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Social Work's Role in Prenatal Diagnosis and Genetic Services: Current Practice and Future Potential

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Abstract

Although the development of sophisticated technologies associated with prenatal testing processes have assisted in the practice of prenatal diagnosis, limited attention has been given to the complexities surrounding the decision-making processes for pregnant women following a poor or fatal diagnosis. An emerging international body of knowledge suggests that the process of having prenatal testing and then deciding on whether to continue a wanted pregnancy is often difficult and traumatic. In the last 50 years, social workers have played an invaluable role in the provision of holistic counselling and support for children and families in a range of areas and contexts. This paper highlights the unique contributions that social workers can bring to the field of prenatal testing. It emphasises the consideration of strengths and values inherent within social work practice that provides appropriate and timely support for women who have received a poor or fatal diagnosis following prenatal testing.

Keywords: Prenatal Diagnosis; Genetic Social Work; Prenatal Testing; Australian Social Work; Genetic Counselling; Pregnancy Counselling

Over the last 70 years, social work has emerged internationally as a profession renowned for its support and advocacy of individuals and family, both through practice and policy development. Social work practice is undergirded by core values that acknowledge the rights of the individual and support self-determination. From as early as 1966, social work clinicians have explored the effects of prenatal diagnoses on women and their partners (Taylor-Brown & Johnson, 1998). Schilds and Beck (1984), pioneers of genetic social work, predicted that preparing social workers for engagement in the field of genetics in general and prenatal testing in particular would be of critical importance, given the emergence of the Human Genome Project. Considering the psychosocial impact of the decision-making process for women, their partners, and families following a prenatal diagnosis and the beneficial contribution of social work interventions implemented in a number of Western contexts, this paper emphasises the need for the development of social work practices and related

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policies in Australia that support individuals through the often complex and traumatic process of prenatal testing.

Background

Currently between 2% and 4% of pregnant women will receive a prenatal diagnosis that requires them to make a decision about a potential termination because of a poor or long-term prenatal prognosis (Abeywardana & Sullivan, 2008). The term “poor or fatal prenatal diagnosis” refers to a prenatal condition that would justify a doctor offering a woman a termination of pregnancy. While most women are now offered to terminate their pregnancy after a fatal prognosis, routine care and advancements in technology have contributed to an increasing number of women also offered a termination of pregnancy for nonlethal conditions such as Down syndrome, limb anomalies, nonfatal cardiac issues, and conditions that would impact on the child’s mental and physical development (Bijma, van der Heide, & Wildschut, 2007; Gregg, 1993).

According to Abeywardana and Sullivan (2008), in 2002–2003 15,251 women in Australia gave birth to a baby with a congenital diagnosis, representing 3.1% of the births in that time period. Considering that only two states in Australia (Western Australia and South Australia) have mandatory obligations to report data on terminations performed within their borders, it is impossible to accurately estimate how many terminated pregnancies also received a poor or fatal prenatal diagnosis in that same period. However, it is possible that the number of women who received a poor or fatal prenatal diagnosis would be higher than those 15,251 births reported in Australia in 2002–2003 if the terminated pregnancies were also included.

It has been widely accepted that an adverse prenatal diagnosis presents a considerable legal, ethical, and emotional dilemma for those involved (Turner, 1994). It challenges the women’s and their partners’ views on moral issues such as abortion and disability. Additionally, it raises questions around religious beliefs as well as views on life, goals, and coping abilities (Statham, 2003). Rothman (1987) states that a great amount of pressure is placed on women and their families after a prenatal diagnosis to consider the impact of birthing a disabled child in terms of the financial and social costs. In view of the ethical dilemmas raised after a poor prenatal diagnosis, Bewley (2003) proposed three moral frameworks to understand how professionals and women may view termination and its ethical implications: (a) The duty-based framework is broadly a religious framework that in the abortion debate sees most terminations as immoral; (b) The goal-based framework is a consequentialist approach that may imply that terminations should be obligatory if foetal abnormalities are found; (c) The rights-based framework provides individuals with inherent rights that may include women’s rights to terminate their pregnancy and to choose to give birth to a child with a disability.

Despite the move towards “choice” after a prenatal diagnosis, around 80% of medical professionals still assume that women should or would terminate after a prenatal diagnosis (Drugan et al., 1990; Statham, 2002). However, the “rights based”

framework is a framework to which most professional bodies including the Australian Health Ethics Committee and the National Health, Medical and Research Council would adhere (Abeywardana & Sullivan, 2008; Australian Law Reform Commission, Australian Health Ethics Committee & National Health Medical Research Council, 2003).

Current Literature Focusing on Social Work and Prenatal Testing

As part of the development of this paper, an extensive review was undertaken focusing on the impact of psychosocial support after a prenatal diagnosis. More particularly, the impact of social work input after a prenatal diagnosis on a woman's wellbeing was explored. The process included the identification of published work that contributed to knowledge on the issues raised by women and professionals in the field of prenatal testing. An electronic search of the Medline, Psych Info, PubMed, ProQuest, and Griffith University databases was undertaken covering the period from April 2010 through to December 2012. Books were also searched in the online Griffith University library. Key search terms included "Prenatal testing", "Social work AND genetic support", "Counselling AND prenatal testing", and "Mental health AND prenatal diagnosis".

Although articles were not automatically excluded based on date of publication, most articles read and used in this review were published between 1995 and 2012. Further searches were then carried out using references cited in the initially identified papers. An articles was subsequently included in the review if it discussed the role of social work, the impact of psychosocial support and genetic support, and/or prenatal testing. Articles that only discussed pregnancy loss, medical social work, and genetics without the stated keywords were excluded from the review. Finally, findings of all the articles and book chapters that were identified as relevant were combined using a systematic approach to generate this review.

Overall, while research focusing on genetic counselling and grief and loss is well represented, in contrast there is little literature centring on the role of social work with women and families experiencing the impact of a negative prenatal diagnosis. This trend suggests that, while social work practice has been incorporated to a limited capacity in supporting women undergoing prenatal diagnosis, the field of genetic social work as a recognised specialty of its own requires extensive future development.

Prenatal Testing in a Developing World

Modern factors are impacting on a woman's decision to fall pregnant, including a decrease in family size, access to contraception and assisted conception, costs of living, and the changing roles within Western societies (Gregg, 1993). In the midst of complex social dynamics including social, cultural, and vocational factors there is an increasing trend for women and their partners to choose the timing of pregnancy as

well as options to terminate (Gregg, 1993; Rothman, 1987). In this complex psychosocial context, difficult and at times ethically charged decisions are being experienced by both clients and health practitioners.

Sandelowski and Jones's (1996) study of 15 women focused on the impacts of having to choose a termination or to continue an affected pregnancy after a prenatal diagnosis. This study provides significant insights into the complexities associated with routine testing. In a similar manner to other studies (Fonda Allen & Mulhauser, 1995), participants described their experience to include a revised viewing of their lived experience that would "change their world forever". For example, participants indicated that they had changed as women; they had become overprotective or engaged in negative or fearful thinking, partly as a result of the fear of losing their child. They had also ceased believing in a benevolent world where "good people" reap "good consequences" as they developed the realisation that "bad" things could happen to good people, such as receiving a poor or fatal prenatal diagnosis. In general, without support, women's perceptions of the future and what it held for them and their families were adversely affected as they continued to question the nature of the world and the emerging issues surrounding their negative experiences.

A number of authors suggest that further support for women experiencing a prenatal diagnosis would be highly beneficial to women in addressing wider issues of self-esteem, biological identity, parenting, and new world views (Hutti, 2005; Kersting et al., 2009; Korenromp et al., 2007; Lilford, Stratton, Godsil, & Prasad, 1994; Statham, 2002). Those women who have received supportive interventions state the benefits derived from such help (Gordon, Thornton, Lewis, Wake, & Sahhar, 2007; Howard, 2006) as highlighted from the following excerpts from Azri's (2013) case studies. These quotes demonstrate how comprehensive and timely support can assist women in their adjustment to an adverse prenatal diagnosis:

We had good support from our consultant. One of the really nice things she did was she actually referred to the baby as "baby", didn't say it was a foetus or you know ... She always referred to baby as baby so he had an identity, he was a person ... It was lovely to have someone sit with us while we cried. (p. 124)

The treating team was really nice. If I didn't understand things, I'd ask and they would re-explain. I really sensed that these people were genuinely sorry for what we were going through. You could tell that they cared. (p. 132)

I saw the social worker. I talked to her, it was good to discuss ways of bonding with my baby and they did a lot of things of organising for me. We went through my choices and this helped. (p. 133)

I think sometime in that period of time I spoke to [the social worker] from [a hospital] as well. She spoke to me for ages on the phone, just kept on talking about all different aspects of the diagnosis and answered all my questions and said I am here anytime you need me. (p. 131)

Psychosocial Consequences Associated with Prenatal Testing

Prenatal diagnosis testing, whether a woman terminates her pregnancy or carries to term after a poor or fatal prognosis, comes with long-term implications including psychiatric, emotional, and social problems (Howard, 2006; Korenromp et al., 2005; Lathrop & VandeVuss, 2011b; Statham, 2003; White-Van Mourik, 2003). The social and emotional issues for women responding to prenatal diagnoses are complex. First, these women may potentially experience feelings of grief, trauma, and loss of biological and sexual esteem (Hutti, 2005; White-Van Mourik, 2003). Second, they may also suffer parenting and relationship issues (Fonda Allen & Mulhauser, 1995; Howard, 2006). Third, the grief process is influenced by the culture and beliefs of the women in a psychological, social, and religious context. As Neimeyer, Prigerson, and Davies (2002) note, bereavement carries very individual biological, cognitive, and emotional responses, resulting in grief and loss experiences that are both culturally and symbolically grounded (Neimeyer et al., 2002). Finally, the type and severity of the diagnosis in utero received, and whether a termination occurred and in which circumstances also influences women's experiences of grief, trauma, and psychological wellbeing (Chescheir & Cefalo, 1992; Gordon et al., 2007; White-Van Mourik, 2003). The following excerpts from case studies (Azri, 2006) highlight some of the feelings women have described after receiving an adverse prenatal diagnosis:

I went home feeling very ill, I had this feeling of being in a rollercoaster that would never stop and I felt so alone ... I felt as though my life had ended but I couldn't really say why. (p. 33)

Being told that our daughter would be born with spina bifida and very probably Down syndrome meant a lifetime of care, special needs and being looked at by other people. Although we should have not cared about others' opinions, in the first few days we felt like failures and felt our child would be a burden. It was hard to see beyond our pain. (p. 32)

The consultant put down the transducer and quietly said, "I'm so sorry". I got up and leaned on the edge of the bed. Her words didn't register. Again, she said, "Lynda, I'm so desperately sorry". And then it hit me ... I collapsed at the end of the bed and crumpled into a heap of tears. (p. 65)

A prenatal diagnosis brings many changes to the women and their families in addition to the difficult loss and emotional trauma (Green & Statham, 1996; Korenromp et al., 2005). These may include:

- financial (health conditions of the baby or the pregnant woman may involve treatment costs or time off work due to physical or psychological reasons)
- marital issues (partners may struggle to support one another or focus on parenting rather than the marital relationship)

- sibling issues (other children may grieve if the baby dies, or the pregnancy is terminated, or develop resentment towards the new sibling who needs special care and attention)
- social issues (the women may withdraw from friends and family due to feeling judged for terminating their pregnancy or having a child with special needs)

The impacts of the factors outlined above are illustrated in the following case studies (Azri, 2006):

Because we terminated the pregnancy, not many people asked us how we coped. They assumed that terminating our baby was a “choice” and assumed we would feel relieved rather than bereaved for our lost child. We lost many friends. (p. 122)

I was sometimes pulled up in the supermarket by people wanting to know what was “wrong” with Jared. I wished that they wouldn’t say that in his hearing. And sometimes they would talk to him like he was deaf, or extremely depressed: “Keep your head up mate, you’ll be okay”, “Don’t you worry, love”. Some people have said things out of ignorance at times, and I know that they would never have wanted to hurt or upset us, but they just didn’t realise about his condition and what it meant for us. (p. 54)

I was devastated; I came from a family of high achievers and believed in success in life. My husband was really upset because we had already found out the baby was a boy and, overnight, he stopped picturing his son at his side, playing cricket and imagined a life with a boy who would never fulfil any of the dreams we had for him. It sounds really harsh but unfortunately that is what everybody believed—our family, our friends and our son’s own parents. The pregnancy was not the best; some people asked us why we didn’t terminate and frankly we wondered why ourselves. I guess we felt “guilty”, were overwhelmed by the news and had no support. (p. 63)

Until recently, little attention had been drawn to the psychological and social aspects of prenatal testing. Psychosocial adjustment, counselling, education, and liaison services are areas that are emerging in parallel with the burgeoning interest in women’s experiences of trauma and bereavement. Counselling in the area of prenatal testing encompasses medical, psychological, and social factors (Abramsky & Chapple, 2003; Schwaber Kerson & McCoyd, 2010). Schwaber Kerson and McCoyd (2010) acknowledge that the practical and medical support offered to women after a prenatal diagnosis are often prioritised over their emotional needs. Given this concern with current practices, there appears to be merit in utilising other support professionals such as social workers trained in genetics in redressing limitations that fail to be directed towards the psychosocial needs of women—particularly given the training and expertise inherent in social work practice that focuses on the psychosocial functions of the individual (Schwaber Kerson & McCoyd, 2010; Mealer, Singh, & Murray, 1981). Overall, there is a concern that some professionals providing support to women who receive a prenatal diagnosis are experts in medical

information-giving and treatment options but lack understandings associated with human behaviour and family systems inherent to constructive prenatal counselling practice (Howard, 2006; Schwaber Kerson & McCoyd, 2010; Mealer et al., 1981; Schilds & Beck, 1984).

Social Work in Australia

Although social work is not a registered profession in Australia, the Australian Association of Social Workers (AASW) is a governing body that regulates social work practice within the Australian context. Social work is a growing profession in Australia with approximately 1,300 social workers graduating yearly from the 25 accredited courses in Australia offering the mandatory 4-year degree. The lack of professional recognition has historically caused contention within the field, with key literature giving limited references to the development of the social work profession (Mendes, 2005). Further, documenting the history of the profession has been problematic due to the limited fragmented historical research conducted through political and ideological divisions among social workers (Mendes, 2005). However, the strong engagement of the AASW with academia, research, advocacy, and policy development has served to increase the profile of social work over time (Gillingham, 2007). It has been argued that in the process of establishing strong professional recognition, social workers need to clearly articulate their knowledge, skills, and values, as well as become active advocates for the value and role of social work in supporting Australian communities (Healy, 2010). In doing so, the role of policy development as part of the social work profession has been highlighted as paramount and as an activity that should be undertaken by social workers of all specialties (Fawcett, Goodwin, Meagher, & Phillips, 2010; McClelland, 2006). Further, recognition has been given to the significance of specialist training to adequately prepare social workers to work in specific areas, in addition to the development of core social work skills and values to ensure appropriate practice across disciplines (AASW, 2010).

Social workers are commonly employed in government and nongovernment organisations, providing a variety of services to a wide range of clients that may include children; families; young and elderly people; individuals experiencing mental, physical, and social challenges; as well as people drawn from minority groups. In terms of their professional role, social workers may be involved in case management, counselling, policy writing, welfare, group facilitation, teaching, management, and research. The core purpose of social workers is to educate clients about issues relating to their wellbeing, and to provide counselling and practical support as members of multidisciplinary teams addressing social, psychological, and physical factors linked to clients' needs (Schwaber Kerson & McCoyd, 2010). Social work is a profession founded on deep reflective practice and evolving theoretical frameworks, which are strongly rooted in the values of social justice, equity, and fairness (AASW, 2010; Dominelli, 2004). Inherent to the identity of social work is a

fundamental role in building relationships, understanding social contexts, and a willingness to adapt to change (Parton & O'Byrne, 2000). Consequently social workers are well positioned to support the complex needs of women requiring support at the time of prenatal testing.

Social Work, Prenatal Diagnosis, and Ethics

In more recent years, and certainly concerning prenatal diagnoses, it has been widely accepted that women should bear the responsibility of choosing the outcome of their pregnancy, emphasising the woman's autonomy, protecting legal and ethical accountability, and socially accepting individuals' views on coping abilities, disabilities, and personal values. Undertaking prenatal testing and facilitating prenatal diagnosis support raises ethical issues that must be considered (Gates, 1993; Schmitz, 2012). As social workers supporting women and families after a poor prenatal diagnosis, within a medical model the goal of which is to address the medical issues, an ethical obligation highlights our multiple roles: to support the woman, but also her family and her unborn baby. Prenatal testing challenges the inherent ethical dilemma that assumes social workers can support both the woman and her baby particularly when discussing conflicting interests such as terminations.

Women's autonomy, legal rights, rights to privacy, and right to uphold a unique set of values are paramount in the prenatal testing debate. However, the invasive and traumatic process of receiving a poor prenatal diagnosis, surrounded by its own legal and ethical parameters, does limit a women's ability to control the decisions made about her pregnancy (Gates, 1993; Schmitz, 2012). For example, the social consequences of choosing an abortion or choosing to give birth to a child with a disability can have long-term impacts. Additionally, women's obligation to undertake a strenuous series of ethical and medical interviews prior to being granted a termination is complicated by the treating team's dual obligation to both the foetus and the women. Nevertheless, it is a process that often causes women and their families distress, trauma, and guilt, highlighting the sensitive issues of prenatal testing and termination. In order for social workers to assist women through this complex maze, the literature agrees that prenatal counselling and genetic counselling aimed at women who receive the news that their child has a life-threatening or long-term disability need to remain nondirective so as to facilitate a choice directed by the woman, in contrast to a preference that reflects the values of the practitioner (Chescheir & Cefalo, 1992; Statham, 2002).

Providing ethical input, adapted to individual women, is paramount for professionals supporting them and should include (Fonda Allen & Mulhauser, 1995):

- Sharing or explaining objective medical information
- Translating medical information into a simple context
- Providing objective nondirective support
- Providing practical assistance

- Facilitating decision-making by exploring all options and the consequences of those choices both in the short and long term
- Normalising parental thoughts and emotions during the process
- Organising referrals to support groups or external organisations

Role of the Social Worker in Prenatal Diagnosis Support

The role of social workers in the field of prenatal testing focuses on client determination, psychosocial and health services, nonjudgmental counselling, and solution-focused interventions, as well as advocacy for clients and the safeguarding of vulnerable individual's rights, including parents and children (Taylor-Brown & Johnson, 1998). Social workers have a specialised knowledge about the impact of ethnicity, culture, religion, beliefs, and socioeconomic status, and can obtain relevant information through holistic psychosocial assessments of women that account for the complexities associated with prenatal diagnosis (NASW, 2003; Schilds & Beck, 1984; Taylor-Brown & Johnson, 1998). Further, social workers who engage with processes of empowerment to address sociocultural challenges for individual women—including language barriers such as poor levels of literacy, English as a second language, emotional difficulties, and differing levels of cognition—will provide a more comprehensive experience for women, facilitating holistic assessment opportunities not limited to medical appraisal (NASW, 2003; Schilds & Beck, 1984; Taylor-Brown & Johnson, 1998). Social workers bring a valuable dimension to the support of women, including psychosocial support and a rich comprehension of the complex interplay of values, religion, family, and societal systems with prenatal diagnoses and decision-making processes (Mealer et al., 1981; NASW, 2003; Schilds & Beck, 1984).

The role of the professional support worker is receiving greater recognition within the field of prenatal care (Elder & Laurence, 1991; Gordon et al., 2007) and encompasses supportive approaches including:

- Education and counselling for women and their families at the point of diagnosis.
- Therapeutic work for women and their families in processing the traumatic impacts of prenatal decision-making including: termination of pregnancy; bereavement following diagnosis or the loss of a child; and adaptive responses to a child with special needs.
- Liaising with medical treating teams and community support workers in partnership with women to assist in transitional processes following an adverse prenatal diagnosis.

In the context of health services, social workers are most often required to work as members of multidisciplinary teams. This routine practice has equipped social workers to work collaboratively with practitioners who engage with women following an adverse prenatal diagnosis, including obstetricians, sonographers, paediatricians, and related community support organisations (Mealer et al., 1981). The AASW Social

Work Practice Standards (2003) further highlights social workers' professional requirements to practise amongst multidisciplinary teams in a way that contributes to the development of the profession and supports both colleagues and clients. The Centre for Genetics Education in Australia advocates that genetic counselling should be facilitated by a multidisciplinary team of professionals including social workers, counsellors, and psychologists with a special interest in genetics and prenatal testing (Barlow-Stewart, 2007). It is clear that psychosocial counselling should be a process offered in the provision of comprehensive services for families following a prenatal diagnosis. Further, there is a significant need for social workers to receive specialised training in supporting women with genetic issues, given the rapid developments in the field of genetics where prenatal testing is becoming more routinely administered and diagnoses are identified earlier in pregnancy (NASW, 2003).

A core value of the social work profession is social justice and emerging from this value are practices including unconditional acceptance of clients and encompassing their values, beliefs, and decisions (AASW, 2010; Schwaber Kerson & McCoyd, 2010). As a result, social workers specialise in crisis and ongoing care that is culturally appropriate and sensitive to the needs of clients. Interpersonal support such as psychosocial counselling, assessments of complex needs, and case management for women and their families are especially well suited to social workers (Mealer et al., 1981). Indeed, social work is a profession that conceptualises the individual within a biopsychosocial perspective and integrates this perspective into a family system theory (Taylor-Brown & Johnson, 1998). In the context of these approaches the worker–client trusting relationship is beneficial to individuals processing grief and trauma resulting from prenatal diagnosis in both the short and long term. These relationships, in contrast to the short-term medical relationships with obstetricians, do not allow for follow-up care or take into consideration the substantial time frame necessary to deal with issues of grief and loss.

Longer-term issues include assisting clients to cope with chronic illnesses and diagnosed conditions, creating and maintaining supportive infrastructures, constructively addressing grief and loss issues, and influencing policy and legislation regarding genetic privacy, potential discrimination, and rights. The latter policy and legislation changes are central to the genetic social work agenda as a means of improving the current care practices for women and their families who receive a prenatal diagnosis (NASW, 2003). The term “inseparable” has been used by Fawcett et al. (2010), to describe the twofold social work task of policy advocating concurrent to providing local services. The authors explain that without policy development, the “on the ground” issues will be slow to change, emphasising the urgency for social work to advocate for women and families on a legislative level. With an historical and international commitment to empowering individuals and communities in human rights and social justice, social work clinicians are well placed to contribute to this developing field (Schwaber Kerson & McCoyd, 2010; Mealer, 1981; NASW, 2003; Taylor-Brown & Johnson, 1998).

Implications for Practice

The care of women after a pregnancy loss has rapidly expanded over the last 20 years and has become a major focus of maternal–foetal health (Lathrop & VandeVusse, 2011b). Given the rapid developments in the field of genetics, prenatal testing is becoming more routinely offered and diagnoses are identified earlier in pregnancy (Bijma, van der Heide, & Wildschut, 2007; Gregg, 1993; Lathrop & VandeVusse, 2011b; NASW, 2003). Consequently, more women are facing the process of decision-making stemming from an adverse prenatal diagnosis and more women are affected by the impacts experienced following pregnancy loss (Hilton-Kamm, Chang, & Sklansky, 2012; Lathrop & VandeVusse, 2011a).

Bereavement support has been recognised as a core skill of social work highlighting the complexities of individuals and their unique situations (Goldsworthy, 2005). Women receiving a prenatal diagnosis often experience extreme grief and loss, with losses encompassing physical, psychosocial, and emotional domains (Hutti, 2005; Korenromp et al., 2005; Leithner et al., 2004). It has been recognised that grief and loss occur in a social context, with meaning creation that is unique to the individual (Goldsworthy, 2005; Lathrop & VandeVusse, 2011b). The values shared by social workers of social justice, human rights, and professional integrity combined with the practice of client-centred work, respect for diversity, disability, and choice are providing social workers with the skills and values to support women in a beneficial way (AASW, 2003, 2010). Increasing the availability of genetically or prenatally trained social workers, or social workers trained in both, would provide women with the opportunity to psychosocially process their prenatal diagnosis in a way that is unique to them and their circumstances, with social workers as catalysts and partners in meaning reconstruction.

With the increasing number of women experiencing prenatal diagnoses, a range of recommendations that focus on the inclusion of specifically trained social workers in the provision of psychosocial interventions has been identified. They include:

1. The development of training opportunities for social workers working with women undergoing routine testing in both health facilities and community support organisations. An extension of the current pregnancy counselling module offered under Medicare may be an initiative as well as the inclusion of prenatal testing related topics in social work conferences/groups.
2. An increase in the availability of supportive interventions facilitated by a specifically trained social worker, in addition to genetic counselling, focusing on the psychosocial impacts of prenatal diagnosis.
3. The facilitation of future research agendas that clearly document the experiences of women accessing psychosocial support after receiving an adverse prenatal diagnosis. Specifically, investigations into the efficacy of specific models of support including the utility of such models would assist in reducing the gap in knowledge focusing on routine care offered to women following a prenatal diagnosis.

4. The advocacy of social work on a legislative and policymaking level regarding the issues of prenatal testing. It has been advised that social workers should act as practice leaders through the development and input around policymaking (Healy, 2010; McClelland, 2006). Only strong advocated changes in policymaking will allow social work to substantially provide “on the ground”, relevant, and targeted service delivery.

Conclusion

The technological and medical advances enabling professionals to offer prenatal diagnosis testing to women in Western societies in the last decade has been significant. With such advances there has emerged a range of complex issues associated with prenatal diagnosis that have created serious ethical controversies for women. Specifically, consequential traumatic responses in women have been widespread following prenatal diagnosis. Further, ongoing psychosocial supportive interventions have been limited to highly medicalised approaches that fail to give consideration to the broader complexities of individuals’ lived experiences of loss and grief following a poor or fatal prenatal diagnosis (Hall, 1994), which has resulted in some families feeling unsupported in their decision-making and subsequent loss.

It is of great importance that professionals working in the area of prenatal testing are trained and equipped to support women in a compassionate, nonjudgmental, and objective manner. Interpersonal practice that encompasses crisis intervention, facilitates decision-making, and provides both short- and long-term psychosocial interventions may assist in women’s recovery or adaptation after a termination, a neonatal death, or the birth of a child with a disability. Social workers are a clear “fit” in terms of their role and function in contributing to the field of genetic counselling. The role of social workers, and the values and practice frameworks inherent in their work, provides the necessary foundation for the facilitation of supportive services that extend beyond the limitations identified in current prenatal testing practices. Extended inclusion of social work interventions for prenatal testing and diagnosis will enhance the field through the provision of comprehensive and timely psychosocial support for women and families.

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