Complaints T-score was elevated in the intended mothers in comparison with the other groups although it was still within the mean range, reflecting few bodily complaints. A moderate elevation on the Health Concerns subscale for the intended mothers, however, indicated a preoccupation with health and physical functioning. Although the T-scores for the intended mothers on the Anxiety scale were significantly higher when

TABLE 4

Statistically significant differences in Personality Assessment Inventory (PAI) scores of intended mothers (IM), intended fathers (IF), surrogates (S), and partners of surrogates (SP).

			Group score		
PAI scale	**ANOVA between groups (F)**	**$\eta^2_{partial}$**	**Higher**	**Lower**	**Mean difference[a]**
Clinical scales					
Somatic complaints	61.63	.241	IM	IF	9.60
			IM	S	9.38
			IM	SP	8.26
Conversion	24.00	.110	IM	IF	5.71
			IM	S	5.27
			IM	SP	4.13
Somatization	10.73	.052	IM	IF	3.49
			IM	S	4.59
			IM	SP	3.24
Health concerns	114.07	.370	IM	IF	15.17
			IM	S	13.97
			IM	SP	13.21
Anxiety	9.81	.048	IM	IF	3.68
			IM	SP	3.59
Cognitive	10.69	.052	IM	IF	4.19
			IM	S	3.77
			IM	SP	4.33
Affective	12.35	.060	IM	IF	4.56
			IM	SP	3.61
			S	IF	3.09
Mania					
Grandiosity	9.96	.049	IF	S	4.07
			SP	S	5.51
Treatment considerations					
Alcohol problems	15.75	.075	IF	IM	4.11
			SP	IM	5.33
			SP	S	3.39
Non-support	9.74	.048	IF	IM	2.42
			IF	S	2.99
			SP	S	2.68
Interpersonal scales					
Warmth	21.96	.102	IM	IF	5.08
			IM	SP	6.88
			S	IF	4.33
			S	SP	6.12

Note: ANOVA = analysis of variance.
[a] All mean differences were valid with a Bonferroni $P < .001$.

Montrone. Altruistic surrogacy psychosocial profiles. Fertil Steril 2019.

compared with the other groups, the average scores suggested that the participants experience little distress across many situations. A difference was observed on the Mania-Grandiosity subscale, with the surrogates' scores being significantly lower than those of the men; however, all scores were within the average range, so this suggests a normative self-evaluation of talents and abilities.

No between-group difference was observed between the intended mothers and the surrogates on the Alcohol Problems scale, but the men's scores were statistically significantly higher than the women's, although all scores were again in the population normative range. This pattern was also found on the Non-Support scale, with women (i.e., the intended mothers and the surrogates) having lower scores reflective of more support as differing from the men (their respective partners); however, once again a normal range of mean scores was exhibited by all groups. This suggested that all the participants groups have close, supportive connections with family and friends. Similarly, although the intended mothers and the surrogates scored statistically significantly higher on the Warmth scale compared with the male participants, all of the group mean scores were indicative of individuals who were able to tolerate attachment and distance in interpersonal relationships.

DISCUSSION

Using a large Australian sample, this research represents the first comprehensive study to explore psychological and sociodemographic variables from the perspective of all participating parties in an altruistic surrogacy arrangement, thereby providing novel data. It reveals that intended parents contemplating an altruistic surrogacy arrangement predominantly seek support for their family formation journey from close family and friendship networks rather than alternative networks. This result to some extent was anticipated: people do not tend to make reproductive decisions in isolation from the influences of their cultural and living contexts (15, 37).

Also, within Australia formal surrogacy intermediary agencies do not exist, so intended parents are likely in the first instance to rely on those who are close to them. This is in contrast to the United Kingdom, another altruistic surrogacy jurisdiction, where there are intermediary surrogacy agencies; this may explain the greater number of U.K. surrogates without a prior relationship with the intended parents and also the higher proportion of genetic surrogacy (13, 27) in comparison to Australia, where gestational surrogacy through IVF clinics is predominant. Moreover, our findings differ from compensated surrogacy arrangements such as those found in the United States, where surrogates are primarily sourced via external agencies (38) or Internet support groups; the latter option represented only 5.1% in our study.

The interpersonal connectedness of parties to surrogacy in our study may be related to many factors. These include convenience of surrogate recruitment in the context of legislative prohibitions to compensate surrogates limiting their availability, comfort with long-term trusted relationships, perspectives about biological or social relatedness, or even Australian societal acceptance of surrogacy. That is, although surrogacy is legal in most jurisdictions (16), it is not accepted by all sectors of the community (39, 40). Consideration of these factors warrants further exploration in future quantitative and qualitative studies; gauging knowledge about how, why, and where intended parents locate specific altruistic surrogates is valuable because it has relevance to guiding clinical practice.

Sociodemographic differences can present a potential risk to the optimal functioning of interpersonal relationship dynamics (41); thus, if differences are present, they may impact power-control dynamics, ethical dilemmas, and decision making between parties to the surrogacy arrangement. Relatedly, differences in educational level and socioeconomic status can be factors associated with qualitative differences in interpersonal communications and dominance within interactions (42). In the context of surrogacy, it may be particularly relevant that "higher class contexts tend to foster independent models of self and lower-class contexts tend to foster interdependent models of self" (43). Therefore, a substantial class differential could affect relationship expectations during the surrogacy.

Consistent with prior studies in the United States and the United Kingdom (20, 22, 44), our study revealed sociodemographic differences between the intended parents and the surrogate mothers in altruistic surrogacy arrangements, although these were not all in similar directions. Contrary to countries with compensation systems (22) where most surrogates are aged in their early 30s, the surrogates and their partners in our study were mainly aged in their late 30s; on average, they were older than the intended parents. Moreover, the education and occupation levels were lower for the surrogates and their partners than for the intended parents, but there appeared no evidence of overall socioeconomic disadvantage; the majority of participants in our study resided in areas reflecting a relatively high SEIFA (35) grouping, albeit the surrogates and their families were less likely to live in the most advantaged areas compared with the intended parents.

Collectively these sociodemographic findings highlight that, at least in this Australian study sample, the altruistic surrogates and their partners—who were slightly older than the intended parents and not financially disadvantaged—can be perceived as relative sociodemographic equivalents. They are thus likely to be protected from the potential risks of coercion that may emerge from a position of financial disadvantage or immaturity due to age (41). This finding could also be reflective of a "comparatively flat social structure" in Australia, where there is a "perceived social equality among people" (45). This may explain the relatively small differences in education, occupation, and SEIFA levels between the intended parents and the surrogates and their partners in our study, in comparison to altruistic systems such as the United Kingdom where surrogates have been reported to have lower education and occupation levels than the intended parents (28).

Existing psychological health and personality predispositions are reported to influence surrogacy treatment outcomes (46, 47). For example, interpersonal dynamics could be affected by an imbalance of dominance, leading to control issues in decision making; or emotional warmth could be protective if it is common to the intended parents as well as the surrogates, supporting each other during difficult times. Personality attributes are important in managing the rigors of surrogacy treatment (20) as well as sensitive discussions about prenatal screening, pregnancy termination, reproductive autonomy, process of infant relinquishment, and postnatal adjustment. In our study, the PAI clinical scale scores mostly averaged around the mean for all surrogacy participant groups, which indicated positive psychological well-being and personalities typical of average adults in line with the U.S. PAI community normative sample. These results fit with the studies that have explored the psychological profiles in commercially based U.S. surrogacy arrangements, where psychological assessments, at least of the surrogate party, do occur (19–22).

Moderate elevations on the PAI Positive Impression and Treatment Rejection scales scores may indicate defensive responding; possible suppression of clinical scales, which though found previously, (21) was not found in our study. There were significant between-group differences on the Somatic Complaints scales, with the intended mothers having higher scores; this is not surprising owing to their likely history of investigations relating to infertility. However, a moderate elevation on the Health Concerns subscale, though congruent with a history of substantial reproductive health problems for the intended mothers, indicates a need for investigation because an elevation on this subscale may be a major component of self-image, with the person accustomed to being in the patient role (34). In the context of clinical history this may indicate vulnerability, which supports a referral for therapeutic counseling as a target of adjunct psychotherapeutic care.

In regards to the male perspective, most of the participant PAI scale scores were unremarkable and fell within the normal range. Subtle gender differences were found on the PAI Non-support scores and Alcohol Problems scales, but inspection of the scale scores failed to yielded results of concern.

To the contrary, the male participants' scores were suggestive of psychologically well-functioning individuals who reported close supportive family and friendship networks. These male participant findings, although statistically unremarkable, are nevertheless interesting because descriptive large-scale clinical information on male psychological profiles within the surrogacy context is lacking. Indeed, men per se can be seen as secondary to women in fertility care, so the repercussions of infertility treatment for men and male concerns are not always addressed, a perspective that appears to apply to infertility treatment in general (48). These findings highlight the necessity of ensuring that the male partner's psychosocial needs are at least considered during surrogacy implications counseling because the partner's well-being and associated support are likely to be important to the surrogacy journey.

The findings of our study need to be considered in the context of the following methodological limitations. First, because all surrogacy cases were sourced through one clinical practice (M.M.) with the majority of surrogacy cases approved (95.6%), the possibility of sample bias is acknowledged. However, the surrogacy approval rate is similar to that found in other smaller studies on altruistic surrogacy arrangements in New Zealand (18) and various U.S. studies of gestational carriers (20–22). Second, the possibility of socially desirable responding must be considered; the PAI Positive Impression and Treatment Rejection scores are at the high end of the average range, though lower than the scores documented in compensated surrogacy studies (20–22).

To some extent the presence of positive self-representation is unsurprising, given the history of close familial or social relationships among the participants; maintaining good personal standing both during and after surrogacy would be important. Moreover, the finding is less concerning when considered in the context of altruism: the surrogate and her partner's decision for surrogacy is not determined by financial gain but more likely pertains to reciprocal self-regard and compassion. This proposition is supported by the high average scores for the intended mothers and the surrogates on the PAI Warmth scale, reflective of effort to maintain relationships. There also were no concerns about PAI Dominance difference. These are both prognostic indicators that can be drawn upon to mediate relationships during what can at times be both intense and challenging surrogacy experiences (46).

A third limitation of our study relates to the limited number of cases involving male same-sex relationships available for evaluation. With no surrogacy legislation in New South Wales before 2010, only heterosexual couples were treated for surrogacy at Sydney clinics. However, after the introduction of the surrogacy legislation in 2010 (6), same-sex male couples were able to access treatment, with the first case in this study in 2012. Therefore, only limited conclusions about male same-sex sociodemographic analyses and psychological profiles can be made. However, recent research by Jadva et al. (49) found that sexual orientation was not an important factor in determining the type of relationships couples have with their surrogate.

Limitations notwithstanding, the primary strengths of our study include sample size, sample groupings, and completeness of the psychological data set. Prior studies investigating compensated and altruistic surrogacy arrangements have addressed only the surrogate perspective or were limited by small sample size or poor survey response rate. Our study furthermore provides data specific to altruistic surrogacy arrangements and particularly for the male partners, who were previously unexplored, which adds an important contribution to our understanding of the psychosocial aspects of surrogacy. Thus, the detailed sociodemographic and personality assessment of all parties to an altruistic surrogacy arrangement (the intended parents and the surrogate mothers and their partners) presents a unique perspective to this field.

In conclusion, the results of our study provide novel information about the psychological and sociodemographic profiles for all participant groups contemplating an altruistic surrogacy arrangement. Our main findings suggest that most participants have PAI scores in the normal ranges, indicating that they are psychologically healthy and well-functioning, and have sociodemographic equivalence and protective interpersonal factors. From a counseling perspective, knowledge about these findings can be used to shed light for other prospective patients and clinic stakeholders on the characteristics of participants who consider venturing into altruistic surrogacy arrangements, with some reassurance about the profiles of those who partake in this form of treatment program.

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Comparación de las características sociodemográficas y psicológicas entre futuros padres, subrogados y parejas involucradas en acuerdos de subrogación altruista en Australia.

Objetivo: Caracterizar los perfiles sociodemográficos y psicológicos de los grupos participantes involucrados en la subrogación altruista australiana.

Design: Estudio transversal.

Setting: Consultorio psicológico individual en Sydney, Australia.

Patient(s): 602 individuos involucrados en 160 acuerdos de subrogación altruista: 143 futuras madres, 175 futuros padres (incluyendo 17 parejas de futuros padres del mismo sexo), 160 subrogadas gestacionales, 124 parejas de las subrogadas.

Intervention(s): Ninguna

Main Outcome Measure(s): Respuestas a un protocolo de asesoramiento sociodemográfico previo a la subrogación y a un inventario de evaluación de la personalidad (PAI).

Result(s): Las subrogadas fueron principalmente hermanas, cuñadas, madres (48.6%) u otras familiares lejanas o amigas (46.3%) de los futuros padres. La mayoría de los participantes vivían en áreas residenciales dentro del quintil de más estatus socioeconómico, aunque las futuras madres eran mas proclives que las subrogadas a vivir en las áreas residenciales aventajadas, a ser más jóvenes, más educadas y empleadas en trabajos profesionales. La mayor parte de los perfiles psicológicos de los participantes fueron normales. Las futuras madres presentaban un mayor PAI-Quejas Somáticas - reocupaciones de Salud de forma significativa, cuando se comparó con el resto de los grupos participantes.
Las futuras madres y subrogadas obtuvieron una mayor puntuación en la escala PAI Warmth que resultó estadísticamente significativa al compararla con sus respectivas parejas, aunque no diferentes entre las unas y las otras.

Conclusion(s): Se observaron algunas diferencias sociodemográficas y psicológicas entre los grupos participantes que justifican el asesoramiento pretratamiento de la subrogación. Es importante destacar que las puntuaciones más altas en la escala PAI Warmth conseguidas por las futuras madres y subrogadas en el contexto de relaciones familiares y de amistad cercanas probablemente sirvan como mecanismos de protección para el resultado de la subrogación altruista.