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Sarah Williams
Exploring the Experiences of
Lesbian Couples Using Fertility
Services

ABSTRACT

This qualitative study explores the experience of lesbian couples that have used, are using, or attempted to use fertility services since 2003. Thirty-three self identified lesbian women who were in a lesbian relationship at the time of using fertility services participated in the study by completing an online survey consisting of primarily open ended questions. Demographic information such as age and race were asked about both member of the couple.. Findings were analyzed using content analysis. Participant narratives revealed the complexities, challenges, successes, supports relied upon and obstacles encountered when using fertility services; as well as the strength and resiliency of lesbian couples. The findings illustrate the need for gay friendly fertility service providers and resources.

The major findings revealed that the process of using fertility services for lesbian couples involves multiple decisions prior to accessing fertility services, lesbian couples have varied experiences at fertility clinics and working with providers, there are obstacles when approaching and/or using fertility clinics, there are supports that are needed, the experience impacts the couples relationship, and some lesbian couples experience instances of discrimination and heterosexism. Findings not found in the literature included obstacles in using a known donor and evidence of heterosexist practices within insurance and medical policy's, family law, paper work, and in interactions with providers at clinics.

EXPLORING THE EXPERIENCES OF LESBIAN
COUPLES USING FERTILITY SERVICES

A project supported by an independent exploration,
submitted in partial fulfillment of the requirements
for the degree of Masters of Social Work.

Sarah Williams

Smith College School for Social Work
Northampton, Massachusetts 01063

2011

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CHAPTER 1

INTRODUCTION

Lesbian artificial insemination (AI) “radically challenges the power structure, assumptions, and presumed naturalness of major social institutions”(Agigian, 2004, p.2). Lesbian artificial insemination challenges heteronormative patriarchal traditional discourses of family. Simultaneously some argue that lesbian insemination reinforces “the status quo of commercial culture, conservative family values, class based legal and medical norms, and bio medicalized understandings of body and kinship”(Agigian, 2004, p.2). Lesbian artificial insemination has created controversy since it began to be used by lesbians. Even though the number of lesbians with children as a result of artificial insemination has increased in the past 20 years, it remain an under studied area in research and theory.

Until the late 1980’s lesbians were denied access to fertility clinics. The tendency of physicians to reject lesbian women from fertility clinics was documented in a 1988 Office of Technology Assessment (OTA) survey, “which found that physicians were more likely to reject AI requests from lesbians than other stigmatized groups of women” (Agigian, 2004, p.5). Prior to the late 1980’s lesbian women practiced self-insemination at home and through non medical women empowerment health clinics. As fertility services became medicalized and lesbian women gained access to such services, self-insemination decreased and the use of medical fertility clinics increased. This was the beginning of the “lesbian baby boom.” The 2000 United States Census reports 297,061 lesbian families. However, the Human Rights Campaign estimates

that the 2000 US census count of lesbian families could be undercounted as much as sixty two percent (Smith & Gates, 2001).

As it was not long ago that lesbian women were denied access to fertility services there is a need to explore what the current experience is of lesbian couples using fertility services in order to address any unmet needs or issues of heterosexism in fertility clinics. Much of the current literature on lesbian families focus on the family once the child has been born versus the process of using fertility services. The largest and longest longitudinal lesbian family study was initiated in 1986 and is ongoing. The information collected regarding the fertility process was collected from 1986-1992 and did not inquire about discrimination, heterosexism, or barriers. (Gartrell, Hamilton, Banks, Mosbacher, Reed, Sparks, & Bishop, 1996, p.279). There is a need to explore more recent experiences of lesbian couples using fertility services currently as there have been many changes since 1992.

The purpose of this qualitative study was to explore the experiences of self identified lesbian couples (n = 33) that have used, are using, or attempted to use fertility services since 2003. Specifically, this project explored decision making regarding choosing what fertility services to use, using a known or unknown donor, doing insemination at home or at medical fertility clinics, the experience as a couple at the clinics, discrimination, obstacles encounters, supports used and needed, and the impact of the experience on their relationship. The research contributes to the following question: What are the experiences of lesbian couples who use fertility services?

The research is relevant to social work clinical practice as it aims to contribute to a greater understanding of the experience, obstacles encountered, and needs of lesbian couples using fertility services and can highlight the ways in which clinical social workers can better

support their clients. Results could be used as evidence to address any obstacles or barriers in the fertility services process, could be used to develop staff trainings, service and development provisions, and could also be used as a tool for policy makers and social workers doing social justice work

CHAPTER 2

LITERATURE REVIEW

History of Reproductive Technologies

The idea of reproductive technologies intended for human conception dates back to the 1500's when Bartholomeus Eustachius "recommended a husband guide his semen towards his wife's cervix with his finger to enhance the chance of conception"(Mamo, 2007, p.25). However the first reproductive technologies created were actually intended to breed animals. In 1792 Ludwig Jacobi, a German philosopher, artificially fertilized salmon eggs (Mamo, 2007).

Prior to the 19th century women did not seek medical attention to address "sterility." A woman's inability to conceive was not viewed as a medical issue but as a moral issue. Women who could not get pregnant were deemed immoral or had poor character. In the 20th century fertility became medicalized. During this time the medical field, dominated by men and absent of all women's voices, continued to learn about reproduction and frame the way in which infertility is viewed today. Although new contributions to reproductive knowledge found that some women could not conceive due to infertility in the male sperm, the primary focus continued to look at the moral character of the woman.

In the 20th century the focus eventually turned to biology and the first "cure" for sterility was documented in 1909 through the use of a sperm donor. It was actually in 1884 when Dr. Williams Pancoast from Jefferson Medical College in Philadelphia performed the worlds first case of donor insemination. The procedure was kept secret until 1909 because the idea of using sperm donors as a fertility treatment was very controversial. The new treatment resulted in fear

“that the practice would harm the nation by destabilizing the presumed naturalness of heterosexual marriage”(Mamo, 2007, p.27).

It wasn't until 1978 when the first “test tube baby” was created through In vitro fertilization. The media highlighted “stories of “miracles” of heterosexual white upper class couples who had babies who could not conceive “naturally” (Mamo, 2007, p. 32). This was a pivotal moment in the history of reproductive technologies. It demonstrates the shift from an infertility model to assisted reproduction as well as the heterosexism in which fertility treatments were founded upon. Reproductive technologies “can be read as a means of promoting childbearing at any cost and thereby strengthening the hetero-normative family form” (Mamo, 2007, p.34). Simultaneously reproductive technologies opened up doors for lesbian and single women, challenging the idea of “conventional procreators beyond the heterosexual married couple”(Mamo, 2007, p.34). Although reproductive technologies have shifted from an infertility based treatment model to assisted reproduction model, the history of heterosexism and the infertility model that reproductive technologies were founded upon remain strong in current practices which will be explored in the following study.

The Lesbian “Baby Boom”

Lesbian reproduction has been shaped by the women's health movement, the feminist movement, the lesbian, gay, bisexual and transgender (LGBT) rights movement, the reproductive rights movement, and the development of reproductive technologies (Tasker & Bigner, 2007; Ryan-Flood, 2009). In the 1970's most sperm banks denied access to single and lesbian women. In reaction, lesbian women mostly used known donors and performed insemination at home through self-insemination and had children in earlier heterosexual marriages. In the 1970's women centered, non-professional women's health clinics started to form. These women's health

clinics were founded on empowerment principles and were operated outside of the male dominated medical institutions and provided education and assistance on self-insemination. In 1978 the first self-insemination group was founded. It wasn't until 1984 that the first edition of *Our Bodies, Ourselves* first published a discussion on self-insemination (Mamo, 2007).

The focus shifted from self-empowerment to a medical 'patient' as assisted reproduction became mainstream and lesbian women gained some access to fertility services. Women's non-professional empowerment health clinics were taken over by the medical field as fertility became medicalized, creating a shift in power (Mamo, 2007).

The number of children with lesbian parents have increased since the 1980's with more lesbian couples having children "in the context of a lesbian identity" through assisted conception (Tasker & Bigner, 2007, p.11) as opposed to within the context of a heterosexual relationships. Some authors have suggested that there are two very different generations of lesbian families; lesbian women who had children in the context of a heterosexual marriage and lesbian families who created their family in the context of a lesbian identity through the use of reproductive technologies (Ryan-Flood, 2009). These lesbian families created in the context of a lesbian identity have been called the families of the "lesbian baby boom" (Tasker & Bigner, 2007; Kranz & Daniluk, 2006).

The numbers of lesbian families have not been well documented as "nationally representative surveys have often failed to ask questions about sexual orientation" (Tasker & Bigner, 2007, p.13). The 2000 United States Census collected data from 600,000 same gender partners finding that "34% of the lesbian couples and 22% of the gay male couples described themselves as involved in parenting" (Tasker & Bigner, 2007, p.13). Another United States Survey found that "approximately one in five lesbians identified as mothers" (Tasker & Bigner,

2007, p.13). However these numbers are higher based on how one defines parenting and/or family (Tasker & Bigner, 2007).

Family

The idea of family as a two-parent family is shifting to “include a wide variety of alternative family forms”(Kranz & Daniluk, 2006, p.2). However, most lesbian family research examines the meaning of family within the context of a couple. An Australian qualitative study with lesbian co-parents examined the meaning of family and how “participants fluid narrative identities are deconstructed in order to better understand how language constructs relationships within private and public domains”(Tasker & Bigner, 2007, p. 267). The study involved 25 lesbian families who were interviewed between 2002-2005. The findings included 45 different terms used to describe the co-parent and sometimes multiple terms were used by different family members and in different contexts. Language changed over time as the children grew older. The findings highlight that, “meanings and understandings about family are generated by those who participate in the actions of doing family” and parenting relationships are negotiable, fluid, and changing and the language used to describe these relationships is a dynamic process”(Tasker & Bigner, 2007, p.277).

My study explores the experiences of lesbian couples using fertility services. Although the participants are or were in a lesbian committed relationship at the time of using fertility services the meaning of family and how each participant defines one family will vary.

Lesbian Family Research

Much of the lesbian family literature in the 1970’s and 1980’s focused on children originally conceived in heterosexual marriages (Kranz & Daniluk, 2006). The more recent literature on lesbian parent families conceived in the context of lesbian identity has focused on

three main categories: “psychological outcome studies of children of lesbians,...psychological and socio cultural accounts of the experience of lesbian mothers and their families, ... and theoretically oriented work examining lesbian parenting in terms of practices and symbolic meaning” (Ryan-Flood, 2009, p. 5). However the research has primarily focused on the children of lesbians as opposed to the experience of the parents (Ryan-Flood, 2009). Further research is needed on the experience of lesbian mothers pre, during, and post conception. My study begins to address this gap in research.

The longest running national study on lesbian families is the U.S. National Longitudinal Lesbian Family Study (NLLFS). The NLLFS “was initiated in 1986 to provide data on a cohort of lesbian families from the time the children were conceived until they reach adulthood”(Gartrell & Goldberg, 2010, p.3). The original sample included 84 lesbian families who conceived their children through donor insemination. Participants were predominantly white (94%), college educated (67%), middle and upper-middle class (82%), and Jewish (33%) or Christian (56%)” (Gartrell, et al?, Hamilton, Banks, Mosbacher, Reed, Sparks, & Bishop, 1996, p.275). Interviewing began in 1986 and was closed to new participants in 1992. The study has primarily focused on the experience of the children. It has explored the impact of having a known or unknown donor, sexual orientation, sexual behavior and sexual risk exposure, family characteristics and stigmatization, psychological adjustment, and resiliency.

The longitudinal study has published twelve articles at this time, only one of which took place during the donor insemination process. This article reported on parental relationships, social support, pregnancy motivations and preferences, stigmatization, and coping strategies. Although the study has created contributions to knowledge concerning the experience of the donor insemination process the research questions and findings did not explore the narrative

experience or if the mothers experienced stigmatization throughout the process of using fertility services. Stigmatization was instead explored in terms of projected fears about stigmatization in the future. My study begins to address this gap in the research.

There is a growing amount of research on lesbian families however there is little known about the experience of negotiating and interacting within the fertility services system throughout the conception process. There is a need for future research to reexamine these areas of interest and specifically to look at the experience of stigmatization, discrimination, and heterosexism.

Decision Making

Getting pregnant for lesbian couples involves many decisions before even beginning the process; such as who will get pregnant, what type of donor to use, picking a donor, and what services to use to get pregnant (Kranz & Daniluk, 2006). The current literature on the process of lesbian couples getting pregnant primarily focuses on these major decisions prior to accessing the fertility services..

Research regarding the decision making process of using a known or unknown donor have consistently found that couples that used known donors report the following contributing factors in the decision making process: Wanting a father figure, less expensive, and “not realizing insemination was available for lesbians at clinics” (Wilson & Donovan, 2008, p.655). Many lesbian couples initially imagine using a known donor and eventually shift and use an unknown donor. Research reports this change is mostly due to fears of possible complications in negotiating with the donor and lack of legal protection. Green and Mitchell, the authors of the clinical paper *Different Storks for Different Folks: Gay and Lesbian Parents experiences with alternative insemination and surrogacy*, report “historically, decisions about sperm donors have been strongly influenced by fears that, sooner or later, this person might come forward to

challenge custody and try and take the child conceived in this fashion”(Green & Mitchell, 2007, p.85). This sentiment is echoed by Donovan and Wilson based on a qualitative study looking at the decision making process of lesbian couples who use medically provided donor insemination. Donovan and Wilson (2008) write, “given the lack of protection in the law for lesbian co-parents when respondent embarking on the creation of their families, the decision in favor of an unknown donor is emphatically rational” (p.656).

The meaning of family also contributes to decision-making regarding conception. A pilot study of lesbian parents in the UK who used medicalized donor insemination with unknown donors found that the “perception of family, particularly the centrality of the lesbian couple as the key parenting relationship, is crucial” in deciding to use a known or unknown donor (Donovan and Wilson, 2008, P. 649). The findings suggest that it is the perception of “what family means and their desire to protect the integrity of their family that leads them to negotiate social questions, particularly in relation to the presence of a “father” and choosing a known or unknown donor (Donovan & Wilson , 2008). While there are many reasons couples choose a known or unknown donor, many lesbian couples choose an unknown donor to protect their “family” while others choose a known donor to ensure a possible father figure for their child (Donovan & Wilson, 2008; Kranz & Daniluk, 2006).

The meaning of family and the lack of legal protection are a theme in choosing both a known and unknown donor. These are two areas for further research. The research explores the decision making process however does not include the experience of using the services, getting sperm, and the experience at the clinics. My study will expand on the previous research by exploring the decision making process of choosing a known or unknown donor, as well as looking at the role of the donor, and the actual process of insemination.

Accessing Fertility Services

Although there is little research on the actual experience of lesbians who use fertility services literature demonstrates that there is inequality and many barriers when accessing fertility services based on socio-economic status, race and ethnicity, and marital status and sexual orientation. The following study will explore these barriers. Fertility services such as IVF cost \$10,000 to \$20,000 per cycle. Fertility services are not included in most health insurance plans. Fourteen states mandate medical insurance coverage however coverage is based on infertility. Infertility is defined as an inability to conceive through heterosexual intercourse (Cahill, & Tobias, 2007). Therefore lesbian couples are not seen as qualifying. Using fertility services to get pregnant for lesbian couples “is not viewed as a medical necessity in the same way as an infertile heterosexual couples need for assistance is deemed a necessity” (Cahill, Tobias, 2007, p.26). Consequently lesbian women are often not included in this definition. Therefore “the population that can access such services tends to display homogeneous wealth and employment characteristics” (Darr, 2008, p.41). Money and socio-economic status play an incredibly important role in deciding to use fertility services due to the high cost (Back & Taylor, 2007). Therefore the cost of fertility services creates inequality based on who can access fertility services due to socio-economic status.

A second inequality in accessing fertility services is the discrepancy between races and the use of fertility services. Recent research “confirms disparities in both the incidence of infertility and the utilization of fertility treatments among women of different races.”(Darr, 2008, p.41) Judith Daar, the author of *Accessing Reproductive Technologies: Invisible Barriers, Indelible Harms*, states, “women of color are far less likely to seek treatment than white women.” (Darr, 2008, p.41) This discrepancy in race and use of fertility treatment has been

called “stratified reproduction” and “has been described as the “eugenic logic of IVF’ because the cost barriers to ART services disparately impact low-income couples who are primarily of color” (Darr, 2008, p.41). Dorothy Robert, the author of *Race, Gender, and Genetic Technologie;; A New reproductive Dystopia?* argues that racism is embedded in reproductive technologies. Therefore it can be determined that “access to reproductive technologies is diminished for racial and ethnic minorities as compared to non-minority populations”(Darr, 2008, p.41).

A third barrier to fertility services and the most relevant to the following study is based on marital status and sexual orientation. Single women and lesbian couples “face reduced access from at least two additional sources: Provider discrimination against single and lesbian women, and legislative efforts to ban access to unmarried individuals” (Darr, 2008, p.44). A University of Pennsylvania Study report that one in five providers refused treatment to unmarried women (Darr, 2008). Darr states, “documented cases of provider discrimination against single women and lesbian couples are few, but recent research suggests that such conduct is widespread” (Darr, 2008, p.44). This is consistent with Donovan and Wilson’s (2008) qualitative study that found couples experienced heterosexism and “expressed resentment at having to explain their desire to parent and ‘perform’ in what they experienced as a ‘test’ or ‘game’ or ‘hoop’ to jump through” (p.657).

Legal barriers to fertility services for lesbian couples include screening policies, and state laws concerning parental rights. Past legal decisions concerning lesbian parents who have used assisted reproductive technologies demonstrate that “existing law inadequately addresses the circumstances of same gender parents”(Skinner & Hare, 2008, p. 365) Same-sex marriage is not legal in multiple states, as a result same-sex couples are denied 1,138 plus rights that help protect

and keep a family together (Kotulski, 2004, p.144). Literature confirms that laws regarding same sex families and reproductive technologies are inadequate. The legal framework to support and protect same sex families using reproductive technologies is lacking (Cayton, 2010, & Vandervort, 2006).

Perceived Discrimination and Health Care

The cited literature has highlighted the primary areas that were focused on when exploring the lesbian headed family with children. There is some literature on the experience of using fertility services and barriers in accessing services. The current study expands on the previous literature and identifies barriers, inequities, heterosexism and discrimination reported in the narrative. Since there is little research specifically looking at lesbians' experiences of discrimination when using fertility services the following cited literature highlights experiences of perceived discrimination in the larger institution of health care and the effects of perceived discrimination on mental health.

Multiple studies provide evidence of discrimination based on sexual orientation within the health care system (Macmillan, 2006). Discrimination in the form of "heterosexism and homophobia in the health care system continue to be an added source of stress and a barrier to seeking care for women belonging to sexual minorities" (Ross, 2010, p. 98). A secondary analysis of data from a descriptive study completed in 2001 examined "delay of health care related to sexual identity issues" (Van Dam, Koh, & Dibble, 2001, p.12). The study included thirty-three health care sites across the US and included 1,362 participants who completed written surveys. The data found that "lesbians in this study... delayed seeking health care because of fear of discrimination against sexual identity" (Van Dam et al, 2001, p.17).

These findings are supported by O'hanlan, Dibble, Hagan, and Davids (2004), the authors of *Advocacy for Women's Health should Include Lesbian Health*, who report a need for research on lesbian health and discrimination within the health care system as lesbians demonstrate high rates of health risks and mental health symptoms. The authors argue the higher rates of illnesses are because "some lesbians experience discrimination in healthcare and avoid routine primary healthcare"(O'hanlan et al, 2004, p.227). These findings are consistent with the affects of perceived discrimination on mental health and accessing mental health services.

Perceived Discrimination, Mental Health, and Unmet Mental Health Needs

Perceived discrimination affects mental health. Literature consistently exposes that LGBTQ individuals report experiences of "perceived" discrimination, negative mental health effects, and unmet mental health service needs. These findings are highlighted in a cross sectional strata-cluster study that compared experiences of perceived discrimination, the affects on mental health, and mental health services used between heterosexual (n=7,412) and LGBT identified participants (n=472) (Burgess, Lee, Tran, & Ryn, 2007). The study reported higher incidents of perceived discrimination, mental health issues, need for mental health services, and unmet mental health needs amongst LGBT participants. The results suggest "that experiences of discrimination, in addition to being a life stressor that harms mental health and increase substance use, also has a negative impact on mental health by increasing the likelihood that individuals will avoid seeking needed mental health care services" (Burgess et al, 2007, p.11).

Lesbians are faced with many psychological and social challenges when using alternative reproductive technologies, including perceived discrimination (Mitchel & Green, 2007).

Research is limited however, there is some evidence of discrimination and an unmet need for

mental health services when using fertility services (Steele, Ross, Epstein, Strike, and Goldfinger, 2010).

A cross sectioned study among 73 participants, self identified women who identified as other than heterosexual in the perinatal period aimed to assess “past year mental health service use and perceived unmet need for mental health services” (Steele, 2008, p.99). The study looked at the following predictors: family role, mode of conception, degree of being out, perceived discrimination scale, and depression. The findings reported 90.5% of participants disclosed sexual orientation to their provider, 23.8% of participants providers inquired about sexual orientation and “almost a quarter of women reported that their providers had assumed they were heterosexual” (Steele, 102). Thirty-three percent reported using mental health services in the past year and 30.6% of participants reported an “unmet need for mental health services in the past year” (Steele, Ross, Epstein, Strike, and Goldfinger, 2010, p.102). The women reported mostly an unmet need for counseling and help with relationships. The most frequent reported barriers to accessing these services were financial barriers and “a preference to manage the problem themselves” (Steele, 2008, p.102).

When looking at the reported unmet need for mental health services and the predictors the highest rates of unmet needs were by women in the process of trying to get pregnant, women who used known sperm donors or had sex with a man to get pregnant, women who experienced more than three episodes of discrimination (1/5) and low outness scores. These are areas for future research. The study’s limitations include a small sample size and homogeneity in terms of race and education. The method used was a survey that collected standardized answers. Therefore the narrative experience of these participants is missing.

The following study will expand on these studies by looking at perceived discrimination and supports used and needed in the narratives. The following research will also note differences reported by participants based on multiple identities and modes of conception.

Need For Research

The National Lesbian Family Study is an excellent example of the primary focus of lesbian family research which focused on children of lesbian families as opposed to the lesbian mothers. Most research regarding the conception process highlights the process of choosing a known or unknown donor versus the process of interacting with and using fertility services. There is evidence of some experiences of heterosexism and discrimination in using fertility services and themes of lack of a legal framework to support these families. These are areas that need further research.

The NLFS sample also is representative of who is and who is not represented in lesbian family research. The NLFS sample, which includes 94% white participants, represents trends in lesbian family research that is dominated by white middle class participants. Most research pertaining to people of color and particularly African Americans “tends to ignore the issue of sexual orientation, and most research pertaining to LGBT tend to ignore the issue of race” (Harris, 2009, p.434). Collins (2000) claims, “African American women have been “silent” in discussions of African American lesbians (Harris, 2009, p. 435).” Therefore there is a strong need for research with higher numbers or participants of color as the experience of lesbians of color is missing (Harris, 2009, p.434).

The following research will expand on the previous literature and explore the experience of lesbian couples using fertility services including the decision making processes, experiences at the clinic and with providers, experiences of discrimination, supports used and needed that were

not in place, and the way in which the experience affected the couples relationship. The purpose of the research is to gather the fuller experience of using fertility services in order to fill in missing pieces from previous literature in order to better address the needs of lesbian couples.

Theoretical Framework

Heterosexism will be used as the primary theoretical framework to analyze and report on the data. Heterosexism is the belief that heterosexuality is the norm and superior to homosexuality, which is perpetuated through individuals and society's structural institutions. People who identify as heterosexual "are regarded as prototypical members of the category people." Heterosexuality is assumed, leaving people who do not identify as heterosexual invisible. People who identify as LGBTQ are "presumed to be abnormal.. and inferior as requiring an explanation" (Herek, 2007, 909). Gregory Herek defines these processes of heterosexism as the "cultural ideology that perpetuates sexual stigma" (Herek, 2004, 16).

Heterosexism is perpetuated and maintained on an institutional level through policy such as the Defense of Marriage Act (DOMA) that defines marriage between a man and a woman, denying same sex couples the right to marry and the civil rights and privileges of marriage. Heterosexism is also maintained on a cognitive level, on an attitudinal level as judgment is placed, and on a behavioral level through the manifestations of attitudes (Eliasons, 1996). Heterosexism differs from homophobia because it encompasses systemic oppressions. Homophobia is categorized as individual's attitudes and prejudices towards people who identify as gay, bisexual, or lesbian. Institutional heterosexist practices "work to the disadvantage of sexual minority groups even in the absence of individual prejudice or discrimination" (Herek, 2007, p.908).

Herek describes heterosexism as perpetuating sexual stigma. Sexual stigma “signifies the fact of society’s antipathy toward that which is not heterosexual, heterosexism can be used to refer to the systems that provide the rational and operating instructions for that antipathy” (Herek, 2004, p.15). Therefore heterosexism provides the structure for the sexual stigma. Herek describes three types of sexual stigma: enacted stigma, felt stigma, and internalized stigma. Enacted Stigma refers to “overt behavioral expression of sexual stigma” (Herek, 2007, p.909). Felt stigma is the “knowledge that enacted stigma can occur under certain circumstances often motivates people to modify their behavior in order to avoid enactments” (Herek, 2007, p.909). Felt stigma affects behavior. People develop coping strategies to avoid enacted stigma. These coping strategies such as avoiding places and hiding sexual orientation and relationships can “significantly disrupt the lives of stigmatized individuals, limit their options, reduce opportunities for social support, heighten their psychological distress, and increase their risk for physical illness” (Herek, 2007, p. 910). The last form of stigma outlined by Herek is internalized and or self stigma. Internalized stigma is the acceptance of the sexual stigma (Herek, 2007). These forms of sexual stigma are manifested through heterosexism.

As demonstrated by the historical underpinning of reproductive technologies, fertility services as an institution is historically rooted in heterosexist ideology. In the discussion of the data I will use heterosexism as the theoretical framework to identify individual and institutional heterosexist ideology, heterosexist practices, and instances of sexual stigma. Heterosexism will be used as the primary theoretical framework.. I will also use intersectionality as a framework to look at the way in which the participant’s experiences are impacted by their multiple identities. Intersectionality looks at the way in which socially constructed categories such as race, class, gender, sexual orientation, and disability intersect and contribute to systematic social inequality

(Collins, 2000). Racism, sexism, heterosexism, classism, and ableism create an interconnected system of oppression that impact the persons experience based on their multiple identities.

Therefore, although heterosexism will be used as the primary theoretical framework, intersectionality will be used to maintain awareness of the participants multiple identities and all forms of intersecting oppression.

CHAPTER 3

METHODOLOGY

Qualitative methods were used to gather data from self identified lesbian women who have used, are using, or attempted to use fertility services since 2003. The research question explored was: What are the experiences of lesbian couples who use fertility services? The project was exploratory because there is limited data on the experiences of lesbians who use fertility services. The method used was an online survey that collected demographic information of both partners and open ended questions about the experience of using fertility services.

In this project *Fertility services* will be used as an umbrella term to include the following services: Sperm banks, assisted reproductive technologies, artificial insemination and all other fertility services provided by fertility clinics. *Sperm Banks* are clinics in which sperm is deposited and stored to be used for insemination. *Assisted Reproductive Technologies (ART)* will be defined as according to the Center for Disease Control: “ART includes all fertility treatments in which both eggs and sperm are handled. In general, ART procedures involve surgically removing eggs from a woman’s ovaries, combining them with sperm in the laboratory, and returning them to the woman’s body or donating them to another woman” (<http://www.cdc.gov/art/>). An example of ART is In Vitro Fertilization (IVF). *Artificial Insemination* include the following procedures: Intrauterine insemination, Intravaginal insemination, Intracervical insemination, and Intratubal insemination. *Fertility Clinics* will be defined as providers that specialize in fertility services. All other fertility services provided by fertility clinics could include consultation, testing, and treatment for infertility.

In this project I was interested in the experience of using fertility services and any institutional, social, and economic barriers that lesbian couples may encounter. I was particularly interested in the experience of discrimination and homophobia within the fertility clinics process, and the way in which these challenges have an effect on the couple's relationship. People have multiple identities and the way these identities intersect impact the individual's experience. In order to explore the participants experience in terms of identity, collecting demographic information was a required piece to this study such as age, race/ethnicity, and income.

Sample

Thirty-three individuals participated in this study. The study was limited to self identified lesbian women who used fertility services in the United States between 2003 and 2011, were 18 and older and in a committed lesbian relationship at the time of using fertility services. Specific exclusion criteria included the following: lesbian women who have used, are using, or attempted to use fertility services who were not in a committed relationship at the time of use, used the services prior to 2003, are younger than age 18, and those who used services outside of the United States.

Demographic information such as age, race, and income were collected on both the individual completing the survey, the primary participant, and the person in which the participant was in a committed relationship with at the time of using fertility services.

The average age of the primary participant at the time of using services was 32 and ranged from 25-48. The participant's partner's average age at the time of using services was 35 and ranged from 24-49.

Table 1

Age of participant and partner

Age	Participant Frequency	%	Partner Frequency	%
25-30	7	21%	8	24%
30-35	12	36%	11	33%
35-40	10	30%	9	27%
40-45	3	9%	4	12%
45-50	1	3%	1	3%

Participant's socioeconomic status varied. Please see the following table for the participant annual income and partner annual income.

Table 2

Annual income of participant and partner

Income	Participant Frequency	%	Partner Frequency	%
Less than \$25,000	5	15%	7	21%
\$25,000 - \$50,000	8	24%	6	18%
\$50,000 – \$100,000	14	42%	16	48%
Over \$100,000	6	18%	4	12%

The majority of the sample identified as white. Ninety-one percent (n= 30) of the participants identified as white and 82% (n=27) of the partners were identified as white. The sample included seven (21%) interracial couples. Please see the following table for race and ethnicity breakdown.

Table 3

Race/ ethnicity of participants

Race/ Ethnicity	Freque ncy	%
White	30	91%
Asian	1	3%
Hispanic/ Latina	1	3%
Multiple ethnicities	1	3%

Table 4

Race/ ethnicity of partners

Race/ Ethnicity	Frequency	%
White	27	82%
African American	2	6%
Hispanic/ Latina	2	6%
Multiple Ethnicities	2	6%

Thirty-three participants reported using fertility services in nine States. The majority of participants (55%) used fertility services in California. Please see the following table for location of using services breakdown.

Table 5

States services used

State	Frequency	%
District of Columbia	1	3%
California	18	55%
Colorado	1	3%
Massachusetts	1	3%
New Hampshire	1	3%
New Jersey	1	3%
North Carolina	9	27%
Vermont	1	3%
Washington	1	3%

Data Collection

Participants were recruited through purposive and convenience sampling with a snowball effect. I posted recruitment materials (See Appendix B) to list serves specific to the LGBTQ community, motherhood, and ethnicity in order to actively recruit participants of color. An email (See Appendix B) was sent to the identified list serves that introduced the study and linked the participant to an online informed consent form and then to the online survey. Recruitment materials asked participants to forward recruitment materials to people who may be interested in

this study. Therefore snowball sampling may have taken place. Access to list serves was possible through joining specific lists serves and forwarding recruitment materials to individuals involved in LGBTQ activist work to be posted on list serves in which they are participants.

Empirical data was collected by an online survey through Survey Monkey. Survey Monkey is a website used to create online surveys. All collected responses through Survey Monkey are anonymous. The survey included demographic information and open ended questions. Therefore the empirical data includes demographic information and written narrative. Please see Appendix D for survey. Questions were specific to the experience of using fertility services throughout the process. Questions were specific to the decision making process, the experience, what supports were used and needed, and reflecting on the impact of the experience on the couple's relationship. Examples of questions exploring multiple sides of the experience included: "How did you decide what services, clinics, and or medical providers to use?" and "What support systems were not in place, if any?"

Design and Procedure

The email sent to identified list serves introduced the study, participant inclusion and exclusion criteria, and included a direct link to the "welcome page" through Survey Monkey. Participants were greeted by a "welcome page" which outlined the participant criteria. Participants were asked to check "yes" or "no" if they met eligibility requirements. Those that did not meet the inclusion criteria were thanked for their interest, informed that they did not meet the criteria to participate, and were invited to forward the email onto others who they thought may be interested in the study. If they checked "yes" they were directed to the online consent form (see Appendix C). After reading the consent form they could agree to consent by checking "I agree". They were only able to move forward onto the survey by checking "I agree". After

reading the informed consent form if the participant did not agree they could click the “I disagree” button. They were then directed to a page that thanked them for their interest and they could exit the survey.

One survey was completed per couple. The couple could complete the survey together or one of the two could complete the survey individually. However partners were asked to not both complete the survey individually in order to avoid skewed and repetitive data.

I had planned to use the first fifty surveys completed from white participants and the first fifty completed from participants of color as data. However after posting the recruitment information on multiple list serves between February 2011 and May 2011 only thirty three participants had completed the survey. Therefore the thirty three surveys completed were used as data. The determination of the race of the participant was based on the individual physically completing the survey. However, demographic information of both the participant and the partner was collected in the demographic portion of the survey. Therefore interracial couples experiences has been examined in the data analyses.

Answering demographic information was a requirement of the study in order to address the intersectionality of identities, all other questions were voluntary. Questions were open-ended and collected the narrative response in order to obtain rich narrative data and to explore the multi dimensional experiences of lesbian women who use fertility services.

Limitations of the sample are a small sample size, few participants of color, and a high percentage of participants from California. Therefore the sample is not generalizable. A limitation to the method is that the data collection method was online and only available in English. In result the method excluded people who do not have access to a computer or do not speak English. Limitations to the design include language used in the recruitment information

and participant criteria. The use of the term lesbian may have excluded women who identify as “gay,” “queer,” or “bisexual.” The use of the word fertility services versus assisted reproductive services may have excluded women who used assisted reproductive services but did not have any fertility complications.

Methods of Measurement and Analysis

Participant responses were collected through written narrative. The written narratives were used as empirical data and analyzed through thematic content analysis. Data was analyzed by myself, Sarah Williams. Demographic data was used as descriptive statistics. All other material was used as qualitative data. After closely reading the collective responses to each question I identified themes in the written data. I then created categories based on the themes and counted the number of times the identified category was present in the responses. Incongruence between the empirical material will be discussed in the discussion section.

The method of measurement guaranteed accuracy by collecting the narrative written responses by the participants. To address issues of validity and reliability in the analysis, reflexivity was practiced since my own biases influenced choosing which statements were used to illustrate the identified themes in the findings. Using “a reflexive research process means a continuous process of critical scrutiny and interpretation, not just in relation to the research methods and the data but also to the researcher, participants, and the research context” (Guillemin & Gillam, (2004), p.276). I am a white woman,. I identify my sexual orientation as fluid.. I would like to be a mother one day, and I believe in lesbian reproductive rights. These values, beliefs, and identities impact the way in which I view the world. Therefore throughout the research process I reflected upon my own biases, values, and identity and the way in which these factors may contribute to the lens in which I was viewing the data. Through an awareness

of this lens I actively worked to see possible blind spots that would have been missed without practicing reflexivity.

CHAPTER 4

FINDINGS

Introduction

This qualitative study explored the experiences of lesbian couples that have used, are using, or attempted to use fertility services since 2003. The study was conducted to contribute to the following question: What are the experiences of lesbian couples who use fertility services? In this chapter the findings explore the multiple dimensions of using fertility services including: choosing services, choosing donors, the experience at clinics, including discrimination sometimes faced by lesbians using fertility services, the obstacles and overcoming obstacles, supports relied upon and needed, and how the relationship of the couple has been affected by the process.

Sample

Thirty-three individuals participated in this study. The study was limited to self identified lesbian women who used fertility services in the United States between 2003 and 2011, were 18 and older and in a committed lesbian relationship at the time of using fertility services. The average age of the primary participant at the time of using services was 32 and age ranged from 25-48. The participant's partner's average age at the time of using services was 35 and ranged from 24-49. Participant's socioeconomic status varied. The majority of participants (n=20, 60%) reported making more than \$50,000 annually. The majority of the participant's partners (n=20, 60%) were reported to make more than \$50,000 annually as well. The majority of the sample identified as white. Ninety-one percent (n= 30) of the participants identified as white and 82% (n=27) of the partners were identified as white. The sample included seven (21%) interracial couples. The participants reported using fertility services in nine States. The majority of

participants (n= 18, 55%) used fertility services in California. Twenty seven percent (n=9) of participants reported using services in North Carolina. Other states that participants used services in are the following: District of Columbia, Colorado, Massachusetts, New Hampshire, New Jersey, Vermont, and Washington.

Out of the 33 participants 22 participants (67%) reported trying themselves to get pregnant, 3 (9%) reported their partner tried to get pregnant, and 8 (24%) reported both tried to get pregnant. Five participants (15%) got pregnant and miscarried, 1 participant (3%) reported being pregnant at time of completing the survey, 19 participants (58%) reported conceiving a child, 9 participants (27%) did not conceive a child, and 4 participants (12%) are currently in the process of trying to get pregnant. The numbers reported are higher than the number of participants due to some participants reporting on multiple experiences of trying to get pregnant.

Forty-five percent (n=15) reported using Intrauterine Insemination (IUI) . IUI is a procedure that places sperm inside a woman's uterus. Twenty four percent (n=8) reported using In Vitro Fertilization (IVF). IVF is a procedure to fertilize an egg through combining sperm and an egg in a lab dish. The combined sperm and egg are then placed inside the woman's uterus. Thirty percent (n=10) of participants reported using fertility drugs, 21% (n=7) reported using sperm banks, 9% (n=3) reported using Artificial Insemination (AI), and 6% (n=2) reported using donors eggs. Some people report various combinations of the previous methods.

Process of Choosing Services, Medical Providers, and Clinics Used

There were six significant factors that contributed to the decision making process of choosing what services, medical providers, or clinics to use, including: Gay friendly (n=13, 39%), financial (n=4, 12%), medical (n=8, 24%), insurance (n=10, 30%), location (n= 8, 24%),

and based on research, word of mouth, or reputation (n=12, 36%). Most participants reported multiple considerations.

The highest reported factor (n=13, 39%) was based on if the service, clinic, or medical provider was “gay friendly.” Participants did research and compared providers prior to choosing providers/ services to ensure that the provider was “gay friendly,” “queer friendly,” and “in line with our needs/ beliefs.” One respondent reports, “the one we chose was more gay friendly, as opposed to the other option, which actually erred towards homophobic.”

Some respondents reported choosing a “gay friendly” service/ provider, or clinic through a process of experiencing discrimination and homophobia at clinics and then switching to a “gay friendly” provider. One respondent reports, “tried one clinic, didn't like it (they wouldn't allow us to use a known donor because he wasn't my intimate partner). Switched clinics to another one.” Another respondents chose the closest fertility service that would inseminate her based on her sexual orientation and marital status. She reports “we started the process and had to drive an hour and a half to the only infertility doctor that would inseminate "single" women. They didn't even call it partnered or lesbian women at the time either.”

Other respondents reported doing research and choosing a “gay friendly” service provider and avoiding certain providers due to fear of discrimination and homophobia. A respondent reports,

We wanted to avoid doctors and hospitals as much as possible both for financial reasons and very much for social, cultural and political reasons—ie. we were concerned that as an interracial and multicultural family, a femme lesbian and butch/transgender couple, with a known donor- that we would encounter a stressful combination of racism, sexism, homophobia, transphobia and classism in the reproductive community.

The findings suggest that choosing a “gay friendly” service provider is highly important when choosing fertility services and confirms that there are providers that are not “gay friendly.”

The second highest (n=12, 36%) reported factor was the consideration of the reputation of the provider, clinic, or service based on research and word of mouth. Research included “yelp reviews, word-of-mouth reviews,” “list-serves” “referral from friends,” “the internet,” and calling the “office to get a feel about their practice.”

One participant reported “We wanted a sperm bank that had very strict regulations on donors.” Although this was not reported in the group experience it highlights the factor of looking at policy’s and legal issues involved in choosing a sperm bank and donor.

Choosing a Donor, Known Versus Unknown

The majority of participants (n = 21, 64%) used an unknown donor. Only five participants (15%) used a known donor. Some participants used both a known and unknown donor throughout their process of trying to get pregnant.

Unknown donor.

The majority of participants (n=12, 57%) who used an unknown sperm donor reported wanting to protect their family legally as a contributing factor in their decision to use an unknown donor. One respondent writes, “We did not want to risk the donor coming back to claim custody of our child.” Another writes, “Didn’t want any legal / paternity issues.” Twenty eight percent of participants who used an unknown donor reported they did not want the involvement of a “donor dad.” One respondent writes, “Didn’t want our lives to necessarily be intertwined with someone not in our family.” Another writes, “Do not feel that donor is needed in life of any children we have.” Other factors in the decision making process included emotional concerns such as “not wanting emotional issues down the road” or “attachments,” and not knowing someone who was willing or who the couples wanted to use as a known donor.

All but one participant reported knowing the sperm donor number. The answers demonstrated that this was an important number. For instance, one participant reports, “I do. We talked about it all the time. It's a number I haven't been able to forget yet.” Another writes, “yes. (I can't imagine that anyone who used a sperm bank would answer "no" to this question.)”

Participants reported wanting to know the number for many reasons including, medical and family history, for re-ordering purposes, meeting half siblings, and for accessing willing to be known donors once the child turns 18. One participants writes,

Yes. We actually printed out everything from the bank (the donor profile, interview transcript, health history, etc.) and put it in a 3-ring binder that sits on the bookshelf in our living room. We want our son to grow up feeling like this information is really open and always accessible to him if he is curious. It is absolutely everything we know about the donor which isn't much but at least we are open about what we do have. We also pre-purchased additional sperm from this donor in hopes of having another child who is biologically a full sibling for our son.

Known donor.

Participants who used a known donor reported choosing a known donor based on three common identified factors: Cost, the individuals, and wanting the involvement of the donor. Sixty percent (n = 3) of the respondents using a known donor reported cost was part of the decision making process and that using a known sperm donor is cheaper. Sixty percent (n=3) reported wanting the involvement of the donor in the child's life. One participant writes about the many contributing factors in choosing to use a known donor including economic, medical, race, ethnicity, culture, location, and languages spoken.

We chose to have a known donor for many reasons. For cultural and family reasons (my spouse is Chinese and Mexican, and our donor is Chinese and Argentinean-I am Scottish-Irish- and we all value extended family)...for medical/practical reasons (fresh sperm has a higher likelihood of pregnancy than frozen sperm)...and for economic reasons (we are a working class family and do not have the money to pay for freezing sperm and paying for 2-3 sperm vials a month on top of medical and drug costs).

When asked how participants identified and decided on the known sperm donor used one respondent wrote “the process to select the donor was intense and very detailed.” Other responses included meeting the donors at work, “friend of a friend,” and “a wonderful friend.” Contributing factors to choosing the specific person included race, culture, languages spoken, health, and trusting the individual, which is illustrated in the following response.

We chose to have a known sperm donor, who is local, healthy, and has been very supportive, accessible and involved in the conception process and in the life of our daughter and family.” “It has been particularly important for us as an interracial couple and multiracial family (my spouse is Mexican Chinese Catalan American and I am Scottish Irish American) that we were blessed to find a gay, healthy, ethical man who is Chinese and from Argentina-- so that both my spouse's mother and our donors family speak Spanish, and my spouses extended family speaks Cantonese and our donors parents/extended family speaks Mandarin. These are rich, wonderful and irreplaceable dimensions to our daughter's life, heritages and legacies-- and we would have found it VERY difficult to find a Chino Latino donor in the sperm banks (in fact I remember we did find ONE Mexican Chinese donor at a local sperm bank). We are also a working class, union family who have experienced disability, unemployment and a great deal of financial stress during the process of trying to have our first child - and through the process of parenting, and it makes a HUGE difference to have a free, local, willing man who has offered his time, assistance and, frankly, sperm for free.

The participant's story highlights the multiple factors in deciding on using a known sperm donor and what factors were considered when choosing the individual. Another respondent highlights the fear of lack of legal protection when using a known donor. She writes, “seemed easygoing -- very unlikely to want to threaten our relationship with the child or claim any rights, if our legal protections in place did not hold up in court. He was also young and healthy.”

Participants had varied responses when asked about how the donor fit into the experience. One participant had very little contact with the donor. She wrote, “He signed a contract and we called him whenever I was ovulating. Rarely spent time together socially; we didn't want someone who was involved in our lives. He was not planning to be involved after conception.”

The other two participants who responded to the question reported higher levels of involvement and support from the donor. One participant writes,

We (my spouse and I) are the legal, practical and names PARENTS of our daughter, and our donor has released all legal parental rights and responsibilities. However, he and his parents, uncles, aunts, cousins and other extended family, are a PART OF OUR FAMILY. We spend Thanksgiving, Christmas, Chinese New Year and Gregorian New years, birthdays and other holidays with them. As we get older I imagine that our relationships will deepen. Our donor is an intimate part of our daughter's life, and our life, and we intended this to be so.

Therefore the respondents reported a range from very low to high involvement.

At home versus medical fertility clinics/ facilities

Only 6% (n=2) of respondents reported doing all fertility treatments at home, 33% (n=11) reported doing treatments at home and at medical facilities, and 61% (n=20) reported doing everything at medical fertility clinics.

All respondents who did everything at home reported that finances and cost were part of the decision to do everything at home. Other factors included wanting the process to “be personal,” have “control over timing,” and based on location of fertility clinics, which is illustrated in the following quote.

We wanted the process to be personal. It would be dramatically more expensive for us to work with a fertility center. We also wanted more control over the timing of the inseminations. The nearest fertility center was almost 2 hours away. If I happened to ovulate on a weekend, a typical clinic is closed so you just skip that month. The whole thing sounded like a lot of hassle and expense.

Themes in the decision making process to do everything at medical facilities included medical necessity, legal and policy issues, based on success rates, and respondents not feeling confident or comfortable with inseminating self at home. The highest reported factor was not feeling comfortable with inseminating self at home or feeling “more comfortable and safe with having it done medically.” One respondent writes, “We did nothing at home. We were concerned

that we wouldn't be able to thaw the sperm correctly and we'd kill it." Twenty five percent (n=5) of participants who only used medical fertility clinics reported making the decision to use medical fertility services based on success rates. One respondent reports "The percentage of success with at home insemination is lower than in a clinic." Twenty five percent (n=5) reported using medical facilities due to medical necessity. Fifteen percent (n=3) reported using medical facilities due to legal or policy issues. One respondent reports, "No, it is illegal in NC and VA to inseminate at home, it must be done by a physician". Another reports "We considered using a friend as a donor and using fresh sperm that way but ultimately decided against it for legal reasons." Two respondents (10%) reported questioning their decision to use medical facilities.

Thirty-three percent (n=11) of participants did fertility treatments at home and at medical facilities. Out of these eleven participants 64% (n=7) tried to get pregnant at home before using a medical facility. Forty-three percent (n=3) of participants out of the seven who tried to get pregnant at home first reported they "didn't want a clinic setting," and "thought it would be more intimate/personal." Reasons for switching to a medical facility were mostly due to lack of success at home and medical necessity. One participant used medical facilities initially due to legal and policy issues and then later used at home insemination due to finances. She reports, "our cryobank wouldn't let us ship the samples to a home, only a dr office. Later we tried at home because it was free (with a known donor) and we wanted to save all our money for the adoption."

Costs and insurance coverage

The costs of fertility services varied based on services used and if at home insemination versus using fertility services at medical facilities. Twenty-six participants answered the question, "What was the total cost of fertility services?" The financial cost of fertility services

ranged from \$20 to \$75,000. The average cost was \$17,719. However this average may be skewed due to the large range of costs. The largest percentage of participants (n=14, 54%) reported total costs between \$1,000 and \$10,000. Please see graph for total costs breakdown.

Table 6

Total cost

Cost	Frequency	Percentage
Less than \$1,000	1	4%
\$1,000 - \$10,000	14	54%
\$10K- \$20K	1	4%
\$20K - \$30K	5	19%
\$30K - \$40K	1	4%
\$40K - \$50K	2	8%
\$50K - \$60K	1	4%
\$60K - \$70K	0	0%
\$70K - \$80K	1	4%

Participants reported using seven insurance companies including: Blue Cross Blue Shield, Blue Cross, Blue Shield, Kaiser, Aetna, Cigna, and “private insurance.” Five participants (15%) reported not having insurance. The majority of participants reported having some cost of fertility services covered by their insurance. Eighteen percent (n= 5) of the twenty eight participants who reported had insurance reported that their insurance did not cover any costs of the fertility services used.

Reasons provided for no insurance coverage included the following: “Considered an elective procedure,” “They specifically noted that they did not pay for any fertility services.” and “did not ask and did not think I could get it covered.” One respondent wrote, “I wonder what the cost of birth control (covered by insurance) is over the lifetime of a typical heterosexual woman.... it seems like it is a fair trade-off that if they don't have to pay for lesbian birth control it would be nice to get some fertility expenses covered instead.” This respondent is commenting on heterosexist insurance coverage practices and policies. These heterosexist practices are evident in the other responses such as insurance not covering fertility treatments due to viewing the procedure as elective.

The majority of participants who reported what was covered and what was not covered by insurance reported that sperm and fertility treatments such as IVF and IUI were not covered by insurance. One participant wrote “We didn't meet the requirements of failure to get pregnant for 1 year.” She is referring to the insurance companies policy of who is covered and not covered which is determined by infertility and a definition of “infertility” based on heterosexual intercourse. Five participants reported that IUI and IVF were covered by insurance. Other services covered included lab work, hospital birthing visit, diagnostic testing, and some medication.

Experience at Medical Fertility Clinics/ Facilities

The majority of couples (61%, n= 20) that used medical fertility clinics/ services both attended all appointments, 27% (n=9) sometimes both attended appointments while 6% (n=2) reported that they did not attend appointments together. Two participants responded “n/a.” Out of the thirty-one participants who responded to the question “Did you feel comfortable or welcome at the clinics as a couple?” seventy one percent (n=22) reported feeling comfortable at

the clinics together as a couple. These participants described feeling comfortable, accepted as a couple, and welcome. Many of these participants reported it was “very clear that they welcome lesbian couples.” Couples reported doing “research to ensure that we chose places that would treat us well and that marketed to lesbian couples.”

Twenty-nine percent of the thirty-one respondents (n=9) reported they did not feel comfortable or welcome as a couple or had a varied experience at the clinic. These participants described incidents of heterosexism such as “initial paperwork and fees setup not designed for a lesbian couple,” discrimination and racism “Once the doctor asked me why I decided to have a biracial child. I was offended by that. My partner is Black and I am White, and partners feeling not included in the process. Respondents reported “sometimes not recognized as a couple,” “at times I didn’t feel like they saw us a couple” and “they did not look me in the eye when my partner was trying. I didn’t always feel a valid part of the process.” One participants reports,

While there were some warm practitioners and staff, particularly a warm front desk person who verbally stated that she was glad we were there as a culturally diverse lesbian/transgender couple....we felt "defacto" exclusion and segregation and differential treatment because while different gendered couples, regardless of whether they were married, were able to do "one stop services" and do fresh sperm insemination at RSC-- we were told that because our donor was not my sexual partner they would have to freeze and quarantine his sperm.

The reports demonstrate that some participants experienced multilayered discrimination, heterosexism, and racism when at fertility clinics resulting in participants not feeling comfortable or welcome as a couple at the clinics.

Discrimination

Twenty-six participants responded to the question “did you experience any discrimination in the process?” Sixty five percent (n=17) of these participants reported “no”. Three of these participants differentiated between discrimination and perceived discrimination. These

participants wrote “Certainly not overtly.” “None that I was aware of,” and “We do not believe we experienced any discrimination.” These respondents answered differed from participants who reported “no” or “none.”

Thirty-five percent (n=9) of participants reported they experienced discrimination in the process. Incidents of discrimination included heterosexist practices through forms, denial and discontinuation of services, “the whole can’t use a known donor part” and “discrimination indirectly though lack of coverage from insurance/ managed care.”

Two participants reported experiencing discrimination through forms that were intended for heterosexual couples. One participant writes “only thing was all the never ending forms one had to fill out were always woman/man mother/father.” Three participants reported being labeled as having fertility problems when requesting insemination and being tested excessively for infertility, which increased costs. The following are the three reported incidents of discrimination:

I was required to test excessively for infertility despite no evidence of this condition.”

In order to get an appt. with the fertility dr. at Kaiser (in order to get Clomid prescribed) we had to attend a "fertility class" which was clearly for straight couples who had been trying to conceive for a year not for people who just wanted to get pregnant without a man..

Doctors also labeled us with a fertility problem simply because we came in asking for IUI's. Short of inseminating at home, IUI's are the only way that lesbian women who do not want to sleep with a man can get pregnant. Research shows that IUI's result in more success than inseminating at home. We were penalized financially by managed care for choosing the procedure with better odds.

Two participants reported that they were assumed to be heterosexual. One participant reports “If I had different physicians or nurses they frequently assumed I was a straight woman having sex with a man with infertility issues.” Two participants reported denial and

discontinuation of services. One respondent writes, “Yes, there were no clinics at first that would inseminate a lesbian (or "single" mother). I found the place we used to be VERY heterosexist.”

The other respondent reports being told to discontinue services.

She said there was only one doctor in the clinic that might have an issue with our situation. I never knew who that person was. There was a doctor, who part way through the process, told us we should discontinue. Not sure if he would or would not have said the same thing to a straight couple, he did suggest we adopt.

The responses illustrate that some participants experienced discrimination and heterosexism when accessing fertility services.

Relationship

Twenty-five participants responded to the question “how did the experience of using fertility services and trying to get pregnant affect your relationship with your partner?” Sixty-four percent (n=16) of the twenty-five respondents of participants reported experiencing challenges in their relationship, 48% (n=12) reported the experience made the couple stronger, 12% (n=3) reported no changes, and 8% (n=2) reported they are no longer together.

Multiple participants reported the experience of trying to get pregnant “brought us closer together.” One participant writes, “It brought us closer together and allowed us to really understand one another on a deeper level.” Many of those participants also reported challenges as well. It was through overcoming the obstacles that made the couples stronger. One participant writes, “We have been through a lot of loss and disappointment. Times have been difficult and couples therapy has been helpful. We have different ways of grieving and we have learned a lot about each other and our relationship has certainly deepened. We are determined to create a family together and have not given up hope.” Another participant reports on the challenges and the increase in closeness she experiences with her partner. “It's caused stress, agreeing on a

donor and the ups and downs of the actual attempts and waiting to find out if we're pregnant have made for more pressure and shorter tempers at times. It's also drawn us closer as we continue to try.”

The majority of participants reported challenges within the relationship during the process of trying to get pregnant mostly due to stress, dealing with loss and disappointment, and feeling alone or isolated. Participants reported an increase in crying, conflict, difficulty getting “on the same page regarding what treatment course” and feelings of guilt when unable to get pregnant.

Participants reported feeling alone, feeling that their partner could not relate, and fear that their partner did not feel part of the process. One participant writes,

It is complicated. I really felt alone in the process most of the time. She did not understand how it was for me to have unsuccessful tries and how much I really wanted to be pregnant. Also, because the clinic we used was so far away, I frequently had to go by myself. So, it was me, my issues, not feeling support from her. We are still dealing with this to some degree I think.

Another participant reports, “My wife is incredibly supportive. I think she doesn't feel like she has much role in the process though.” Some respondents reported feelings of guilt and concerns of disappointing their partner when they had difficulty getting pregnant. One participant who is no longer with her partner reflects on the way in which trying to get pregnant affected their relationship, she writes,

I think I really disappointed her in not getting pregnant after 3 tries. And after the disappointment and the pressure, I wanted to take time off and I think my partner's clock was so busy ticking that it really affected our relationship and made her feel like it wasn't working because the family hadn't happened yet. It was a very frustrating process and we both dealt with it differently.

The following respondents story highlights multiple stressors in the process of trying to get pregnant including negotiating both partners desire to get pregnant. The story demonstrates challenges and the strengthening of the couple's relationship.

We have experienced a lot of stress and challenges throughout this process. Overall, we have remained strong in our partnership, but there were definitely moments when our strength was tested. In particular, it has been hard on me as the process has been prolonged and I have not conceived to know that soon (because of my partner's similar desire to conceive and her age) we are going to have to stop trying with me and start with her. The initial agreement that we had was that after a year of trying with me we would begin trying with her. This was changed (it will have been a year and a half of trying with me) due to the fact that our financial situation prevented us from trying consistently for a year. I feel guilty for prolonging my time and worry about future consequences of delaying the start with my partner, but I also know that I would be heartbroken if we did not utilize the last covered IVF cycle for me and I don't want to ever feel resentful towards my partner for any reason. I also feel guilty that my body is not cooperating due to the fact that both of us want to be moms soooo badly. I know that my partner, after living through my fertility journey, is now very concerned and anxious about having fertility problems herself. She is nervous because she is getting older which may decrease her chances of conceiving and we have not yet started with her. Overall, however, this process has engaged us in an important process of honest communication and, through this, we have become much stronger. I now feel very comfortable in my knowledge that no matter what happens with me during this last IVF cycle, I will be able to let go and let my partner try... and be happy for her!

Two participants reported the process affected their relationship negatively and they are now no longer with that partner. One participant reported,

Yes. We are no longer together. She had an affair not even 9 months later with a younger woman and they are planning a family already (we have been apart only 4 months). I think I think the end of this quote is a repeat. I really disappointed her in not getting pregnant after 3 tries. And after the disappointment and the pressure, I wanted to take time off and I think my partner's clock was so busy ticking that it really affected our relationship and made her feel like it wasn't working because the family hadn't happened yet. It was a very frustrating process and we both dealt with it.

Another participant reports "we are now broken up--- but that is due to having the child and the other person did not really want to."

The responses demonstrate that the process of trying to get pregnant involves many stressors and challenges in which impact the couple's relationship both negatively and positively.

Obstacles and Overcoming Obstacles

One respondent writes "It has been very stressful, expensive, time consuming, frustrating, sometimes very humiliating and isolating-- although we have also met some wonderful practitioners and reproductive advocates along the way." The quote is representative of the many obstacles and challenges involved in the fertility process. Thirty-two participants responded to the question "What obstacles if any did you encounter?" Most (n= 7, 78%) respondents reported encountering obstacles throughout the process of trying to get pregnant. Obstacles included financial, medical, relationship issues, mental health issues, insurance, donor issues, and heterosexist practices.

Thirty-one percent (n=10) of respondents reported medical obstacles such as infertility and side effects from fertility drugs. Twenty five percent (n=8) reported financial obstacles based on the high cost of fertility services. Twenty-five percent (n=8) reported obstacles that can be defined as heterosexist practices. Thirteen percent of the heterosexist practices reported involved using a known donor. A participant reports, "using a known donor as a lesbian couple presented many obstacles." Some participants explained that hospitals and most fertility clinics will not use live sperm from a non intimate partner and therefore couples who would like to use a known donor with live sperm are forced to go through extra steps including washing and freezing the sperm before being inseminated. This also results in extra costs. The following participants story highlights the obstacles faced when using live sperm from a known donor as a lesbian couple. The couples story also expose heterosexist practices.

While different gendered couples, regardless of whether they were married, were able to do "one stop services" and do fresh sperm insemination at RSC-- we were told that because our donor was not my sexual partner they would have to freeze and quarantine his sperm. We did not/do not have the money to work with a sperm bank to freeze his sperm, and also know that fresh sperm is superior in quality and effectiveness for conception. Our donor has been celibate for more than 13 years-- and as our public health nurse at Rainbow Flag Fertility Services informed us, the fact that we did/do home insemination means that from a PUBLIC HEALTH PERSPECTIVE he and I are intimate sexual partners and therefore should be treated just as a heterosexual intimate sexual partners are treated- we both voluntarily expose ourselves to the possibility of STDs and health risks by having sperm put into our body unwashed-- and unless the FDA or the CDC want to be the "sex police" it is not their business whether the sperm is put into my body via a penis or a syringe....We finally found out about Laurel Fertility Services in SF via our gay nurse. He said he met a Doctor when he was speaking on a panel at the Gay and Lesbian Medical Association about cutting edge work he is doing on doing IUI and IVF with HIV+ donors. The doctor is a Chinese gay man, and has been willing to work with our family classifying our donor and me as "intimate sexual partners" and thereby allowing us to do fresh sperm insemination with IUI that is covered by our health insurance." "We feel strongly that the right to CHOOSE to have a known donor is an issue of reproductive rights and choice, as important as when an individual chooses a life partner, boyfriend/girlfriend or spouse/husband/wife.

Other obstacles based on heterosexist practices included being labeled as having fertility issues by doctors and insurance companies when not infertile and therefore requiring extra testing. Some participants report the fertility clinics paper work and contracts were not inclusive of lesbian couples and therefore created obstacles. One participant reports,

First issues were contract issues. Had we used the contracts which the clinic provided (and insisted that we sign in order to proceed) we would have both been required to give up our parental rights. They treated me like an egg donor and my partner like a surrogate. I had to rewrite the clinics contracts in order to account for our situation and then had to petition the clinic owner by enlightening them on their flawed logic.

The quote illustrates the lack of legal framework to support lesbian families using insemination and that the contracts and paper work were created for heterosexual couples. This participant and her partner were treated like an egg donor and a surrogate versus two partners conceiving a child together.

Other obstacles included confusion over and lack of insurance coverage, relationship issues including “getting on the same page”, and mental health obstacles such as trauma of failing and trying for so long, anxiety, disappointment and loss, and stress.

Participants reported they overcame such obstacles through medical help, persistence, getting support from friends and family, doing research and reading books, confronting difficult emotions through therapy, advocating for themselves, and accumulating debt and making strict financial budgets. The following responses represent the variety of different ways that participants overcame obstacles throughout the process.

We just refused to give up. We did a lot of crying, soul searching, budget crunching, and research. In our many talks we decided that we wanted to be moms more than anything in the world no matter what. Everyone said our persistence was admirable. But to us there was no other choice. Life wasn't worth living without kids.

The following quote demonstrates the participant's strength as she reports on being an advocate for herself. She writes, “We are still working on it patiently. I did a lot of advocating for myself. I also involved my regular nurse practitioner to help advocate for me and avoid unnecessary testing.” Another couple overcame obstacles by changing roles in who will carry the child. She writes, “We gave up on me and went with my partner to get pregnant.” The responses illustrate the many obstacles the participants encountered and the variety of ways in which they overcame such obstacles.

Supports Relied Upon and Needed

Thirty-two participants answered the question “ what supports did you rely upon?” Couples reported relying upon the following supports: Friends (n=19,59%), each other (n=17, 53%), family (n=12, 38%), online communities, blogs, and books (n=7, 21.9%), therapists (n=4, 13%), medical professionals (n=2, 6%), and classes (n=1, 3%). The majority of couples relied

only on the support of one another while others used a variety of supports. The following responses demonstrate the complexities of accessing support and a variety of supports used throughout the process.

For many months, we relied solely on each other and the medical professionals we were seeing -as well as anonymous lesbian women through an online support system. In Seattle, we were both also seeing individual therapists already and they helped us deal with the emotions involved in finding out that we were not pregnant again and again. As the process continued and we still did not become pregnant we started telling family and friends. They have been mostly supportive, though with my family it is still quite complicated since my parents have difficulty accepting that there might come a time when my partner and I will stop trying with me and move on to her.

The following quote reiterates relying on each other, highlights the importance of getting support from other LGBTQ folks who have gone through the process of trying to get pregnant, and illustrates the complexities of family of origin issues.

Each other-- we have a group of multicultural lesbian, bisexual and transgender parents and prospective parents we talk and email with. I started a "Spring Cleansing and Fertility Preparation class in 2009 with a multicultural group of lesbian and queer and single women that was VERY helpful. I talk on the phone with several other queer friends who are going through similar things. We also have taken classes and gotten consulting which has been helpful. We've talked with our extended family to some extent- but they often can't relate.

Twenty-seven participants responded to the question, "What supports were not in place, if any?" Six participants (22%) reported feeling supported and not needing any other supports. Other participants reported the following supports were not in place and needed: family support, financial support, support from partner, legal support and advising, insurance, counseling, social networks, books and resources specific to lesbian conception, gay friendly support groups and clinics, and help navigating homophobia.

The responses highlight incidents of discrimination and heterosexism. One participant writes, "The clinic has mostly straight couples and was a bit to navigate initially. Not being

recognized by some of the staff as a couple was difficult in the beginning.” Another participant reports not accessing support due to fear of discrimination. She writes,

There is a support group in the area, but I don't want to go because I'm concerned that it will just be a bunch of heterosexual women who think they have nothing in common with me, or think that I should not expect to get pregnant (or do not deserve to get pregnant) because I'm gay.

The following responses illustrate the need for LGBTQ friendly services and highlight the many supports and resources that are not in place to support lesbian couples throughout the fertility process. The participant reports needing, “other families as resources, legal help and support, more information about having a glbt family and legal resources as well as social network/supports.” The need for these support services and resources are supported by the following quote. The participant reports needing,

Help navigating homophobia and insurance....LGBTQI (Lesbian, Gay, Bisexual, Transgender, Questioning, Intersect) and culturally competent services...LGBTQI legal resources that are informed of and passionate about LGBTQI reproductive rights...therapeutic services and counseling WHICH ARE COVERED BY OUR INSURANCE so we can afford them to deal with the stresses, questions and struggles... I would appreciate it if the organizations we go to for LGBTQI parenting resources had resource lists of LGBTQI friendly/welcoming fertility resources.

These findings demonstrate that there are many resources and support services needed to better support lesbian couples using fertility services.

Summary

The highest reported factor in deciding what services to use was based on if the service, clinic, or medical provider was “gay friendly.” The majority of participants used an unknown sperm donor and reported wanting to protect their family legally as a contributing factor in their decision to use an unknown donor. Participants who used a known donor reported choosing a known donor based on three common identified factors: Cost, the individuals, and wanting the

involvement of the donor. Respondents reported a range of involvement from known donor based from very low to high involvement. The majority of participants used medical fertility services. The narrative responses illustrate a theme of wanting to do self-insemination and shifting to medical facility clinics. The findings exposed many barriers to using known donors. Themes in the decision making process to do use medical facilities included medical necessity, legal and policy issues, based on success rates, and respondents not feeling confident or comfortable with inseminating self at home. The costs of using fertility services ranged from \$20 to \$75,000. Insurance coverage varied and narratives exposed barriers to accessing services based on insurance policies. The majority of couples went to clinics together and felt comfortable. The majority of participants reported they did not experience discrimination however there is evidence of heterosexism throughout the narrative answers to other questions. The findings illustrate that the experience of using fertility services impacted the relationship of the couple both negatively and positively. Most respondents reported encountering obstacles throughout the process of trying to get pregnant. Obstacles included financial, medical, relationship issues, mental health issues, insurance, donor issues, and heterosexist practices. Respondents reported a variety of supports used including each other and friends. Participants reported the following supports were not in place and needed: family support, financial support, support from partner, legal support and advising, insurance, counseling, social networks, books and resources specific to lesbian conception, gay friendly support groups and clinics, and help navigating homophobia.

CHAPTER 5

DISCUSSION

The purpose of this exploratory qualitative study was to examine the experience of lesbian couples using fertility services. The basic question that the study explored was: What are the experiences of lesbian couples who use fertility services? The narratives collected through the online survey inquired about decision making processes prior to using services, experiences using fertility services, obstacles, discrimination, supports used and needed, and the impact of the experience on the couples relationship. Demographic information such as age, race, and socio economic status were collected.

Major Findings

The results indicate that the process of using fertility services for lesbian couples involves multiple decisions prior to accessing fertility services, lesbian couples have varied experiences at fertility clinics and working with providers, there are obstacles accessing fertility services, the experience impacts the couples relationship, and some lesbian couples experiences instances of discrimination and heterosexism.

Heterosexism

The highest reported factor in choosing fertility services, medical providers, or clinic was determined by if the provider/ service or clinic was “gay friendly.” These findings suggest that there are fertility clinics, services, and providers that are not gay friendly. Heterosexism is the belief that heterosexuality is the norm and superior to homosexuality. It is perpetuated through individuals and society’s institutions. Heterosexuality is assumed and homosexuality requires an

explanation. Herek describes heterosexism as “cultural ideology that perpetuates sexual stigma” (Herek, 2004, p. 16). Herek describes three types of sexual stigma enacted stigma, felt stigma, and internalized stigma. The history of reproductive technologies has heterosexist underpinnings as the creation of reproductive technologies were intended for heterosexual couples, excluded lesbian and single women, and were also viewed as threatening the hetero-normative family form. The historical heterosexist roots which reproductive technologies were founded upon have had a lasting impact on the institution as demonstrated by current heterosexist practices within fertility services such as the working from an infertility model versus an assisted reproduction framework. The findings expand on the cited literature as research on heterosexism and discrimination within the process of using fertility services is lacking. The findings illustrate evidence of heterosexist practices in the process of using fertility services and incidences of enacted and felt stigma. One participant reports,

There were no clinics at first that would inseminate a lesbian (or “a single mother”). I found the place very heterosexist. If I had different physicians or nurses they frequently assumed I was a straight woman having sex with a man with infertility issues.

This finding provides evidence of enacted stigma, which is direct discrimination. The quote highlights heterosexism in that the participant was assumed to be heterosexual. The quote also illustrates the larger framework in which fertility services or reproductive technologies are framed, based on an infertility model versus an assisted reproduction model, which marginalizes and excludes lesbian couples using fertility services for reproductive assistance as opposed to infertility issues. Another respondent writes,

There is a support group in the area, but I don't want to go because I'm concerned that it will just be a bunch of heterosexual women who think they have nothing in common with me, or think that I should not expect to get pregnant (or do not deserve to get pregnant) because I'm gay.

This finding is an example of felt stigma that is perpetuated by heterosexism. Herek writes felt stigma “is the knowledge that enacted stigma can occur under certain circumstances often motivates people to modify their behavior in order to avoid enactments”(Herek, 2007, p. 909). The participant chose not to attend a support group due to felt stigma. This is also an example of one not using services due to fear of perceived discrimination as discussed by Macmillan (2006), Van Dam, Koh, & Dibble (2001), and Burgess, Lee, Tran & Ryn (2007).

A participant reports, “it is illegal in NC and VA to inseminate at home, it must be done by a physician.” Another reports, “tried one clinic, didn’t like it (they wouldn’t allow us to use a known donor because he wasn’t my intimate partner). Switched clinics to another one in the area”. These findings provide evidence of enacted stigma that is maintained by heterosexist policy. The reported experience highlights the way in which heterosexism is maintained through institutions and individual practices as theorized by Herek. The North Carolina heterosexist policy resulted in these participants being denied services and an inability to conceive their child in the way in which they wanted, through a known sperm donor. This is a reproductive rights issue that will be discussed further in the discussion chapter.

These examples provide evidence that some lesbian couples experience discrimination and some fertility clinics do have heterosexists practices. Heterosexist practices range at fertility clinics from paperwork and contracts being heteronormative assumed heterosexuality, to denial of services due to sexual orientation. These practices are perpetuated and maintained by individuals and through larger policy. These findings were not explored in the cited literature and are an area for future research, policy, and advocacy work.

Self-Insemination: A Need for Support Services

As stated in the literature review, prior to lesbian and single women having access to medical fertility services, women centered non-professional women's health clinics formed. These clinics were founded on empowerment principles and provided education and assistance on self-insemination. These clinics were eventually taken over by the medical field as fertility became medicalized and lesbians gained some access to fertility services. There has since been a shift to higher numbers of lesbian couples using medical fertility services which is illustrated in the findings. For instance, 94 percent of the participants reported using medical fertility services as opposed to doing self-insemination at home.

The majority of participants reported doing all inseminations at medical fertility clinics, a smaller percentage did inseminations both at home and at medical fertility clinics, and a few did all inseminations at home. The highest reported reasons for using medical fertility services were not feeling comfortable doing insemination at home, concern of not inseminating correctly, and concern over the success rate of home insemination. A percentage of respondents reported wanting to do everything at home and then shifting to use medical fertility service providers due to lack of success. These findings demonstrate that there is a desire to inseminate at home, however there is concern about success rates and knowledge about inseminating correctly. The high numbers of respondents reporting concern about success rates, safety, and lack of knowledge on self-insemination indicate that as fertility has become medicalized and the women health centers were taken over by the medical field, there is a lack of services that educate and provide assistance on self-insemination. This is an area for future research. I am curious about the success rates of self-insemination for lesbian and single women who have been educated on self insemination through classes, personal research, or using a trained person at home versus

those who have not used such services. I am also curious if more women would do self-insemination if resources and support services were available.

The Meaning of Family and a Lack of Legal Support

The findings demonstrate that the meaning of family and legal protection are two key components when choosing to use a known or unknown donor. These findings are consistent with Mitchell and Green (2007) and Wilson and Donovan's (2008) study found that the meaning of family is fluid and the meaning of family impacts the decision of using a known or unknown donor. Fifty-seven percent of participants reported wanting to protect their family legally as a contributing factor in choosing to use an unknown donor. These findings suggest that there is not a legal framework to support lesbian families using known donors.

Wilson and Donovan (2008), Mitchell and Green (2007), and Kranz and Daniluk (2006) focus on the decision making process of choosing a known donor and highlight the meaning of family. A very small percentage of participants used known donors and the responses collected varied on reasons for using a known donor and in terms of meaning of family. Some participants did not want the involvement of the donor while others did.

Obstacles Using a Known donor

Although few participants used a known donor, a reported theme was initially using or wanting to use a known donor and then ultimately using an unknown sperm donor. This is consistent with Green and Mitchell (2007), The highest reported reason for choosing a known donor was due to economic reasons. The shift to use an unknown donor mostly was due to lack of success with self-insemination at home with a known donor and needing to use medical fertility services. The narrative responses exposed a barrier in using known sperm donors at medical fertility clinics which was not in the cited literature. In order to use a known sperm

donor at a medical fertility clinic the sperm must be washed and quarantined due to concerns about HIV/AIDS. This process involves time and increases the costs. If the sperm is from an intimate partner then the sperm does not need to be washed and quarantined. Therefore lesbian women who want to use a known donor are forced to go through extra hoops because she is not sexually intimate with the sperm donor. This finding was not discussed in the cited literature and is important to explore further in future research. This is heterosexist and an area for future research and advocacy work. As a result many lesbian couples shift to using an unknown donor. This is a reproductive rights issue.

Insurance

Insurance policy's regarding fertility treatment coverage is also heterosexist. Coverage is determined by infertility. The definition of infertility is based on the definition of an inability to get pregnant after one year of heterosexual intercourse. Therefore lesbian women are excluded from this definition. This policy has implications on the treatment of lesbian women using fertility services. Participants reported not meeting the definition of "infertility" and unnecessary infertility testing when accessing services to be inseminated, which as a result increased costs. The increased costs limited access to fertility clinics based on socio economic status.

The findings demonstrate that the majority of participants had a portion of the fertility services covered and that coverage varied. However mostly the insemination procedure was not covered. Some participants received no coverage due to the insemination being seen as an "an elective procedure." This is an example of enacted stigma that is structured by heterosexist insurance policy. The enacted stigma results in felt stigma and internalized stigma. This can be seen in the following response by one participant, "Nope, did not ask and did not think I could get it covered." The findings are consistent with Cahill and Tobias (2007) who highlight the

policy implication of insurance companies coverage based on infertility and a heterosexist definition of infertility. The high cost of fertility services is one barrier to accessing fertility services that is highlighted by Judith Darr (2008) and Beck and Taylor (2007) The high cost and lack of insurance coverage for lesbian couples due to the heterosexist definition of infertility and the exclusion of lesbian women who are not infertile results in inequality in who can and can not access fertility services. What is covered and what is not covered needs further research to fully understand the implications of the definition of infertility used by insurance companies.

A Comparison of Geographic Location

The majority of the sample (55%, n=18) used services from California. Twenty-seven percent (n=9) used services in North Carolina. Three out of the nine participants (34%) who used services in North Carolina reported discrimination and heterosexism. Seven out of eighteen participants (39%) from California discrimination and heterosexism. I had imagined that California would have a lower frequency of heterosexism and discrimination reported in comparison to North Carolina due to the political climate of the states. However when examining the examples of discrimination and heterosexism reported more closely, North Carolina shows higher rates of enacted stigma or direct discrimination in comparison to California.

Discrimination and heterosexism reported from participants using services in North Carolina included issues related to using a known donor, being denied services, and not accessing support services due to fear of discrimination. Heterosexism and discrimination in California included issues relating to using a known donor, excessive infertility testing and lack of insurance coverage, assumed heterosexuality, paper work that was designed for heterosexual couples, and feeling “defacto exclusion and segregation.” The highest reported incident of heterosexism in California was paper work. Both California and North Carolina reported

obstacles in using a known donor. This is an area for much needed research. The comparison demonstrates that heterosexist practices are not geographically isolated however discrimination and heterosexist practices are much more overt in North Carolina in comparison to California. All forms of heterosexism need to be addressed. The comparison simply highlights that the experience of a lesbian couple using fertility services may differ based on geographic location, which is directly impacted by policy and the political climate of that state. Future research would benefit by using a larger and more diverse geographic sample.

Race

Intersectionality looks at the way in which socially constructed categories such as race, class, gender, sexual orientation, and disability intersect and contribute to systematic social inequality (Collins, 2000). The study intended to use intersectionality as framework when looking at the collected narratives and notice the impact of multiple identities including race and social class. The survey did not directly ask about the impact of race on ones experience and I would suggest that future studies directly inquire about the participants multiple identities. Two participants of color reported no discrimination in the process of accessing services; the third participant did not answer the question.

The sample consisted of thirty white participants (91%) and only three participants of color (9%). The sample included seven interracial couples. These numbers are consistent with most lesbian family research such as the NLFS sample that was 94 percent white. Most research pertaining to people of color and particularly African Americans “tends to ignore the issue of sexual orientation, and most research pertaining to LGBT tend to ignore the issue of race” (Harris, 2009, p.434). Collins (2000) claims, “African American women have been “silent” in discussions of African American lesbians” (Harris, 2009, p. 435). There is a need to include the

voices of lesbians of color in research. I actively recruited lesbians of color through joining yahoo groups and sending out recruitment information that were specific to people of color.

However unfortunately the sample is disproportionately overwhelmingly white. One respondent discussed race and the impact of race and culture throughout the experience of using fertility services. The participant reports fear of discrimination based on race. She writes,

We wanted to avoid doctors and hospitals as much as possible both for financial reasons and very much for social, cultural and political reasons,-- ie. we were concerned that as an interracial and multi cultural family, a femme lesbian and butch /transgender couple, with a known donor- that we would encounter a stressful combination of racism, sexism, homophobia and classism in the reproductive community.

This participants quote highlight intersectionality and the way in which the combination of the couples multiple identities impacted on the couples experience including felt stigma as discussed by Herek. This participant also reports on race and culture being a factor in choosing to use a known donor. She writes,

It has been particularly important for us as an interracial couple and multiracial family (my spouse is Mexican Chinese Catalan American and I am Scottish Irish American) that we were blessed to find a gay, healthy, ethical man who is Chinese and from Argentina-- so that both my spouse's mother and our donors family speak Spanish, and my spouses extended family speaks Cantonese and our donors parents/extended family speaks Mandarin. These are rich, wonderful and irreplaceable dimensions to our daughters life, heritages and legacies-- and we would have found it VERY difficult to find a Chino Latino donor in the sperm banks (in fact I remember we did find ONE Mexican Chinese donor at a local sperm bank).

This quote illustrates the importance of culture and race and the difficulty in finding a cultural and racial specific sperm at the sperm bank. As using a known donor at fertility clinics has many obstacles, a lack of racially and culturally diverse sperm available at sperm banks is problematic. This may be a common experience however we do not know based on the lack of inclusive research that is racially and culturally diverse. Future research must include the voices of lesbians of color.

Research Implications

This research project aimed to explore the experiences of lesbian couples using fertility services with the hope to contribute to a greater understanding of the needs of lesbian couples and identify any obstacles, discrimination, and barriers encountered when using fertility services. Future research would benefit from a larger and more diverse sample in terms of race, socioeconomic status, and geographic location. The findings demonstrate that there are obstacles, access issues, and heterosexism in the process of using fertility services. Areas for future research include using known donors, insurance coverage, support services in self-insemination, the impact of perceived discrimination on mental health, and the interpersonal strengths and difficulties in the couple's relationship.

Social Work Implications

The literature discusses perceived discrimination and the impact on mental health and also resulting in delayed access to services. The findings demonstrate that discrimination and heterosexist practices are evident during the process of using fertility services. The findings also demonstrate that the process impacted the couple's relationships both negatively and positively. There is a consistent theme in the narratives that there are obstacles and significant challenges throughout the process. Participants reported experiencing the following obstacles: financial, medical, relationship issues, mental health issues, insurance, donor issues, and heterosexist practices. Participants reported the following supports were not in place and were needed: family support, financial support, support from partner, legal support and advising, insurance, counseling, social networks, books and resources specific to lesbian conception, gay friendly support groups and clinics, and help navigating homophobia. The research findings provide

information on areas that lesbian couples using fertility services need further support on a micro and macro level.

Clinical social work can respond to addressing these obstacles and needs of lesbian women using fertility services through education, providing clinical support, and advocacy. Support services could include providing support and education on self insemination, assisted reproductive classes that some clinics require people to use must be inclusive, provide trainings to fertility clinic staff on heterosexism, and provide individual and couples counseling. It is important that social work schools include LGBTQ specific issues in their curriculum. One must examine these issues through a clinical lens as well as understanding the way in which heterosexist policies such as DOMA, insurance policy's, and North Carolina's law that self-insemination is illegal, directly impact upon these clients. Social workers can do advocacy work on behalf of lesbian women and reproductive rights to encourage changing these heterosexist policies. Clinical social workers can also contribute to a greater understanding of the needs of lesbian women using fertility services through continuing to do research on this topic and continue to assess who is and or is not being represented in the research. There is a great need for research to include the voices of lesbians of color.

Limitations

Limitations to the generalizability of findings include a small sample size that is homogeneous. Ninety one percent (n=30) of the participants are white. Fifty five percent (n=18) of the participants are from California. The sample is lacking in diversity and a range of geographic locations. Another limitation to the study was the recruiting method and design. Participants were recruited through online list serves. I joined list serves and yahoo groups that

were specific to lesbians, mothers, or people of color. Therefore the recruiting method excluded people who do not use online list serves or yahoo groups and people who do not speak English.

Conclusion

The hope of this project is to contribute to a greater understanding of the experience of lesbian couples using fertility services. The findings are consistent with previous research on various areas of the process of using services, such as contributing factors in the decision making of choosing a donor. Findings that were not in the cited literature were the obstacles of using a known donor, supports needed, heterosexist practices within some fertility clinics and insurance policy's, and the way in which the experience impacted the relationship. The findings most importantly have highlighted areas for further research, advocacy work, and supports services needed. These are areas where social work can intervene.

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Appendix A

Approval Letter from Human Subjects Review



Smith College
Northampton, Massachusetts 01063
T (413) 585-7950
F (413) 585-7994

February 28, 2011

Sarah Williams

Dear Sarah,

Your revised materials have been reviewed and they are fine. We are happy to give final approval to this very interesting and useful study.

Please note the following requirements:

Consent Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your project. Don't undermine your good work by insisting on a 50/50 racial split. It just may not be possible.

Sincerely,

A handwritten signature in cursive script that reads "Ann Hartman".

Ann Hartman, D.S.W.
Chair, Human Subjects Review Committee

CC: Pearl Soloff, Research Advisor

Appendix B

Recruitment Email

Hello,

My name is Sarah Williams and I am a graduate student from Smith College School for Social Work. I am currently conducting research for my masters thesis exploring the experiences of lesbian couples who are using, have used, or attempted to use fertility services between 2003 and 2011.

Participation criteria include the following: Lesbian self identified women, who is using, has used, or attempted to use fertility services between 2003-2011, age 18 and older at the time of use of services, in committed lesbian relationship at the time of using services, and used services in the United States.

I want to hear your voice, your experience, your story, your strengths, and difficulties throughout the process of using fertility services.

Participation includes completing one online survey. If you are interested in participating in this study, please follow the link below to the online informed consent form and survey.

If you know someone who you think may be interested in participating in this exciting lesbian reproductive rights advocacy research, please pass along this email.

If you have any questions please feel free to contact me at (email address).

Thank you,
Sarah Williams

<https://www.surveymonkey.com/s/6SSVVDD>

This research is advised and supervised by:

Smith College School for Social Work, Lilly Hall, Northampton, MA 01063

Appendix C

Informed Consent

Dear Potential Research Participant:

My name is Sarah Williams and I am a MSW student at Smith College School for Social Work. Thank you for taking the time to consider participating in my online survey. The purpose of my study is to explore the experiences of lesbian couples who have used, attempted to use, or are using fertility services. I am conducting a qualitative research study and survey questions are designed to understand your experience using fertility services. This research is being conducted as part of the thesis requirements for my Master of Social Work degree at Smith College School for Social Work, future presentations, and possible publication.

In order to participate in the study I ask that you meet the following criteria: You are a self identified lesbian woman, have used, are using or attempted to use fertility services between 2003-present, you used services in the United States, were 18 and older at the time of use, and were in a committed relationship at the time of using fertility services. Participant involvement includes completing an online survey individually or with your partner which includes demographic information including race, ethnicity, income, and geographic location at the time of using services and questions regarding your experience of using fertility services. Demographic information is required to assess for diversity, however all other questions are voluntary. Only one survey per couple should be completed. The survey will take approximately 45 minutes.

A potential risk of participating in this study may be that during the process completing the survey you may encounter some difficult emotions and/or feel triggered by the exploration of your experience. You may withdraw from the study and or I will also provide a list of resources. You will receive no financial benefit for your participation in this study. However, you may find it beneficial to share your personal experience and contribute to research that may benefit therapists' and service providers working with lesbian women using fertility services and or be used as a tool for lesbian reproductive rights advocacy.

Your survey responses and identity will be anonymous. No names or email addresses will be collected. The anonymous survey responses will be shared with my research advisor. The general summary of data collected may be used for presentation among the Smith College School for Social Work community, for my MSW thesis and for possible publication. Any potential identifying information in quotes or vignettes will be disguised when presented and in the final thesis write-up. All data will be stored in a secure file for a minimum of three years as required by Federal regulations. After three years all information will be destroyed unless needed in which case it will continue to be kept secure and it will be destroyed when the data is no longer needed.

Participation in this study is voluntary. Demographic information is required however you may refuse to answer any other question. At any point before you submit your data, you can choose to withdraw from the study. Once you have submitted the survey you will no longer be able to withdraw due to the survey being anonymous. After submission, there will be no way to

separate your data from the group as a whole. If you have any concerns about your rights or about any aspect of the study, I encourage you to contact the Chair of the Smith College School for Social Work Human Subjects Review Committee at (413) 585-7974. You are also encouraged to contact me with any questions or concerns at (email address).

Thank you for your time and willingness to participate in this study.

Sincerely,
Sarah William

BY CHECKING “I AGREE” BELOW YOU ARE INDICATING THAT YOU HAVE READ AND UNDERSTAND THE INFORMATION ABOVE AND THAT YOU HAVE HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

Appendix D

Survey

Thank you for your interest in my research. The purpose of this study is to explore the experiences of lesbian couples who are using, have used, or attempted to use fertility services.

1. Do you meet the following eligibility criteria?

- Self identified lesbian woman
- Are using, have used, or attempted to use fertility services between 2005-2011
- Age 18 and older at time of using services
- In committed lesbian relationship at time of using services
- Used services in the United States

The survey can be completed individually or as a couple. Please only submit one survey per couple. If you choose to complete the survey as a couple please choose one person to be the primary participant. Completing the demographic information is a requirement of the study to move onto the survey. All other questions are voluntary.

1. Primary Participant: What was your age at the time of using fertility services or age range if the process took more than one year?

2. What was your partner's age at the time of using fertility services or age range if the process took more than one year?

3. Primary Participant: What was your individual annual income at the time of using fertility services?

- Less than \$25,000 per year
- Between \$25,000 and \$50,000 per year
- Between \$50,000 and \$100,000 per year
- Over \$100,000 per year
- Other (please specify)

4. What was your partner's annual income at the time of using fertility services?

- Less than \$25,000 per year
- Between \$25,000 and \$50,000 per year
- Between \$50,000 and \$100,000 per year
- Over \$100,000 per year
- Other (please specify)

5. Primary Participant: What is your race/ethnicity?

6. What is the race/ethnicity of your partner?

7. In what city and state did you use fertility services?

1. What is one thing that you would like all people to know about your experience trying to get pregnant through using fertility services?

2. Who would you like this information disseminated to?

3. What is your story about trying to get pregnant?
4. Who tried to get pregnant?
5. Did you conceive a child using fertility services?
6. How old is your child or children?
7. What services did you use?
8. How did you decide what services, clinics, and or medical providers to use?
9. If you used a clinic or medical facility, did you both go to the clinic? Why or why not?
10. Did you feel comfortable or welcome in clinics as a couple?
11. Did you do everything at home? Why or why not?
12. What obstacles, if any, did you encounter throughout the process?
13. How did you overcome road blocks and obstacles?
14. What support systems did you rely on?
15. What support systems were not in place, if any?
16. What was the total cost of fertility services?
17. What insurance did you have at the time of using service?
18. Did insurance cover any portion of the cost? Why or why not? How much?
19. What kind of donor did you use?
20. Donor
21. Why did you use an unknown donor?
22. Do you know the sperm donor number? Why or why not?
23. Unknown Donor
24. Why did you use a known donor?
25. How did you meet and/or identify the donor?
26. How did the known donor fit in to the experience?
27. Known Donor
28. Did you experience any discrimination in the process?
29. How did the experience of using fertility services and trying to get pregnant affect your relationship with your partner?

Thank you for your time and interest in this research.

Appendix E

Resources

If this survey brought up difficult feelings surrounding your experience trying to get pregnant I have provided a list of resources in order to find support.

RESOURCES:

NASW National Association of Social Workers

<http://www.naswdc.org/resources/default.asp>

Centerlink: The Community of LGBT Centers

<http://resources.lgbtcenters.org/Directory/Find-A-Center.aspx>

GLBT National Help Center

<http://www.glnh.org/index2.html>

The American Fertility Association Therapist Network

http://www.theafa.org/resources/therapist_network/all

Appendix F

Messages from Participants

When asked the question, “What is one thing that you would like all people to know about your experience trying to get pregnant through using fertility services?” participants reported the following responses:

“Just keep trying. Try not to stress about it. Be honest with each other from the beginning and know how many times you are willing to try.”

“We learned you need to be really proactive and do a lot of research on your own. Don't just listen to the doctor when he says "trying for 12 months is normal." That data is based on straight healthy couples trying at home for free. Listen to your gut if you think you have a fertility problem, and don't waste your time and money on a Dr. who is not being your advocate. Also, we learned to plan breaks into our schedule from all the stress. After the failed adoption we went on a cruise. After 3 years of saving every penny and denying ourselves every fun thing, it was the best thing we could have done. To try to remember how to laugh and relax, and to remember your partner before all the fertility crap. That's the best way to survive such stress on your marriage.”

“To be aware that not everyone conceives easily (lesbian or not), and to be sensitive to the fact that others may be struggling with fertility when you are announcing a pregnancy.”

“I think just to be prepared emotionally. When it works, it is great. But when it doesn't, it's hard to cope with.”

“It's very hard, emotionally, but also a bonding experience and more than worth it.”

“I wish the forms asked if your donor was male and if not let you skip those sections.”

“I think it is important for people to understand the expense of using fertility services. We had a wonderful experience with our providers, however it was also a sad process in realizing the financial burden we carried due to being gay. Our insurance does cover fertility services for heterosexual couples that have proven fertility issues.”

“If you want to have kids using your own eggs start ttc earlier then we did....we had NO CLUE that by the time we were ready to have kids that there was less then a 5% chance of become pregnant even using ivf....we waited too long. of course though we then found out about donor eggs and cant imagine life without our boy/girl twins which are the loves of our lives.”

“I don't know that I have a special message for lesbians, if that's what you mean. Trying to get pregnant is hard. I have a straight friend who is going through it as well, and it's hard for her too. Our constellation of issues is different, but we're both on an emotional rollercoaster and don't really know when it's going to end. I never knew I had endometriosis. If I had known, maybe I would have pursued adoption from the start. But I am very healthy and I had no idea getting pregnant would be any problem at all for me.”

“Do your research and understand the process. Make sure you and your partner are comfortable with the doctors/clinic that you are working with during this process.”

“It was great, the process was easy once we got started.”

“I think that there are a lot of people who do not appreciate how much work, stress and money is involved in gay and lesbian couples trying to conceive, that we are all so invested in being parents, that our children are so cherished for this reason. When people want to say it is bad for kids to be raised in gay/lesbian households, I really wish they could understand how incredibly loved and well cared for these kids are. I also, I wish I could give advice on how to most effectively use the services, if I had only known that shelling out \$150 for a fertility monitor could have saved me thousands of dollars of insemination costs.”

“Have a wonderful support somewhere. Never go to appointments alone. Try to be heard.”

“Make sure that your partner really is on board with getting pregnant.”

“Be sure to find a clinic or facility that is clear about their commitment to lesbian couples. It makes it so much easier to never feel the slightest bit uncomfortable in the office.”

“I would recommend our sperm bank (pacific reproductive services) to everyone. I would also recommend saving up the money you want to use in advance and quitting once you've used that money. Don't start a family in debt; babies are expensive.”

“Don't wait to get help. Time is of the essence.”

“Speak up for yourself and do research on your options.”

“It is a very intense and long experience.”

“We found a reproductive endocrinologist who is smart and extremely supportive of lesbian couples! This has made this difficult process more possible.”

“For lesbians and single-by-choice women specifically, we really appreciated working with a sperm bank that treated that as a priority.”