

RCN Podcast - Episode 7 - BICA - Walk a mile

Episode Summary

In this episode of the Royal College of Nursing Fertility Nursing Forum podcast, Sarah Beveridge, Clinical Nurse Specialist for Fertility Preservation and Donor Coordinator, is joined by Gill Aldridge, a psychotherapist specialising in sex therapy, trauma and fertility. Gill also works as a fertility counsellor within an HFEA-registered clinic and is part of the training team for BICA, the UK Fertility Counselling Association.

The discussion explores the important role of counselling within fertility care and the psychological and social impact that fertility treatment can have on patients, couples and families. Gill explains the difference between therapeutic counselling and implications counselling, including the particular considerations surrounding donor conception and surrogacy.

Sarah and Gill discuss the importance of multidisciplinary working and how nurses, counsellors and other fertility professionals can work together while maintaining appropriate confidentiality. They consider the impact fertility treatment can have on relationships, communication, identity, grief and emotional wellbeing, as well as the importance of recognising when patients may benefit from additional support.

The episode also explores the move towards online counselling following the COVID-19 pandemic, considering both the increased accessibility it offers and some of the challenges associated with remote support.

Finally, Gill introduces BICA's *Walk a Mile in Their Shoes* course, which has been developed for professionals who support fertility patients but are not counsellors. Sarah reflects on her own experience of attending the course and how it encouraged her to consider fertility treatment from the patient's perspective and reflect on ways to further improve her own practice.

Learning Outcomes

By the end of this podcast, listeners should be able to:

1. **Describe the role of fertility counselling**, including the differences between therapeutic and implications counselling and how these can support patients at different stages of their fertility journey.
2. **Recognise the psychological, emotional and relationship impacts of fertility treatment**, and identify how members of the multidisciplinary fertility team can recognise concerns, offer appropriate support and signpost patients to counselling.
3. **Understand the purpose of BICA's *Walk a Mile in Their Shoes* course** and how professionals working with fertility patients can use a greater understanding of the

patient experience to support compassionate, psychologically informed care while also considering their own wellbeing.

Accessible Podcast Transcript

Sarah:

Hello and welcome to another episode of the Royal College of Nursing Fertility Nursing Forum podcast.

My name is Sarah Beveridge. I'm based in Dundee in Scotland and I'm a Clinical Nurse Specialist for Fertility Preservation and a Donor Coordinator. I'm also a member of the Fertility Nursing Forum Committee.

I'm delighted to be joined today by Gill Aldridge. Gill works as a psychotherapist specialising in sex therapy, trauma and fertility. She works in private practice and as a fertility counsellor within an HFEA-registered clinic, and she's also part of the training team for BICA, the UK Fertility Counselling Association.

Welcome, Gill. Thanks for joining us.

Gill:

It's good to be here.

Sarah:

We met when I attended the first BICA *Walk a Mile in Their Shoes* course, which is designed for non-counsellors who support patients through their fertility journey. I thought the course was fabulous, which is why I asked you to join us today.

Could you start by telling us a little about BICA and the role of a fertility counsellor?

Gill:

Of course. BICA is the UK professional body for fertility counsellors. It provides training for accreditation, continuing professional development, and sets standards and guidelines for practice. Its focus is on the psychological and social impact of infertility and fertility treatment.

The role of a fertility counsellor can be slightly different from counselling in other settings. In private practice, you might see someone regularly over many months or even years. Within a fertility clinic, you might see somebody two or three times, or at different points during their treatment.

Fundamentally, though, it's about providing a confidential space and building a therapeutic relationship. It's about listening, validating people's feelings, exploring what is happening for them and helping them find strategies to cope.

Sometimes it involves providing information or psychoeducation, and sometimes safeguarding is part of our role.

Within a fertility clinic we're also working as part of the multidisciplinary team. Other members of the clinic may bring something to our attention, or there may be occasions when we need to communicate something back to the wider team, while maintaining appropriate confidentiality.

Ultimately, we're trying to support people, give them time to recognise what's happening to them and help them find ways through it.

In many ways that's also what the medical and nursing teams are doing, but they have many other responsibilities and don't necessarily have the same amount of time that we have to explore those issues in depth.

Sarah:

I think it's incredibly valuable that people having fertility treatment in the UK have access to counselling.

It provides a safe space to explore the experience of fertility treatment. Depending on someone's previous experiences, fertility or otherwise, treatment can be traumatic or triggering.

It's also important that the counsellor understands fertility treatment but isn't directly responsible for that person's medical or nursing care.

Gill:

Absolutely. People sometimes come to counselling and tell me they've previously had therapy, perhaps relating to cancer or another significant experience, but their therapist didn't understand the fertility aspect.

They want somebody who understands what they're talking about when they mention surrogacy, donation, injections, treatment protocols or their experiences within a fertility clinic.

It matters because they feel that somebody understands and is sitting alongside them.

We do have more time than members of the nursing or medical team may have, although the amount of counselling available through clinics can still be limited. Sometimes people need more support than their clinic can provide and may subsequently access counselling privately.

At least we've begun that conversation and helped them recognise the potential value of counselling.

Sarah:

Can you explain the different types of counselling you might offer someone having fertility treatment?

Gill:

There are two main types.

The first is therapeutic counselling, which is about supporting people through treatment. Depending on the counsellor's style and training, that involves listening, exploring, offering strategies and helping people understand what they're experiencing.

The second is implications counselling.

Within fertility clinics, we're required to provide implications counselling in certain circumstances. This may include patients using donor eggs, sperm or embryos, known donors, surrogacy or other treatment situations where there are wider implications to consider.

Our role isn't simply to check whether somebody understands the factual information. We explore how they feel about it and what those implications might mean for them and their family.

For example, with donor conception we might discuss how somebody feels about their future child potentially being curious about their donor. What could that mean for the parents, extended family, grandparents, the child's identity and family relationships?

These can be difficult conversations because the patient isn't even pregnant yet. Understandably, somebody might wonder why we're talking about what could happen many years into the future.

But it matters. If somebody realises there are aspects of donor conception that they feel unable to accept, it's important to explore that before treatment.

It's also important that people understand the support available to them, including organisations such as the Donor Conception Network, as well as books, resources and research about talking to children about donor conception.

Once people have explored those issues, they may feel much more confident. Alternatively, they may decide that a particular treatment route isn't right for them. Either response is valid. The important thing is that they've had an opportunity to understand and consider the implications.

Alongside therapeutic and implications counselling, fertility counsellors can also be involved in multidisciplinary team meetings, safeguarding, staff training, developing standard operating procedures and discussing complex cases.

Sarah:

I was going to ask what a typical day looks like for a fertility counsellor, but I imagine it's similar to nursing in that no two days are the same.

Gill:

Absolutely.

For example, yesterday I saw four patients during an afternoon. One was for relatively straightforward implications counselling and three were for therapeutic support.

One person was ending treatment, which can be incredibly difficult. They were trying to work out how to move forward and how they were going to cope.

Supporting somebody at that stage can feel like walking a tightrope. They might not know exactly what they need from you; they simply know that they need something.

Some people want you to sit with them and make plans. Others need you to sit alongside them in their grief. Part of our role is working out what that particular person needs at that moment.

There's also lots of signposting. Between sessions I might research organisations and resources, make sure my referral information is current or look for additional ways of supporting somebody.

There can also be safeguarding concerns. Suicidal thoughts are something we encounter in fertility counselling. That doesn't mean everybody experiencing those thoughts intends to act on them, but when concerns arise we have to follow appropriate procedures.

That may involve contacting someone's GP, communicating with safeguarding teams, documenting appropriately and making sure the necessary support is around that person.

Alongside patient work, I might also be planning a counsellors' away day or developing a training session for another part of the fertility team.

It's very varied.

Sarah:

It's important to recognise how stressful fertility treatment can be.

Even if it's someone's first treatment and everything progresses relatively smoothly, they may have experienced a very long journey before they ever walk into a fertility clinic.

For some people that can become overwhelming, and treatment can also place significant strain on relationships.

Gill:

Absolutely. Something we think about a lot is how we can better engage men in fertility counselling.

We tend to see more women. There may be many reasons for that, including women often being more physically involved in the treatment and spending more time within the clinic.

Increasingly, though, we see couples together, and clinics need to consider whether their counselling provision enables that.

The dynamics within a relationship can change dramatically during fertility treatment.

One partner may decide their role is to support and look after the other person. They can move into almost a parental or caregiving role and forget to look after themselves.

Although their intentions are good, the person receiving that care can sometimes begin to feel less independent or less competent.

The medical or nursing team may then notice that the couple seems out of balance, more irritable with one another or less connected.

Counselling provides an opportunity to think about how treatment is affecting both partners. How are they communicating with each other? How are they communicating with friends and family? Have they become isolated? Are they experiencing shame or guilt?

Opening those conversations can help people understand what they're coping with and identify healthier ways of managing it.

Sarah:

That's where members of the clinical team can be really important. We may notice those relationship dynamics when patients attend appointments or procedures with their partner.

Gill:

Exactly.

A nurse or another member of the team might notice that something doesn't feel quite right and gently suggest counselling.

Quite often somebody arrives and says, "The consultant or nurse thought it would be a good idea for me to see you."

I'll ask what they'd like to talk about and initially they may say they don't know. But within five minutes, something often becomes very clear.

That's why it's important that the medical and nursing teams feel confident enough in their counselling colleagues to say, "This is incredibly stressful. Counselling is available. Why not use that resource?"

Sarah:

Different centres will have different levels of counselling availability, but I think it's important to remind patients regularly that counselling is there.

You mentioned implications counselling earlier. This can become particularly important when treatment involves a known donor or surrogate, because joint implications counselling can help make sure everybody has the same expectations.

Gill:

Absolutely.

With known donation and particularly surrogacy involving somebody the intended parents already know, people can understandably come into counselling saying, "We're fine. We've known each other all our lives. We'll work everything out."

That can actually make me more cautious.

If expectations aren't clearly discussed before treatment, there's a risk of damaging an important relationship later.

Our role can be to ask the uncomfortable "what if?" questions.

For example, if somebody's sister has offered to be their surrogate and there are several embryos available, what happens if the first transfer is unsuccessful? What happens following a miscarriage? How many attempts is the surrogate genuinely comfortable undertaking?

The surrogate might initially say, "I'll do anything they need to have a baby." But when you start exploring realistic scenarios, people begin to think more deeply about their own limits.

It's useful to agree boundaries in advance. Those agreements can change, but having those conversations before treatment helps protect everybody involved.

Working with people in those circumstances requires us to imagine different scenarios together and explore them. That can be very valuable in safeguarding relationships and wellbeing.

Sarah:

I think that's why implications counselling shouldn't necessarily be viewed as a one-off event.

How somebody feels before treatment may be different from how they feel when they have a child or when that child becomes a toddler and starts asking questions.

People can return to counselling and access organisations such as the Donor Conception Network for additional support.

We've had situations where conversations with a known donor have revealed differences in expectations. For example, a donor may initially be comfortable helping someone have one child but feel differently about their donation being used for a sibling pregnancy.

Having that conversation before treatment allows everybody to discuss it and reach a shared understanding.

Gill:

Exactly. Those expectations need to be clarified.

I've experienced similar situations in surrogacy. Everything initially appeared straightforward, but a comment picked up by a member of the nursing team revealed that the surrogate's views around termination differed from what had previously been assumed.

Because somebody noticed that comment, we could explore it properly during the joint counselling session and develop a different agreement.

That's why teamwork is so important. Whatever your role within the clinic, you're listening and noticing things that may be important to that patient's care.

Sarah:

I find it incredibly valuable having counsellors within the department.

Sometimes you get a sense that something isn't quite right. Obviously counselling must remain a confidential and safe space, and I wouldn't expect confidentiality to be breached unless there were genuine concerns about harm.

But being able to ask whether something can be explored is valuable. We're all part of the same team.

Gill:

Absolutely.

Confidentiality is key, but there may be occasions when a patient tells me something and I ask whether they'd like me to raise it with the clinic.

For example, they might tell me that their sedation didn't work as expected or that something during their treatment frightened them.

I'll explain that I won't share it if they don't want me to, but that it may be helpful.

Sometimes they give permission for me to discuss their individual situation. Other times they don't want to be identified but are happy for me to raise the general scenario.

That interaction between counselling and the wider clinical team, while remaining mindful of confidentiality, can be really helpful.

Sarah:

We've also had occasions where somebody has raised a treatment concern during counselling and the counsellor has asked whether a member of the clinical team can briefly come in and provide reassurance or answer a question.

That means the patient leaves with both the emotional support of the counsellor and some of their treatment anxiety alleviated.

Gill:

That was particularly easy when everybody was physically in the clinic.

We still try to do it now, although it may involve a phone call or email rather than simply asking a colleague to step into the room.

It's still important that we maintain those connections.

Sarah:

Has there been a significant move towards online counselling since COVID?

Gill:

Yes. We went from almost everybody being seen face-to-face to almost everybody being seen online.

Before COVID, there was a widespread belief that counselling didn't work as well online. I don't think that's necessarily true, although there are differences.

For some people, online counselling doesn't work as well and they want to be physically in the room with their counsellor.

As a counsellor, you may not feel quite the same connection online. Safeguarding can also require additional thought, particularly when somebody is experiencing suicidal thoughts, because you're not physically there with them.

However, online counselling has also enabled many more people to access support.

It has made it easier for couples to attend together, particularly when both are working from home.

There are advantages and disadvantages, but there are definitely significant positives.

More recently, I've noticed a substantial return towards face-to-face counselling in my private practice. It will be interesting to see whether fertility clinics experience the same change.

Sarah:

The accessibility of online counselling is particularly important in fertility because patients may travel significant distances to specialist clinics.

A 45-minute counselling appointment could otherwise require somebody to give up half a day when travel is included.

Gill:

Exactly. Patients are already giving up significant amounts of time for blood tests, scans and treatment appointments. Asking them to find another large block of time for counselling may simply be too much.

Accessibility is one of the major advantages of online counselling.

Sarah:

You mentioned changes to BICA guidance, particularly around implications counselling. Can you tell us a little about those?

Gill:

The changes are really about standardisation and making sure that every clinic and every patient has access to the information they need.

Historically, the information patients received could vary between clinics. Some clinics provide extensive videos, modules and written information, while others may approach things differently.

Counsellors could then find themselves spending much of an implications counselling appointment checking that every piece of factual information had been given to the patient.

That left less time to do what our role is actually intended to do: explore the implications.

The newer approach provides documentation containing the information patients need. They can receive that in advance and have time to read, understand and absorb it before their counselling appointment.

When they then attend implications counselling, we can check that they've received the information but spend much more time exploring the aspects that are personally important to them.

Rather than simply moving from one topic to another to tick boxes, we can focus on the implications of treatment for that individual or family.

Hopefully, this creates greater consistency between clinics, higher-quality counselling and better overall support for patients.

Sarah:

That consistency and equality of access across the country is incredibly important.

You mentioned the courses BICA provides. We originally met because I attended the *Walk a Mile in Their Shoes* course. Can you explain a little more about the course and who it's designed for?

Gill:

BICA traditionally provides training for fertility counsellors. Fertility counsellors undertake foundation and advanced training as part of their accreditation pathway, followed by continuing professional development.

Over recent years, however, we noticed two things.

Firstly, increasing numbers of people who weren't counsellors wanted to attend those courses. That included medical staff, nurses, reflexologists, acupuncturists and other people working with fertility patients.

It was fantastic that they were interested, but the existing courses weren't necessarily appropriate because much of the content was about actually undertaking counselling.

These professionals wanted the knowledge and understanding without training to become counsellors.

Secondly, fertility clinic teams were increasingly asking counsellors to provide sessions helping staff understand the patient perspective.

For example, embryologists are scientists by training but may have to communicate incredibly difficult information to patients. There isn't always a scientific solution to the emotional impact of those conversations, and repeatedly delivering difficult news can also affect staff themselves.

We therefore wanted to consider both how professionals look after their patients and how they look after themselves.

We developed *Walk a Mile in Their Shoes* as a two-day course for people who aren't counsellors but work with fertility patients.

It gives them an opportunity to look through the lens of a counsellor and stand in the shoes of the patient.

People working in nursing and medicine constantly have a huge number of tasks to complete and very little time. The course provides space to step away from that and think about what may actually be happening for the patient.

If you notice something, what might it mean? What could you do? Where could you signpost that person? What resources are available? And how do you look after yourself while supporting them?

The course is very experiential. Everybody is allocated a patient at the beginning and follows that patient throughout their fertility treatment and eventual outcome.

If there are 20 people attending the course, there are 20 different patient journeys being explored.

Participants can discuss their patient and what is happening to them. It brings the experience to life.

We focus on some of the key things that affect fertility patients, including treatment itself, identity, relationships, grief and trauma.

We explore what grief might look like when you're encountering it in a nursing room, embryology laboratory or elsewhere in the clinic.

We also consider trauma: what you might notice, how it might present and what you can do to support somebody.

That overlaps with safeguarding. Some patients may feel they have no time to stop between treatment cycles despite experiencing significant psychological distress because they're worried about declining fertility.

We also look at communication and how professionals deliver difficult information, case studies and support mechanisms for staff.

People working in fertility see a lot of unsuccessful treatment and difficult experiences. That can be very hard for staff too.

So the course is about supporting patients, but it's also about recognising how this work affects us as professionals and how we look after ourselves.

Sarah:

That reflects my experience of the course.

I loved how interactive it was and particularly enjoyed following a patient throughout their journey.

There was a mixture of professionals from different backgrounds, different parts of the country and with different levels of experience. Hearing everybody else's perspectives was incredibly valuable.

The course was online over two days, but the time flew by because it was so interactive.

I've worked in fertility and supported patients for a long time, but I still came away with lots of useful messages.

It made me reflect on my own practice: what could I do differently? What could I feed back to my clinic? What else could we offer our patients?

I would absolutely recommend it.

Are you planning to run the course again?

Gill:

Yes. The intention is to continue running it, potentially once or twice each year.

I hope it becomes a foundation course for people who work with fertility patients but aren't counsellors.

The mixture of professionals attending is an important part of the experience because it's fascinating to hear how different people encounter and understand fertility patients.

The tutors and delegates all learn from one another.

We make sure there's plenty of space for discussion, interaction and group work alongside the teaching. It's definitely not "death by PowerPoint."

Sarah:

I can absolutely recommend it to anyone with an interest in supporting fertility patients.

Before we finish, Gill, do you have any final takeaway messages or anything else you'd like to share?

Gill:

For me, it's all about working together.

It's about looking after patients together and sharing our experiences so that we can help each other as well as the people we're caring for.

We deal with difficult situations and emotionally heavy experiences. Sharing some of that load can make things better for everybody — both patients and professionals.

Sarah:

Thank you so much, Gill. I'm very grateful that you took the time to speak to us today.

Thank you also to everybody listening to the podcast.

The Royal College of Nursing Fertility Nursing Forum website contains our podcasts, blogs, previous webinars and information about courses and other educational opportunities.

We also have our annual Fertility Nursing Forum Conference, which will be held in London on 15 October 2026. Further information will be available nearer the time, and you can keep up to date with the Fertility Nursing Forum through our social media channels.

Thank you very much for your time, and we'll catch you again another time.