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Lesbian women choosing motherhood: the journey to conception

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Lesbian women choosing motherhood: the journey to conception

Abstract

Increasingly, lesbian women are choosing to have children in the context of a same-sex relationship, and their journey to conception and on to motherhood involves a range of decisions that are unique to lesbian couples. While creating a de novo family is burdened with decisions, choosing to be parents was a deliberate and conscious decision made by lesbian women participating in our study. The findings presented in this article focus on choosing which partner would be pregnant, donor decisions, as well as methods of conception used by lesbian women participating in a qualitative study that examined the experiences of lesbian mothers in Australia. This article is not intended to be interpretive, but rather a description of the processes engaged by participants.

Keywords

lesbian, mother, de novo family, conception, alternate insemination, artificial insemination, self-insemination, in vitro fertilization, intra-uterine insemination, pregnancy, donor sperm

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Lesbian women choosing motherhood: the journey to conception

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Abstract

More lesbian women than ever before are choosing motherhood. Some of the decisions around how to achieve a pregnancy are both deliberate and unique to lesbian women. Choosing a known or unknown donor and which partner should become pregnant are two of those decisions explored here. A convenience sample of thirty (fifteen couples) self-identified lesbian women living in Australia participated in the study. In-depth semi-structured interviews, journaling and a demographic data sheet were used to collect data. For lesbian women, the journey to motherhood involves important decisions. Choosing a known or known donor and which partner in the couple will carry the baby are two such decisions. The participants generally decided which partner should carry a potential offspring based on her age, health

status and willingness to be pregnant. Decisions about donor status were driven initially by the women's feelings about donor contact with both themselves and the child and subsequently according to the method of conception chosen or required. Women choosing or requiring in vitro fertilization or intra-uterine insemination could choose a known or unknown donor. Participants choosing vaginal insemination had to use a known donor. There were some hazards identified with vaginal insemination; health risks and unwanted contact from the donor.

Introduction

More lesbian women are choosing to have children in the context of a same-sex relationship than ever before (Australian Bureau of Statistics, 2009; Buchholz, 2000; Gabb, 1999; Hequembourg, 2009; McCann & Delmonte, 2005; Wilton & Kaufmann, 2001). Thus, the terms 'mother' and 'lesbian' are no longer mutually exclusive identities (Reed, Miller, Valenti & Timm, 2011). The journey to conception and on to motherhood involves a range of decisions that are unique to lesbian couples (Renaud, 2007), for example, deciding which partner will become pregnant. Three key decisions to be made during this time include deciding on a known or unknown donor, choosing a method for obtaining suitable spermatozoa, and then choosing a method of conception. This paper will draw on the findings of an Australian study that explored the experiences of lesbian mothers creating *de novo* families to gain an insight into the issues and decisions around conception.

Background

The conventional ideology of 'family' is shifting from the traditional two-parent, heterosexual family to include varying permutations of individuals, including lesbian women and their children. Today, lesbian women have more options to create families than in the past (Ryan and Berkowitz, 2009). Subsequently, the decision to embark on motherhood is being made by increasing numbers of lesbian women in Australia (Rawsthorne, 2009). Lesbian families, sometimes referred to *de novo* families, consist of a same sex female couple and the children they have planned, conceived, birthed and are raising together. *De novo* families challenge the conventional idea of who constitutes a 'family' (Haines & Weiner, 2000). Likewise, Silva & Smart (1999) identified that 'family' 'can incorporate people with intimate connections

Lesbian women wishing to achieve pregnancy have several options available to them (McNair, Dempsey, Wise & Perlesz, 2002; Yager, Brennan, Steele, Epstein & Ross, 2010). The increasing accessibility of assisted reproductive technology (ART) makes conception for lesbian women far less complicated than ever before. Donor sperm can be used for various alternate modes of insemination, including vaginal insemination (VI), intra-uterine insemination (IUI) or invitro-fertilization (IVF). VI can be undertaken either in a medically supervised procedure in a clinical setting or as self-insemination (SI) in the home. Both IUI and IVF take place in a clinical environment. Whilst heterosexual intercourse is another option, this alternative is deemed

unacceptable by most lesbian women as it viewed as disrespectful to their identity (Baetens & Brewaeys, 2001).

The study

The findings presented in this paper focus on the methods of conception (MOC) used by lesbian women participating in a larger qualitative study that examined the experiences of lesbian mothers in Australia. Fifteen lesbian couples participated in the study. Recruitment occurred via lesbian publications, word of mouth and women's health services. The main purpose of the study was to explore the ways lesbian mothers construct mothering. Findings pertaining to heteronormative healthcare interactions and the role of the non-birth mother in lesbian couple families will be reported elsewhere. Data were gathered between March and August 2010 during in-depth semi-structured interviews that employed a story-sharing approach (Hayman, Wilkes, Jackson and Halcomb, 2012), journaling (Hayman, Wilkes and Jackson, 2012). Demographic data were collected including; age, length of time in their relationship and cohabitating, occupation, number of term pregnancies, the age of their child(ren) and their combined annual income. As well details of methods of conception and outcomes were collected. Data generated from the interviews and journals were analysed and coded using constant comparative analysis (Thorne, 2000). Through text analysis, four major themes were identified; becoming mothers, constructing motherhood, legitimizing our families and raising our children. This paper explores the

theme 'becoming mothers'. Demographic data were tallied and summarised; and conception data tallied and tabulated.

Prior to commencing data collection, ethics approval was gained from the relevant institutional Human Research Ethics Committee. Participation was voluntary; all participants provided informed consent and have been assigned a pseudonym in reports and publications to protect their privacy.

The findings

The participants

A convenience sample of 30 self-identified lesbian women, consisting of 15 couples, was recruited to the study. The age of the participants ranged from 28 to 58 years (mean 39.8 years). The couples had been in their relationship between 3 and 18 years (mean 9.6 years) and had been living together between 2.5 and 17 years (mean 9.0 years). Collectively the women had achieved 18 term pregnancies, producing 21 children, including three sets of non-identical twins. At the time of the study, the children were aged from two months to 10 years (mean 2.58 years). The couples combined family income ranged from \$AU23, 000 to \$AU400, 000 (mean \$AU118, 000).

This paper focuses on three themes and the quantitative data related to methods of conception and outcomes that relate specifically to the

participant's journey to conception. These themes are; i) deciding to be mothers, ii) sperm donor decisions and iii) methods of conception.

Deciding to be mothers

While most participants had always thought they would become mothers at some stage in their adulthood, others initially thought that their status as lesbian women would exclude them from motherhood. Tina shared, "I knew I was a lesbian from a fairly early age ... I assumed that children weren't part of that identity". Preclusion from motherhood based on sexual orientation was both internal and external. Participants generally excluded themselves from the prospect of motherhood believing that it was not possible for lesbians to have a family that included children or being unsure of how conception could occur given the obvious lack of spermatozoa available within the dyad. For this reason, lesbian couples trying to conceive (TTC) were required to engage in careful and deliberate planning and decision-making.

Social expectations, both within and outside the lesbian community, also placed reproductive restrictions on lesbian couples and essentially positioned them as childless. Jane said, "I'd built myself up as this lesbian who wasn't going to have children because that's not what lesbians do ... it was my [lesbian] identity I was going against [by choosing to have a child]". Families sometimes struggled with their daughter's disclosure of sexual orientation and subsequently assumed they would not be provided with grandchildren (from

their lesbian daughter). Petra shared that her "...family were a bit more different and a bit wary and I think it was more about what other people would think" . Those outside the family also made assumptions about the lesbian couple, speculating that they would be childless. Sometimes these suppositions were made based on history (previously lesbian women were less likely to have children in the context of their lesbian relationship) and on other occasions, the assumptions were derived from negative judgements about a lesbian couple's ability to successfully parent their children. Dana shared that "We did talk about, how is the child going to be received, like socially? Like is the child going to suffer because we want to have kids".

The lesbian community can also be harsh in its judgement of lesbians choosing motherhood because lesbian motherhood can be regarded extraneous to authentic lesbian culture. Sam confirmed this stating "there are a proportion of the lesbian community who are very anti-children". Some participants discussed their experience of rejection from parts of their local lesbian community because of their choice to have children.

Despite external and internal expectations about lesbian motherhood, participants in our study chose to become mothers in the context of their same-sex relationship. All participants disclosed lengthy discussions, sometimes over several years, prior to making the decision to have a child together. Jane stated, "We talked about it for a year or a year and a half with them [their potential donor] before we decided to go ahead. It would be part of

everyday conversation; every time we saw them and we'd discuss different things". Another couple described discussing the possibility of having a child together for over ten years. The topics of discussion were around, who would become pregnant, the role of the non-birth mother during conception, pregnancy and her future parenting role, known and unknown sperm donors, accessing sperm, and MOC.

While some of the decisions that lesbian couples make are not dissimilar to those made by heterosexual couples, one of the most obvious differences is the choice about which partner will be pregnant. This decision was made by participants based on the age and health status of each woman as well as the individual desire to be pregnant and ability to conceive. Billy, who embraced a butch lesbian identity said, "I'm not the feminine or maternal one". This was predominantly experienced by participants who identified their relationship as a butch-femme dynamic where each partner is essentially more masculine or feminine according to the commonly accepted social expectations of male and female gender roles. For these couples, the femme identified woman was the natural choice for child bearing within the relationship. Gemma said that her more feminine partner "had expressed more of a desire to carry the child. I said I would if she couldn't, but I didn't have that strong desire to actually carry the child, for it to have my biological make-up". Women identifying as butch did not recognize child bearing as part of their role within their relationship and some completely rejected the idea despite their physiological capacity to conceive.

Participant dyads that did not identify butch-femme roles or identities tended to make their decisions about conception based on factors such as age and health status. Some participants were aged over 45 years and felt that pregnancy was too risky for themselves and the child. Other younger couples identified that while their age was not necessarily a barrier to a healthy pregnancy, the younger partner would be less likely to experience health problems associated with pregnancy. One couple however decided that the older partner (Jessie) would TTC as she was reaching menopause and felt that her “time was running out”.

The health status of each partner was a major factor in deciding which woman would TTC. For example, in one dyad, the older partner had a history of cervical cancer and had been told that she would not be able to carry a pregnancy to term. Subsequently, it was decided that the other partner would TTC. On the other hand, one participant aged in her 20s had experienced severe health problems and had been told by her doctor that a pregnancy was a significant health risk for her. She proceeded with TTC as her partner was in her late 50s and therefore unable to conceive and she had a deep desire to be a mother.

Finally, the decision to establish which woman in the couple would TTC was sometimes determined by ability to conceive. For two couples, one partner

had tried to conceive on many occasions and had not been able to achieve pregnancy. Fran stated that “We had a lot of failed attempts and stuff in the beginning ... so it took us quite a while”. In this situation, the participants decided that the partner should TTC.

Sperm donor decisions

Participants explained that they engaged in meticulous research to identify ways of accessing sperm, the pros and cons of known and unknown sperm donor status and various MOC. One participant stated that she researched these areas “within an inch of my sanity” (Lilly). Information was accessed via a combination of; conversations with friends, internet websites and medical consultations. Participants spent time talking with lesbian friends, and in particular, friends who had had children in the context of their lesbian relationship. Websites were accessed as a resource for finding information about donors and MOC. Several couples made appointments with general practitioners, specialists and fertility clinics to seek information about MOC. Sam stated that, “the clinic gave us a very comprehensive package on what we’re about to go through”. Such extensive research allowed participants to be well equipped to decide which woman would TTC. The next decisions focussed on choices about sperm donation and then MOC.

Choosing a known or unknown sperm donor was a major decision for the participants. Together, the couples deliberately and purposefully debated the

benefits and limitations of either a known or unknown donor. Participants choosing a known donor ($n = 18$) fell into two groups. The first group consisted of participants who initially chose a known donor that they engaged for the sole purpose of sperm donation (ie no ongoing relationship with the mothers or the child) ($n = 13/18$) while the second group chose a donor with whom they had regular contact and an ongoing friendship/relationship ($n = 5/18$). In this latter group, the participants chose friends or relatives. Where a relative was chosen, he was the brother of the non-birth mother ($n = 2/18$). Where friends (rather than relatives) were chosen, the father engaged in a parenting role ($n = 2$). Participants choosing the brother of the non-birth mother stated they established a biological link between the child and non-birth mother. This was considered important as it was viewed as a means to strengthen and validate the position of the non-birth mother as a legitimate parent and promote social recognition of her maternal identity. One participant of a couple who chose a known donor who was a relative of the non-birth mother said that, "I think the idea that this child is related to both of us is very important". Another couple (Kelly and Rosie) who also chose a relative of the non-birth mother as their donor expressed the importance of their child having the non-birth mother's genetics. This represented a need to promote a biological tie between the non-birth mother and the child. One participant expressed a definite preference not to use known donor sperm and stated that, "I think for us there was just a little bit of uncomfortableness about friends or acquaintances offering sperm, and I just said, that's too messy for me".

All participants choosing a known donor did so because they felt it was important that the child be able to make contact with their donor in the future. Jade said, “we did want it to be someone who I guess we could point to and say that’s where I’ve [you’ve] come from ... so it wasn’t for us that we made the decision for a known donor. But just for him, if that was ever to be an issue, he could easily find out where he came from”. Hannah also stated that, “Having them [the donor] be known was something we talked about a lot. In the end we agreed that it was an important thing for them [the children] to have that choice when they were old enough”. Most participants ($n = 13/18$) choosing a known donor also expressed that the importance of their child having the option of contacting their donor in the future was an important factor in knowing the donor. Sarah noted “Like he’s our son; like I said that he [their known donor] is an uncle figure; he plays the uncle role so there is no financial involvement and no decision making and nothing like that involved, he’s just like an uncle”.

Participants choosing an unknown donor did so because they felt strongly that they wanted no donor involvement in the parenting of the child. Participants expressed concern that a known donor could stake a claim to the child in the future and by choosing an unknown donor, this was less likely to occur. Sally shared that, “a fear of mine is having a known donor because I feared that the gentleman in question may come back say 12 or 13 years down the track and say, “Oh, he’s a lovely young boy, he’s my son ... and have any sort of right of ownership. That was a big fear from me”. One couple went so far as to deliberately choose a donor from overseas, as this was perceived as further

limiting potential donor access to the child and the likelihood of unwanted contact. Jane said, “We wanted to make sure that he knew that it was going to be our child, not part of – like not his child. That any decisions that were made were ours”. In some ways this decision was also seen to protect the parental position of the non-birth mother. Additionally, choosing an unknown donor meant that conception would occur in a clinical environment and with this came increased health safety. Participants choosing SI assumed some risk of contracting STIs, while couples using IUI or IVF were afforded the peace of mind that semen had been tested and quarantined for six months prior to use, thus significantly reducing the risk of disease transmission.

In addition to deciding whether or not they wanted to know the donor, participants expressed the importance of accessing information about a prospective donor. Firstly, participants tried to choose a donor that matched the non-birth mother’s physical characteristics, for example blue eyes. Unlike birth mothers who are privileged with automatic mother status, non-birth mothers are often excluded from their maternal position and identity because they do not have a biological tie to their child (xxxx: under review). Choosing a donor with similar physical characteristics to the non-birth mother offered the possibility of the child having similar physical features (for example, blue eyes) as the non-birth mother and was perceived as a way of emulating a biological tie and was subsequently perceived to strengthen her mother position (xxxx: under review). Second, the participants explained that it was important to be able to access medical information about a potential donor and his family. In particular, participants preferred a donor who was healthy

and whose family did not have any known serious, hereditary health conditions.

Methods of conception

The decision to use a known or unknown donor was also important in terms of its impact upon the MOC. This is primarily because choosing an unknown donor limits the MOC options to IUI or IVF. Choosing a known donor meant that VI (SI or medically supervised), IUI or IVF could be used for conception. Table 1 illustrates participants' choices about donors and methods of conception. Couples choosing a known donor tended to opt for VI initially at least, while couples preferring unknown donor status tended to use IUI or IVF.

Vaginal insemination

The participants talked at length about how they planned to inseminate at home and researched the process of VI via the internet and through discussions with friends. Participants TTC then charted their menstrual cycle and some measured and recorded vaginal temperature and most started pre-natal supplements to prepare for pregnancy. Lilly said "I had been checking my cycle beforehand so testing with the thermometer and stuff so that when we did decide to begin that I knew when was the right time". Of the 18 women, 12 chose VI as their first preference for conceiving. Of those women, six (50%) achieved pregnancy, all conceiving on the first attempt. The other

six had a total of 60 attempts (range 1-18) at conceiving via VI and then moved onto IVF ($n = 5$) or IUI ($n = 1$).

Three participants inseminated on their estimated ovulation day as well as the day before and after, while all others inseminated only on their ovulation day. The participants who inseminated multiple times in one cycle anticipated this would increase their chances of conceiving. Jane shared, "... we did it a day or two days before and [on] the day and the day later [after ovulation] ..." On most occasions, the non-ovulating partner travelled to collect the sperm from the donor at his home. Fewer participants organised for the donor to deliver the sperm to their home and one couple lived in the same home as their donor. Ellie said, "[Josie] jumped in a car and went, drove, picked it up, put it in her bra to keep it warm! And it's in a sock, he put it in a sock because he thought it would keep the specimen jar warm! Then she put it in her bra and drove it back and we put it in a 10ml syringe ..."

Inseminated participants engaged in post-insemination activities such as leg and buttock elevation for thirty minutes to promote movement of sperm into the uterus. About half the participants waited until the first day of a missed period to do a pregnancy test. The others started testing as soon as five days after insemination and Patty shared that, "We bought pregnancy tests in bulk and just about every time I went to the toilet I was using one" and Erin added,

“I could never wait for their results. I was always too eager to know”. The participants, who did not conceive on the first attempt, described a roller-coaster of emotions. They expressed feelings of guilt, disappointment, frustration and sadness each time they discovered they were not pregnant. Renee shared that the process was “very draining ... became mechanical in the end ...living fortnight to fortnight [and] ... in the end we had given up. We were just exhausting our egg supply before we moved on with our lives”. Most participants were TTC without people close to them knowing and this meant that they had limited options for sharing these feelings and accessing support. One of the benefits of TTC with the assistance of a fertility clinic was seen to be the access to support and information that may not have been available to participants using VI at home.

Intra-uterine insemination

Of the couples who were not able to conceive using AI, one then tried using IUI and was successful after six attempts. Five participants chose IUI as their first preference of MOC. Of those, three conceived and two then attempted IVF. The three participants who conceived using IUI had a total of five attempts (range = 1- 6). Of the participants choosing IUI as their first choice of MOC, four ($n = 80\%$) used sperm from a known donor. Participants opting to use an unknown donor engaged a process of donor selection that included examining the profiles of potential donors. Profile information included age, race, education and occupation, health and physical characteristics.

Participants choosing IUI as their preferred MOC, whether using a known or unknown donor, were interviewed by healthcare staff and counsellors in a fertility clinic. As a couple, their perceived ability to parent children was assessed and the woman TTC had various blood tests and health checks. Jill shared that, “ before they would see us and start taking the initial tests and screenings ... all the ethical dilemmas came up in the counselling session to make sure we were 100% knowing what we were doing and what we were in for”. For participants choosing an unknown donor, the sperm had already been collected, tested and stored at the clinic. Where participants chose a known donor, arrangements were made for the donor to visit the clinic to donate the sperm and have some blood tests. Millie said their donor “went to the clinic and had tests and donated sperm and dah, dah, dah. Waiting time!” In this situation, the sperm was quarantined for six months, after which time, the donor returned to have further blood tests to rule out infections that may not have been evident in the initial blood tests. The participants stated that waiting the six months was often difficult and that once they had made the decision to have a baby and chosen a donor, they were really keen to start the process. While increased health safety was achieved by using IUI, the disadvantage was waiting the mandatory six months to start insemination. Toby confirmed “in that time, the IVF clinic in [city] allowed us to store the father’s sperm, which was a bit exceptional because it wasn’t in law that we would be allowed. But it has to be stored for six months to be able to be used”. Fertility clinic staff monitored the participant TTC to identify ovulation and carried out IUI at that time. Pregnancy testing was carried out two weeks later to determine the success or failure of the insemination.

In vitro-fertilisation

None of the participants chose IVF as their first preference for MOC. This is largely because of local regulations governing women who are eligible to access fertility services. Until recently women had to have a medical diagnosis that reduced their capacity to conceive to qualify for fertility treatments such as IUI and IVF. Some participants were precluded from fertility clinics because they were deemed 'socially infertile' rather than having a genuine fertility problem. Jane confirmed, "... it's only been since January that you can be a fertile lesbian and get access to IVF in [city]. Before that you couldn't be socially infertile which is what they called it, to access it". Three couples travelled interstate, where regulations allowed lesbian women to access fertility treatment. Several participants were able to establish a diagnosis (polycystic ovary syndrome) which meant they were able to access fertility treatment locally on medical grounds. Kelly stated, "We had tried at home for a little while, just artificial insemination at home and that hadn't been successful ... he [obstetrician] just said yeah you've been trying it hasn't worked, you'll have to go straight onto IVF." The remaining participants attempted pregnancy via AI or IUI at first to demonstrate a fertility problem that would in turn make them eligible for medicare-subsidised treatment via a fertility clinic.

The seven participants who conceived using IVF had a total of 32 embryo transfers. Whilst two participants conceived on the first attempt at IVF, the

range of attempts was 1-10 to achieve a pregnancy. Of the participants who conceived using IVF, five (71.4%) used sperm from a known donor.

Discussion

Creating a *de novo* family is burdened with decisions. Choosing to be parents was a deliberate and conscious decision made by lesbian women participating in our study. Choosing to be mothers in a heteronormative societal context poses many challenges for lesbian women. Heteronormativity marginalises and silences lesbian women in many aspects of their lives including their reproductive choices (Osche, 2011). The journey to conception for lesbian mothers is “multilayered and complex” (Chabot & Ames, 2004, p. 348), fraught with challenges (Oswald, 2002) and requires “a great deal of planning and preparation” (Kranz & Daniluk, 2006, p. 17). While there are many options available to lesbian women who want to have children (Kranz & Daniluk, 2006), the initial decision to become parents was not always easy for participants. Of equal difficulty were decisions around which woman in the partnership would TTC, sperm donors and methods of conception. Every stage of the journey was debated and discussed and each decision was made deliberately (Chabot & Ames, 2004; Kranz and Daniluk, 2004; Touroni & Coyle, 2002).

A circumstance unique to a lesbian couple is the option of choosing which partner would TTC. This decision was generally made based on the age and

health of each woman as well as desire to be pregnant. For some participants, pregnancy was not at all appealing and furthermore they did not see it in any way as part of their role in terms of their gender identity within their lesbian relationship. This was particularly so for the participants identifying as butch lesbians. Chabot and Ames (2004) also revealed that participants in their study of lesbian mothering decided which woman of the couple would TTC based on a variety of factors and in particular, the age of each woman. These authors uncovered an additional factor that was not identified by participants in the current study, that is, whether the women were 'out' to their families of origin. Chabot and Ames (2004) identified that if women were not 'out' about their sexual orientation to their families, then it would be more difficult for them to be pregnant. This added another layer to the already complex process of decision-making for lesbian women wanting to conceive using donor sperm. All participants in our study were 'out' about their sexual orientation with their families.

Vaginal insemination is a MOC that has been used by lesbian women since the 1970s (McNair, Dempsey, Wise & Perlesz, 2002) and it was the preferred first choice of MOC for most participants in our study. VI was chosen by participants primarily because they wanted to use a known donor. McNair et al. (2002) identified that participants in their study chose a known donor so that the child could have the option of finding out about their "biogenetic heritage" (p. 44), it met their desire to have a non-medicalised conception and allowed the non-ovulating participant to be involved in conception. These factors were also voiced by the participants in our study as reasons for

choosing SI. One of the challenges of SI that was identified both in our study and by Nordqvist (2011) is the need to access and use sperm in a timely fashion, that is, while it is still mobile. Participants in our study were acutely aware of the urgency required to increase the likelihood of successful conception, and as such shared that they hurried to inseminate as soon as possible after the sperm was obtained. The participants in our study also identified that the non-medicalised nature of SI meant that participants were not required to interact with healthcare providers and this subsequently meant that they avoided anticipated homophobia and heteronormativity (xxxx: under review).

In our study, fewer participants chose a MOC that required medical intervention (for example, IUI or IVF). Participants made this choice because they preferred an unknown donor, had been unable to conceive using other MOCs and/or valued the health safety afforded to them by the clinical environment. McNair et al. (2002) found the participants in their study expressed the same reasons for choosing IUI or IVF. Similarly, Nordqvist (2011) highlighted the health risks associated with VI. Choosing which woman should try to conceive, whether to have a known or unknown donor and which MOC to use are all important decisions that participants consciously and deliberately made on their journey to motherhood.

Conflict of interest statement

There are no conflicts of interest to declare.

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