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**Talking about Bereavement Podcast Series – Transcript of ‘Supporting people through infertility related loss and bereavement: A fertility counsellors’ perspective’ Podcast**

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**Speaker:** Angela Park, Fertility Counsellor, NHS Grampian (AP)

**LI:** Hello and a very warm welcome to the Talking About Bereavement podcast brought to you by the Bereavement Education Programme at NHS Education for Scotland. I’m Lynne Innes from the education team, and I’m so glad you’re here today. In this series, we’re opening up honest and thoughtful conversations about bereavement. I’ll be joined by guests who’ll share their experiences, insights and the meaningful work they’re doing to support others through grief and bereavement. Whether you’re a professional, a carer or someone with a personal interest, there’s something here for you.

**LI:** Hi again and welcome to this episode of the podcast. I’m really pleased to introduce my guest today we’ve got a great conversation ahead, so let’s dive in. If you find this episode helpful, please consider subscribing, sharing it with a colleague or friend, and leaving us a review. Your support helps us reach more people and keep these important conversations going. My guest today is Angela Park. Hello and welcome Angela how are you today?

**AP:** Thank you Lynne, I'm fine and it is a pleasure to be invited I’m looking forward to the discussion [inaudible].

**LI:** Thank you. So, Angela completed her training as a counsellor in the early 2000s and went on to work in the third sector as a volunteer counsellor with a charitable counselling agency where she later became a staff member. She's worked 1 to 1 with adults and then helped to launch a young people's counselling service for 12- to 18-year-olds. She then worked in a secondary school for the charity offering therapeutic support to young people and she also worked in a private counselling capacity at one point. Today we're going to talk with Angela about her work, mainly focused at the Aberdeen Fertility Centre where she now works and has done for the past few years and is their full-time counsellor. Angela, I wonder if you would like to expand a bit on the introduction and tell us a bit more about yourself and how you've got to where you are in terms of your life and work.

**AP:** Sure. Well, just to kind of explain a little bit about kind of what took me into counselling. I think I've probably always had quite a lot of interest in psychology, social work. You know, I was, I was quite interested in that kind of line at work, in many ways I wish I'd done that maybe when I was a young person at school, but I didn't. So it was in like kind of what would I have been, gosh, quite a bit younger. I decided through just why not, I thought I'd really like to maybe change career, change direction. So that took me into my initial training as a person-centred counsellor, which I did through the University of Aberdeen. I did their counselling skills course, which I thought was excellent and it just gave me a real taste for, I really want to go and do this. I went on and did the postgraduate diploma, which is generally speaking, what you would have to do if you kind of did feel that you wanted to eventually kind of work professionally as a counsellor, most employers do need you to have a postgrad qualification. Again, it was a fabulous course at Aberdeen. Thereafter I, I did some voluntary work, as you've said in, in the kind of introduction there. I thoroughly enjoyed that it was working 1 to 1 of with adults in a charitable counselling organisation. It was exciting being at that point because the charity itself was kind of at a period of expansion and, and saying we'd like to maybe offer counselling for young people who deserve that but there’s a real kind of lack of that. And actually that was a, a lovely point in the professional life because we, we kind of, we were a very small team and it just kind of grew. And we eventually when I decided that I was kind of maybe at the point I needed to maybe hand over the reins to someone else, so we have counsellors in the secondary schools in Aberdeen. We have very kind of active service offered to young people and that is still very vibrant and going very strong. And that involved a lot of very interesting training as well. I thoroughly enjoyed my time here. What kind of took me to the fertility side was literally one day there was a job that popped through. It was a part time role in the fertility clinic and just by chance I thought, oh that's funny. One of my former tutors way back was the fertility counsellor…

**LI:** Right.

**AP:** …at, at Aberdeen. I thought, gosh, that's so funny. You know, I wonder if that's her job. Well, actually it wasn't, but our, our paths have crossed nonetheless since then. And it just sounded really interesting. It was a part time job. It was before COVID times I should say. So I applied and I felt very fortunate to be offered it. So I've been there for a few years now and the remit that we have is very much kind of guided by the UK regulator. So that's the Human Fertilisation and Embryology Authority. We kind of usually abbreviate that to HFEA. But they have quite a clear guideline for fertility clinics within NHS and private should have a counsellor available to all patients. That's very much in recognition of the emotional distress that going through fertility and trying to conceive can, can involve. I think it's fair to say that all the NHS clinics in Scotland have staff members like myself and the counselling is seen as equal importance to the kind of medical care. And so the HFEA guide clinics, they want clinics to make sure that patients are offered counselling throughout, before any treatment, during treatment and also after treatment. And that's irrespective of whether there has been actually a pregnancy with a baby. We also, so the therapeutic work is really important. We also provide mandatory implications counselling and that's for anybody who's considering being a donor, an egg donor or a sperm donor. We also have regular donation that sometimes comes along and we have, you know, significant numbers of patients who need to use a donor as a means of family building. That might be eggs, sperm or sometimes in a small number of cases going through donation as well we've got people who are going through surrogacy arrangements and we might be going through fertility preservation on health grounds or, or, or social egg freezing or as part of a transition process as well. So it's quite a vital, it is a varied role and it's a busy job. But I, I can say on my heart that it's certainly in Aberdeen as I say, I'm sure I can say that confidently about the other centres that, you know, support, psychological support, the emotional support is of equal importance.

**LI:** How many other centres do we have in Scotland?

**AP:** We've got the four NHS fertility clinics, so that's Aberdeen, Edinburgh, Glasgow and Dundee. And there is a private clinic based down in Glasgow as well. And there's a significantly higher number of private clinics in London and Wales. And interestingly, the kind of flip is generally speaking the majority of fertility treatment in Scotland is through the NHS…

**LI:** Right.

**AP:** …something in region sort of 60–70% of fertility treatment will be NHS delivered, the remainder private. But in England it's quite the opposite. The majority of fertility treatment is actually through private clinics.

**LI:** Oh right.

**AP:** So I think it's probably fair to say that we're fortunate at the moment in Scotland, that there's, there's good availability of NHS funded fertility treatment…

**LI:** Right, okay.

**AP:** …comparatively in other parts of the UK.

**LI:** So you said that your remit is about providing counselling so is that to everybody that comes through your service?

**AP:** It is actually. We have a variety of start points for patients. So some may have a diagnosis which, which indicates that fertility is going to be difficult with endometriosis, PCOS, they may have an, an illness or some kind of health issue that means that conception is not going to be easy. They may have been in that for a long time, or it may be that the couple, they may have been trying to conceive themselves, which usually without some kind of health diagnosis, usually a couple would have to be trying to conceive for possibly up to about two years before they…

**LI:** Okay.

**AP:** …would be referred…

**LI:** Right.

**AP:** …to a fertility clinic. We obviously have same sex couples. From my experience, it's quite unusual that we have a male same sex couple. But the vast majority of couples that I will see in same sex relationships will be female. And we also have single women who are going through or beginning the process of maybe trying try to conceive. Just going back to the HFEA, the UK regulator, they clearly state that they would like therapeutic support to be offered beginning, middle and end.

**LI:** Okay.

**AP:** And so just keeping that kind of fertility loss, bereavement, there's often quite a recognition at the very beginning of being referred for fertility investigations and treatment. There might well be a kind of sense of this isn't how we'd hoped…

**LI:** Yeah, yeah.

**AP:** …to conceive. So that, there can already be that kind of longed for pregnancy, longed for baby.

**LI:** So when, I suppose people are coming to you who, who have already, I suppose suffered some loss if they've been trying for, for two years or so and they've not managed to conceive, how do you, what do you do to support people who are kind of suffering or, or not suffering, but, but going through this period of loss or grief…

**AP:** Yeah.

**LI:** …or bereavement?

**AP:** Well, I think we kind of a few sort of things came into my mind when you asked that question and I think in the very kind of initial discussions with a patient so that wouldn't be probably myself, but we have a patient information evening session, which I don’t know if it is the evening anymore. But we have a patient information session which we invite everybody to attend. And that is just a kind of introduction to if you become patients with us, which you probably will be because you've been referred, this is what we do. These are the various treatments that we offer. And from that very kind of initial introduction if you like, the counselling service is mentioned. It's explained to patients that they can self-refer any time, but they will always be asked by a nurse, by a doctor, by one of the lab team, “How are you doing?” “Are you remembering that we've got a counselling service here. You can have that at no cost. Even if you're self-funding, there's no cost for that.” So, we have it very embedded in all our communications. There’s a couple of questions: “How are you?” “How’s your partner?” Making sure that a) know and remember that they can have therapeutic support, and b) they want their referral by that nurse or by that doctor or by the endocrinologist. That can happen. We've got information on the website, on our social media, in the kind of waiting room area and so on. It just kind of highlights the counselling services here. You can self-refer, just call or email the clinic anytime. I think in terms of specifically how do we support it would be if, if somebody did feel that they could benefit from counselling, we begin at that point. And I think the important part of that early relationship building is to make sure that that patient's unique individual circumstances are validated. And what that…I would really like to know and understand, you know, what's it like starting this process, you know being referred? How do you feel about it?

And, and so important to kind of acknowledge that say, for example, for that woman who's looking at treatment on her own as a single person. There might well be a sense of well I didn't really think it would end up being like this.

**LI:** Yeah, yeah, yeah.

**AP:** You know, I had hoped that I would maybe have a partner in this journey. For a same sex couple, we want to do this is, is quite often the feel of it when we do this. This is the way, this is the route that we can perhaps have our family, but we're going to have to acknowledge the genetic loss. They're not going to have a child…

**LI:** Yes.

**AP:** …with our joint genetics. For a heterosexual couple as well, as, as often will be the case they have been trying for quite a considerable period of time, maybe up to two years. There could well have been a number of miscarriages in that time. There might never have been a positive pregnancy test in that time. So just being able to kind of acknowledge where are you in all of this, is so important.

**LI:** Yeah, I imagine there's a, a process to, to what they're, they’re kind of going through. But actually to see the people in the midst of that process as, as, as how is this happening to them? Or how, how are they, you know how are they feeling about that? I'm kind of assuming that the counselling is, isn't mandatory, it is something that's invitational to people. Is that right?

**AP:** Yeah, yeah.

**LI:** That it's offered to them, but they don't have to…

**AP:** Absolutely.

**LI:** …go through with it if it's not something they feel that…

**AP:** Absolutely.

**LI:** …they want to? Yeah.

**AP:** Yeah.

**LI:** How, how does that work out? Are you, are you able to say is it most people have the option of some therapeutic support? Or do a lot of people not want it?

**AP:** It's quite an interesting question. And I think I, I kind of do an audit of the, the service every year, the recent audit and the year before that too. How we kind of work it out is you know how many sessions of counselling I've offered, how many individual patients I've seen. And then that's put into a ratio compared to the number of IVF, IUI transfers we've done that year, how many cycles we've done that year. And it does come out quite high. It's probably somewhere in the region of about 80 to 90% of our patients…

**LI:** Okay.

**AP:** …will engage with the counselling at some point in the treatment. The therapeutic counselling is always patient choice. It's flexible. We are lucky in Aberdeen anyway that we don't have a kind of fixed number of sessions. We don't have a long waiting list. We're, we're very fortunate and we really value that. But a patient can ask for a session, they’ll be offered a session then they and I or my colleague who, who works for us part-time. We will speak at the end “What do you want to do?” “Would you like to put in another session?” Or I might sometimes say, “Look, I'm feeling quite a lot of things. Maybe a few sessions would maybe be a good idea” or “Do you want to maybe just kind of keep it open and we can just see how we get on?” “Let's have a, a few sessions, see how we get on”. The, the implications counselling is mandatory.

**LI:** Right okay.

**AP:** But that's important because using a third party to potentially have a child it’s an important consideration. It's important that that person or that couple, you know will know and understand and feel comfortable with the implications of a donor. And likewise, a donor knows what future scenarios could be so that they can all make an informed decision.

**LI:** And, and I suppose I was thinking about keeping this question to the end, but just because I'm thinking about it just now, do you see the outcomes of, of people who go through fertility treatment?

**AP:** I do if we're still engaged together,

**LI:** Okay.

**AP:** …as in we're working together or quite often, which I think is such a kind of privilege I guess I would say in my work, if that patient, either it might be an individual, it might be them with their partner, or it might be a combination, I might have met them as a couple, met them individually as well, they may have got a positive test. And we might then at that point they may decide, “Right, we’d like to just take a break and kind of just keep in touch.” They might want to maybe have one or two sessions after a positive pregnancy test, because it's not always so straightforward to just say, “Great, we're pregnant now, we're, we’re fine.” That can be a period of quite high anxiety. It's taken a long time and there will have been a lot of difficulty reaching this point. So it's not quite as easy to just step into the kind of antenatal care as much as it is fabulous. So we might have a few sessions, maybe until the pregnancy is more advanced.

But I guess either way, it's lovely if a patient who you might have known for however long, keeps in touch and maybe just tells you that they had a baby, all is well, and, you know, maybe sends you a picture. So you do find out the outcome if they share that with you. But you just kind of hope that if you have maybe worked with somebody and they have got to that point of having a positive test and maybe they've had their seven-week scan, which is the, the kind of next stage in planned fertility treatment, they have a seven-week scan to check that there is a kind of viable pregnancy there. The nurses are looking for a nice sort of heartbeat. I might not see them again. And you just hope, well hopefully all will be well, and that they will have their own, have that baby in, arms in, in the future, in the coming months.

**LI:** So I wonder how, how do you ensure that you, that you do this well, in terms of supporting people throughout their fertility pathway?

**AP:** Well, I guess from a kind of technical stand, I don’t know if that’s the right word, we, we do qualitative research with patients…

**LI:** Okay.

**AP:** …throughout the year. We send an anonymous questionnaire that they complete. So there's no means of anybody knowing who has completed that questionnaire. It's sent to patients usually within a kind of maybe six-to-eight-week block. Some may be implications counselling, some may be therapeutic. And that questionnaire is just seeking a kind of range of different responses from kind of “Did, did you feel that the counselling helped? If so, in what way did it help?” And there’s a range of different options. So the qualitative research, which has about maybe ten or so questions, is a really helpful means of hearing about patient experience and taking on board feedback and trying to then accommodate the feedback if we can. So, for example, if maybe someone said that you know they, they felt the times that they could make, they’d like evening counselling right.

**AP:** So do we,

**LI:** Yeah.

**AP:** …do we, maybe need to sort of take that on board because we want to be as inclusive and make sure that everybody is afforded the same kind of chance to have the counselling if they want to. So that's one means you know, literally kind of doing market research…

**LI:** Yeah, yeah.

**AP:** …you know, doing customer feedback. That’s something that the clinic does ongoing anyway, you know, a patient can feedback anonymously anytime via our website, we have a QR code. I think as a counsellor in a fertility clinic, because it is a very kind of niche area of counselling, you have to be very much engaged with CPD. You have to be very aware of kind of what's happening in the kind of assisted reproduction side of things, the science and the medical side of things, legislation. Today, for example, there was a, a, a news article about mitochondrial…

**LI:** Yes, I heard that, yes.

**AP:** Yes.

**LI:** Yeah, yeah, yeah.

**AP:** So, you know, eight, eight babies being born…

**LI:** Yeah, yeah.

**AP:** …with, with really advanced technology. So you just I guess how, how do we make sure we're keeping on top of everything? Well, we're a counsellor. So we hold on to that training. We should be confident in how we deliver that. But the add-on, I guess, is just making sure that you know a lot, as much as you possibly can about what the patient is going through. So when they're talking about that drug and the impacts, or when they're talking about that particular type of procedure, you know what they're talking about. So it's things like that. And I think that's where it can make quite a difference, because I'm speaking very generally right now — but sometimes people going through fertility treatment might feel that people in their kind of social networks just might not understand what it's like, and they get tired having to…

**LI:** Yeah.

**AP:** …explain. You know…

**LI:** Yeah, yeah.

**AP:** …there, there can be maybe a lack of education, a slight kind of naivety that oh well, IVF means you're going to get pregnant, and it doesn’t. How, how exciting is that? And people go you know it’s not quite like that.

**LI:** Yeah, yeah, yeah.

**AP:** So I think it's really important as counsellors in this particular field that we really keep continuing reading, watching, listening. I read my colleagues' medical kind of notes, as it were, to understand so why does that, why does that drug have to be changed? And what does that injection do, you know. So it’s because actually, that’s really important to the patient that they, they get, the counsellor understands, you know when I talk about the long protocol, I know what they mean.

**LI:** Yeah, yeah, yeah.

**AP:** You know.

**LI:** Yeah, yeah, yeah, yeah.

**AP:** So, I hope that’s part of it.

**LI:** Yeah.

**AP:** But I think at the end of the day, I suppose counselling is about the relationship with those people with that patient, that is the most important thing that makes something potentially helpful. The fact that you maybe have the additional knowledge can, can just be actually quite welcome. Because I don't have to explain. I've had to explain to all my friends. I've had to tell the family what egg retrieval…

**LI:** Yeah. But with you they can, they don't need to do all of what that all means and how complex it might be because you are understanding it.

**AP:** Yeah.

**LI:** So I suppose I wonder how, how do you keep yourself well in, in the job that you’re, the role that you're doing?

**AP:** I think it's probably fair to say that that's very much kind of part of your initial training when you first begin as a counsellor is that you have to have a lot of self-awareness. You have to do quite a lot of work on your own self. And part of that is maybe opening stuff that you haven't maybe realised.

**LI:** Yeah.

**AP:** But in order to do that you, in order to kind of grow and, and be say a competent professional counsellor, part of that process is also being very aware and checking in regularly.

I can only offer myself in, in a fair and decent way if I'm aware of what's stirring up in me. Or if I'm tired you know well, I need to take care of that, because that's not going to be good enough for the patients that I'm going to be seeing. So you have to be very aware of right, you know, being a bit tired at the moment when am I going to get a bit of a break, I need to get a holiday sorted don’t I. Or actually why am I tired? What is it about, you know. So I guess in answer to your question it would be very much, I know what I need. And that's getting out for a walk with my dog.

**LI:** Yeah, yeah.

**AP:** It's having a nice swim here and there. It's listening to music. It's doing a bit of gardening.

But just I know what I need to kind of top myself up and, in, in a way that I hope anyway, that I can offer myself in, in a helpful way to the people that I work with.

**LI:** And I suppose that’s, that comes from your own self-awareness, is, is I suppose what you're talking about really, isn’t it? It's being very kind of self-aware of what's going on for you, how are you showing up, you know recognising you're tired or you're, you’re needing a holiday or whatever it happens to be. Or you need a bit of a rest or whatever. You need to go out for a walk. You need to go swimming. You know, those are, that kind of self-awareness of what's going on for you. And we speak a lot about this, this in chaplaincy as well, around having to do a lot of work on ourselves to be in the right place to provide people with the support and the spiritual kind of care that they might require.

**AP:** As, as counsellors as well you know, part of our kind of ethical framework we have to make sure we have supervision every month. And that is so important because you can, it’s a little bit in some ways like your own kind of therapy but it's very much your supervisor kind of keeping an eye that actually you're working ethically and responsibly. So you can, that's another avenue where you can actually say, you know “I'm feeling quite tired at the moment.” It's also, I think, a fairly good indication of the work that we do can often carry so much sadness and loss. And it’s I would say quite often the case that I think, gee, you know, I just feel so gutted for this patient that we've had another negative result. And I'll often sort of sit and think, you know I'm just a tiny grain of sand in their lives.

**LI:** Yeah, yeah.

**AP:** So it gives you such insight maybe to how hard it must be to have another pregnancy test that is saying negative. So I think it maybe helps to, I hope anyway, get an insight and kind of enhance that empathy maybe that I hope the patient feels that I'm feeling so sad and disappointed but you're living and breathing and sleeping with this all the time…

**LI:** Yeah, yeah.

**AP:** …because it's been for the last five years of your life, you know so what other [inaudible].

**LI:** Yeah, yeah, yeah, yeah, yeah. Well, thank you, Angela, for, for sharing some insights into your work and, and how you, how you support people, particularly around loss, grief and bereavement. It’s been really interesting talking to you, and I know we caught up before, and so we've had kind of two sessions, and I’ve found it really interesting hearing what you, what you do and, and the support that you give to people. And you know isn’t it reassuring that people have got counselling services or therapeutic support in all of the fertility centres. It, it feels, it feels like the right thing, and, and it feels, it feels good that they can access that. So thank you very much for taking part in this podcast.

**AP:** Thank you, Lynne. I hope it's helpful to the listeners. And I should just say if there is anything that anyone would like to kind of maybe explore further, you know there, there’s fantastic organisations in the UK that support, provide a lot of information, a lot of great resources. So the likes of the Fertility Alliance, Fertility Network UK, Donor Conception Network, BICA, which is my professional organisation the…

**LI:** Okay.

**AP:** …the British Infertility Counselling Association…

**LI:** Okay.

**AP:** …that is a great source of information about counselling, particularly in the fertility sector. So there is a, a lot, there’s a very strong, vibrant community all about kind of fertility, fertility support and so on. So, you know, I’d welcome any of your listeners who maybe would like to kind of explore things further maybe you know looking up some of those different resources…

**LI:** Yeah.

**AP:** …I’ve mentioned.

**LI:** We’ll put some of the ones that you’ve mentioned there onto the show notes. So when people go into listen to the podcast, they’ll be available for them if they want to have a look at them.

**AP:** Great that would be super.

**LI:** So that’d be really good. So thank you again for your time and for sharing with us your work.

**AP:** Thank you so much, Lynne. It’s been a pleasure.

**LI:** Thank you. Bye, bye just now.

The podcast was recorded in July 2025 and can be found at <https://www.sad.scot.nhs.uk/podcast/> or on [Spotify](https://open.spotify.com/show/11AORpjHqbsYwgg1DJUtLk?si=687dba351d1f45d4).

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