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UNIVERSITY OF NORTHERN COLORADO

Greeley, Colorado

The Graduate School

QUEERING FERTILITY: EXPERIENCES OF
QUEER/LESBIAN PEOPLE UNDERGIONG
FERTILITY TREATMENT IN A
HETERONORMATIVE
SOCEITY

A Thesis Submitted in Partial Fulfillment
of Graduation with the Degree of
Master of Arts

Caitlin Ortis

College of Humanities and Social Sciences
Department of Sociology
Sociology: Thesis

December 2019

This Thesis by: Caitlin Ortis

Entitled: *Queering Fertility: Experiences of Queer/Lesbian People Seeking Fertility Treatment in a Heteronormative Society*

Has been approved as meeting the requirement for the Degree of Master of Arts in College of Humanities and Social Sciences in Department of Sociology in Program of Sociology: Thesis

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ABSTRACT

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Due to the increase in lesbian, gay, bisexual, transgender, queer, and other (+) (LGBTQ+) people seeking fertility treatments or the “Lesbian Baby Boom” (Amato & Jacob, 2004; Batza, 2016; Dunne, 2000; Simon et al., 1993; Mamo, 2013), in which 30% to 50% of women who identify as lesbians hope to become parents (Amato & Jacob, 2004), it is necessary to examine the relationship between a person’s sexual orientation and her experiences receiving fertility treatments. While fertility treatment from a heterosexual perspective has been studied at length, few studies have examined how LGBTQ+ people are treated in fertility clinic settings. In order to determine what role, if any, that sexual orientation plays in the treatment of LGBTQ+ people undergoing fertility treatment, this research analyzes 14 qualitative interviews of LGBTQ+ couples (22 participants total) who have undergone fertility treatments. Using both queer and feminist theoretical perspectives, this study demonstrates the ways that the larger hegemonic systems such as the heteronormative society and healthcare system of the United States, are reinforced through fertility clinic spaces and their non-inclusive policies and procedures. Lastly, this study highlights the ways in which LGBTQ+ people face marginalization in healthcare spaces, looking specifically at how that marginalization occurs in fertility clinics through the narratives of the participants.

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I dedicate this paper to all LGBTQ+ individuals who have felt invisible, ignored, or mistreated by their care team at a fertility clinic, or felt that their parenting capabilities were questioned because of their sexual identity. I see you, you are not alone, you are worthy of this journey.

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CHAPTER I

INTRODUCTION

Because of the “Lesbian Baby Boom” (Amato & Jacob, 2004; Batza, 2016; Dunne, 2000; Simon et al., 1993; Mamo, 2013), in which 30% to 50% of women who identify as lesbians hope to become parents (Amato & Jacob, 2004), it is necessary to examine the relationship between a person’s sexual orientation and her experiences receiving fertility treatments. For the purposes of this study, the sample not only included cisgender women who identify as lesbians, but also included non-binary, gender non-conforming, and transgender individuals, as well as women who identify as queer, pansexual, hetero-flexible, bisexual, and polyamorous. Specifically, I wanted to know in what ways, if any, does sexual orientation play a role in the experiences of Lesbian, gay, bisexual, transgender, queer (LGBTQ+) couples who are receiving fertility treatments/assisted reproduction? (See Table 1 for a full list of acronyms used throughout this paper).

This question, aimed directly at the experiences and narratives of queer couples, examined the larger social issue of the marginalization and oppression of queer folks within a healthcare system that reinforces heteronormativity (Hayman et al., 2013; Ingraham, 1994; Kitzinger, 2005; Nordqvist, 2008; Rich, 1980; Schilt & Westbrook, 2009). By exploring the narratives of queer couples who have undergone fertility treatments, this research utilized queer and feminist theoretical frameworks to challenge

and critique the oppressive system that is heteronormativity, deepening the existing literature about the marginalization of queer people within our (US) society.

Looking not only at the narratives of queer couples from a heteronormative lens, but also at other contributing factors, such as access to healthcare and fertility treatment for both queer and heterosexual couples, revealed the ways in which fertility clinics contribute to the marginalization of queer folks. As Amato and Jacob (2004) pointed out, the number of lesbian women seeking to become parents predicts an increase in the number of queer people seeking fertility treatments. Because we know that queer individuals already experience systemic oppression via the heteronormative healthcare system (Hayman et al., 2013; Malmquist & Nelson, 2014; Meer & Müller, 2017), it stands to reason that they would also experience this oppression when seeking fertility treatments. Based on what we already know about queer individuals' experiences throughout the heteronormative healthcare system, it was important to inquire if individuals experience discrimination or marginalization while seeking fertility treatments in order to move toward a more inclusive healthcare system (Epstein, 2017; Malmquist & Nelson, 2014).

This project extends current literature by taking an intersectional approach, meaning I took a close look at how different identities such as gender, sexuality, and socioeconomic status all factored in to how queer people experienced their identities in relation to receiving and accessing fertility treatment and healthcare (Massaquoi, 2015; Crenshaw, 1991). According to Massaquoi (2015) intersectionality is a complex theory, but combining it with queer theory, creates a new and necessary perspective, bridging the two theories. Lacombe-Duncan defines intersectionality as “a critical social theory that

allows for an understanding of how multiple social identities intersect at the microlevel...to enact systems of privilege and oppression” (2016:1). She explains that studies that utilize an intersectional approach in understanding queer healthcare access, encourage the researcher to “engage with themes related to macrolevel oppression” (2016:1) (in this case, heteronormativity), and how those themes translate the experiences of queer people in healthcare settings (for the purposes of this question, fertility clinics). An intersectional approach to this research further facilitated the exploration and acknowledgement of multifaceted layers of identity, and how hegemonic ideals of heteronormativity within healthcare contribute to the systemic oppression of queer folks. In order to fully understand the ways in which the healthcare system operates as a system of oppression, I needed to examine other facets of identity such as gender and sexual orientation.

I utilized a queer theoretical lens in approaching the question (Butler 1993; Ingraham, 1994; MacKinnon 1983, Rich 1980). Queer theory, developed from feminist theory, focuses on heteronormativity and how heterosexuality is positioned within society as dominant and normative, and how that normativity harms queer individuals. Previous research on queer fertility treatment and queer healthcare relies heavily on queer and feminist theory (Mamo, 2013); and while there are pieces of intersectionality within the research, the concept or theory itself is not named, discussed, or analyzed directly. Intersectionality plays a fairly large role in the heteronormativity of the healthcare system, and I used this framework to examine the ways in which power, privilege, and oppression showed up for queer couples who were seeking and undergoing fertility treatments.

Through the theoretical lenses of queer and feminist theory, I was able to analyze the larger sociological implications and social issues that exist and are further reinforced or demonstrated by the treatment of queer people within fertility clinics and of queer people within the healthcare system. Because of the way that queer theory challenges heteronormativity, I was able to analyze the data collected and reach a conclusion about the ways in which heteronormativity is reproduced in fertility clinics. With the formulation of the research question, topic, and results, I utilized existing literature about fertility treatment/assisted reproductive technology to further validate my findings for comparative value. In exploring the treatment and marginalization of queer people in healthcare, I was able to demonstrate how a heteronormative approach to healthcare and fertility contributes to the systemic marginalization of queer folks.

Table 1. List of Acronyms

Acronym	Meaning
LGBTQ+*	Lesbian, gay, bisexual, transgender, queer, and others (+)
IUI	Intrauterine Insemination
IVF	In-Vitro Fertilization
HSG	Hysterosalpingography
ART	Artificial Reproductive Technologies

*This acronym is not inclusive of all queer identities

CHAPTER II

LITERATURE REVIEW

Existing literature exploring the link between sexual orientation and how a person is treated when receiving fertility treatment is limited. To explore this area of research, I will be using literature about LGBTQ+ healthcare and fertility treatment (including access to and experiences with), the systemic oppression of queer folks within a broader societal context, queer and feminist theoretical framework; in which I will rely heavily on heteronormativity, which is a foundational point within queer theory. There are several existing conversations to which my research contributes, including research about LGBTQ+ healthcare, fertility, and heteronormativity.

HETERONORMATIVITY

Heteronormativity, closely related to heterosexism, is defined as “an ideological system that denies, denigrates and stigmatizes any non-heterosexual form of behavior, identity, relationship, or community” (McDevitt et al., 1993:89). This societal prejudice operates against queer people in the larger social structures and institutions of society (O’Brien, 2001) and consists of the “set of ideas, norms, and practices that sustain heterosexuality and gender differentiation and hierarchy, including romantic love, monogamy, and reproductive sexuality” (Hopkins et al., 2013:98). Heteronormativity is something that queer folks seeking fertility treatment must combat due to heterosexual assumptions by the medical community in which they are engaged (Hayman et al., 2013). In US society today, battling heteronormativity and heterosexism is more challenging as

many believe we are in a post-homophobic society, after the country wide legalization of gay marriage (Hayman et al., 2013). Because of this post-homophobic viewpoint, people tend to focus on how queer couples are similar to heterosexual couples, instead of acknowledging the unique set of challenges queer couples face.

As a term or concept rooted in queer and feminist theory, it is important to note that the conditions of our patriarchal and heteronormative society are more closely related to institutionalized heterosexuality (heteronormativity) than gender (Ingraham, 1994). In this study, I aim to answer my research question primarily from the perspective of sexuality as opposed to gender, which most of the previous literature does not do. However, it is integral in our understanding of the findings that we look at the relationship between heteronormativity and gender.

LGBTQ+ HEALTHCARE

Existing literature regarding LGBTQ+ healthcare can be broken down into many subthemes. For the purposes of this research study, I closely examined how people who hold queer/LGBTQ+ identities, experienced their identities within healthcare spaces (Meer & Müller, 2017). Specifically, I looked at the microaggressions that participants experienced, and was able to determine if the practices of the providers reflected incompetencies in understanding and treating people who hold queer identities. The participants reported experiences of homophobia and related discrimination. Researchers have found several incompetencies within the healthcare system when dealing with those who hold queer identities, which result in the perpetuation of heteronormativity (Hayman et al., 2013; Malmquist & Nelson, 2014; Meer & Müller, 2017). The relevance to heteronormativity within my research is that according to Smith and Turell (2017),

heteronormativity results in LGBTQ+ people experiencing feelings of discomfort while accessing different forms of healthcare, due to a various range of behaviors committed by healthcare staff ranging from microaggressions to blatant homophobia. Because of this, LGBTQ+ people may withhold information from their healthcare providers, directly affecting the level of care they receive, or may resist seeking any form of healthcare all together (Bonvicini & Perlin, 2003; Cant, 2006, Smith & Turell, 2017).

Along with heteronormativity in the literature about LGBTQ+ healthcare, is homophobic attitudes or treatment from professionals within the healthcare system (Jowett & Peel, 2009; O'Brien, 2001). Jodi O'Brien (2001) discussed that even though the overall acceptance and attitudes toward homosexuality in modern day American culture has increased, heterosexist assumptions still drive homophobic, hateful attitudes towards queer people, and that homophobia is institutionalized through social systems, including the healthcare system.

Queer individuals constantly have to navigate the healthcare field from a place where their identity is at the forefront, as there are limited spaces in which queer people can access the healthcare they need without their health and wellbeing being potentially compromised by experiencing microaggressions and other form of bias (Meer & Müller, 2017; Hayman et al., 2013; Smith & Turell, 2017). Hayman et al. (2013) discussed the specific types of homophobia and microaggressions that lesbian women experience when seeking healthcare services, including exclusion (physical environment of office has no media portraying queer couples), the assumption of heterosexuality (health care providers and staff perceiving client as straight, automatically referring to a woman's 'husband' when the woman actually has a wife), asking inappropriate questions (questions about

how a queer couple has sex, or conceived a child), or even being refused services altogether on the basis of sexual identity.

Not only are ‘sexual minorities’ frequently experiencing homophobia from healthcare providers, but they also often engage in higher risk behaviors (for example, not having health insurance), and experience generally worse health outcomes compared to heterosexual people (Durso & Meyer, 2012). Durso and Meyer (2012) also found that LGBTQ+ patients who chose not to disclose their sexual orientation to their providers, had poorer psychological well-being after their encounters with their healthcare provider. Smith & Turell (2017) found that when elements of identity are withheld from healthcare providers, LGBTQ+ people experience increased levels of stress during healthcare encounters, and the quality of care is compromised, specifically when those elements of identity are necessary tools for diagnosis and treatment.

Rossi & Lopez (2017) further discussed LGBTQ+-based competency within healthcare. They found that healthcare providers struggled with identity-based terminology relating to queer identities, including those specifically related to gender identity and sexuality. Because of the care provider’s lack of training and personal prejudices, their lack of use of inclusive language facilitates incompetence (Rossi & Lopez, 2017). Researchers found that competency on the end of the provider is reached when they develop an understanding of vocabulary and familiarize themselves with LGBTQ+ associated issues, use language preferred by patients, “create an inclusive healthcare environment such that the influence of personal biases does not negatively impact care” (Rossi & Lopez, 2017), and are able to separate their personal beliefs from their professional role.

This relates to the larger topic at hand: the marginalization of queer individuals through a heteronormative healthcare system.

Looking at research regarding how queer people are treated in healthcare environments provides narratives that are important in determining where issues lie within the system, as it is only then that we can work to make improvements. McCabe and colleagues say that the “maintenance of heteronormativity is often carried out through microaggressions, defined as messages that communicate hostile, derogatory, or negative slights directed at marginalized groups” (McCabe et al., 2013:10). They explain how microaggressions are brief, can be intentional or unintentional, and occur so frequently that many people may not be able to identify the event as discrimination (2013). The ways in which queer people experience microaggressions in healthcare environments demonstrate how the overall heteronormativity of the healthcare system contributes to systemic marginalization. Because of this existing research on the heteronormativity in the healthcare system, I was expecting to find that heteronormativity exists within fertility clinics in addition to the system as a whole.

LGBTQ+ FERTILITY

There are specific issues related to access to fertility treatment, for both lesbian identifying women and heterosexual women (Batz, 2016; Bell, 2010; Shanley & Asch, 2009). While the majority of assisted reproductive technologies (ART) are utilized by heterosexual couples struggling with some type of infertility, queer couples and single-moms-by-choice more frequently use technologies such as donor insemination, invitro-fertilization, surrogacy, etc. (Shanley & Asch, 2009, Bitler & Schmidt, 2012). Literature suggests that there needs to be a deeper analysis of under-studied populations that utilize

fertility or ART treatments, as well as the greater social policy questions involved in access to these treatments (Greil, 1997).

ACCESS

Access to fertility related healthcare can be looked at from three perspectives: access to affordable healthcare, the costs of fertility treatment, and queer access to fertility treatment (Bell, 2010; Bitler & Schmidt, 2012; Neumann, 1997; Shanley & Asche, 2009). Steinberg (1997) and Bell (2010), discuss how the medicalization of infertility and treatment, contribute to the regulation of sexuality and reinforcement of heteronormative ideas about the nuclear family. This ultimately results in social inequality amongst those seeking fertility treatment or assisted reproductive technologies (ART).

Aside from the legal protections put into place to protect queer individual's access to healthcare, in many cases queer people can still be denied. Fertility clinics vary in their willingness to provide treatment to unmarried heterosexual couples, gay couples, and single moms by choice (American Society for Reproductive Medicine, 2013). In addition to the systemic issues that cause many people who belong to marginalized communities to not be able to access health insurance, many insurance companies do not cover any treatment for fertility/infertility (Shanley & Asche, 2009). Bell (2010), states that it is the extremely high costs of infertility treatments, in addition to sparse insurance coverage, that prevents people from being able to access treatments like in-vitro fertilization (IVF). Only people who can afford to pay for the treatments will receive it. On average, one IVF cycle costs \$12,400 out of pocket (Bell, 2010; Taylor et al., 2008). Even in cases where coverage is mandated across insurance plans, it is still primarily privileged folks (white,

heterosexual, wealthy, educated) who are accessing such treatments (Bell, 2010) due to the high cost of treatment and the systemic barriers that prevent people who hold multiple marginalized identities from affording healthcare. This issue of access to coverage creates and reinforces heteronormativity; “the medicalization of infertility assists in maintaining the norms of family and motherhood” (Bell, 2010:634).

Kitzinger (2005), further discusses how healthcare systems reinforce the heteronormative view of the family by doing an empirical study about after-hours medical calls. She points out how when calling in to access after-hours medical attention, the participants utilized language that reflects their heterosexual family structure and can continue their calls without interruption. However, when a participant in a same-sex relationship would call in and their identity would become apparent, they experienced interactional problems as a result. She concludes that:

The inferences normally associated with [family terms], and the interactional uses to which they may be put in the context of after-hours medical calls have shown that (and how) tacit, taken-for-granted concepts of “the family” are reflected in, and reproduced by social participants. Through their deployment of family reference terms in conducting business of their ordinary lives, the speakers in this dataset both reflect and (re)construct their society’s normative definition of family as composed of a co-residential married heterosexual couple and their biological children. This analysis has also demonstrated that heterosexism can be produced and reproduced (Kitzinger, 2005:495).

Kitzinger’s study reflects the ways in which the nuclear family is reinforced through heteronormativity, which that connects with the data found in this study.

My research contributes to this area of literature, as I asked participants about their health insurance coverage in regards to fertility treatments, and their associated out of pocket costs. The lines are also unclear around who can receive fertility benefits if they are covered under an insurance plan. When contacting the insurance company Anthem

Blue Cross and Blue Shield to inquire about their coverage, I found that they require a person to have a diagnosis of infertility in order to qualify for fertility related benefits; meaning that they have to have had unprotected, heterosexual sex for 12 or more months, that did not result in conception. This regulation further marginalizes queer women who are seeking fertility treatments.

QUEER AND FEMINIST THEORY

Queer theory, developed from feminist theory allows for the articulation of the complexities of gender and sexuality (Massaquoi, 2015), and is designed to challenge what is considered 'normal'. In using queer theory as one of the primary theoretical frameworks for this study, I will be looking at the construction of identity which is based in the normative views within American culture about gender, sex, and sexual orientation (Broido & Manning, 2002). Jones et al. (2013) claim that queer theory works to critique power structures within social environments that create and construct our identities. From queer theory stems the concept of heteronormativity, and queer theory desires to question and resist it. For this study, I examined the ways in which power structures within our society support and reinforce normative beliefs and values about sexual orientation and family structure.

Feminist theorists like Judith Butler frequently challenged patriarchal and heterosexist values and ideas bringing these issues to the surface of discussion. They discuss issues on both sex and gender, and breaking down the gender binary (Butler, 1993; Valdivia, 2002; Ingraham, 1994; MacKinnon; 1983). As explained by Annandale & Clarke (1996), patriarchy conflates the idea of biological sex and gender, while feminism aims to show that gender is a socially constructed concept:

Basic and common to *all* feminisms is the understanding that patriarchy privileges men by taking the male body as the ‘standard’ and fashioning upon it a range of valued characteristics (such as good health, mastery, reason and so on) and, through a comparison, viewing the female body as deficient, associated with illness, with lack of control and with intuitive rather than reasoned action (Allandale & Clarke, 1996:19).

Feminist scholarship and theory is not a new concept within medical sociology, although it has become an underutilized perspective (Allandale & Clark, 1996). In order to understand how feminism is related to gender and health, we need to understand how our patriarchal society is set up to further marginalize women, which is why utilization feminism as a theoretical framework for this project is necessary.

CHAPTER III

METHODOLOGY

Over the course of this project, I conducted semi-structured interviews as my single method of data collection. Conducting semi-structured interviews allowed participants to respond freely to prompts and questions. This form of data collection allowed me to co-construct the project with the participants and allowed me to be responsive to the needs of each participant. I conducted a total of 15 semi-structured interviews which allowed me to gain a deep understanding of their experiences receiving fertility treatments. All interviews were conducted over the phone, with the exception of two which were done via a video call. All interviews were recorded and transcribed. The collected data were then coded and analyzed using a software program called Dedoose, and the later outlined themes and sub-themes were created. All participants of the study signed an informed consent form that was approved through the Institutional Review Board and can be found in Appendix B. All participants names have been changed in order to maintain anonymity and confidentiality.

SAMPLING

In selecting participants for this study, I used specific criteria for participants in order to most precisely answer my research question. Originally, I intended my sample to be restricted to queer women who were currently in same-sex relationships. However, in obtaining a sample and selecting participants, I expanded the sample pool to include queer women who are in queer relationships, not solely same-sex relationships. This

allowed me to include transgender, non-binary, and gender non-conforming individuals who were in queer relationships and were undergoing fertility treatments in a clinical setting. Excluded from the sample were cis-gender women who identified as bisexual, and in heterosexual relationships with cis-gender men. This sampling strategy also eliminated the possibility of having bisexual women who were in heterosexual relationships with a cisgender male, who were experiencing *infertility* from participating in the study. The reasoning behind excluding this specific demographic is that I was specifically looking at fertility treatment and assisted reproductive technology as a means of conception for queer couples, as opposed to bisexual women undergoing *infertility* treatments. Because bisexual women in heterosexual relationships would most likely be seeking fertility treatments due to infertility (e.g., male-factor or low ovarian reserve), their sexual identity would most likely not have been relevant to them receiving treatment. Additionally, because they may pass as heterosexual or would not have to 'out' themselves in the process of obtaining care, it can be assumed that they would not face homophobia microaggressions from their care team. Sprague and Zimmerman (1993) discuss homogenous sampling within qualitative research, pointing out that researchers often aim for a homogenous sample (a sample that shares similar characteristics) as a way of preventing irrelevant information from coming up during the data collection process.

In collecting my sample, I attempted to disrupt irrelevant information and experiences from appearing in the data collection process by following a strict criterion for participation, to maintain a diverse sample. However, a glaring lack of diversity existed in the sample makeup as intersectional identities held by participants, due to

structural inequalities, prevented them from meeting the criteria required for participation. An example of this was couples who were of low socioeconomic status, as they were not be able to afford fertility treatment, therefore making them ineligible for this study. There were also possible participants who were not selected as they were doing at home inseminations with a known donor due to their inability to afford fertility treatment. However, the sample obtained is reflective of the LGBTQ+ population who are undergoing fertility treatment (Becker, 1998) as the systemic barriers preventing marginalized people from accessing healthcare and fertility treatment, were reflected in the sample demographics and the data collected.

To select participants for this study, I utilized targeted recruiting/advertising via the internet. Internet sampling for my study allowed me to access people from a relatively small group, all over the country. I recruited a specific sample which “constrain[ed] the participation to individuals who [met] specific selection criteria assessed before beginning the study” (Nosek et al., 2002:66). There are many online support communities and forums for people who are undergoing fertility treatments, and there is a heavy queer presence amongst many of these groups. Utilizing these forums and communities to locate participants was extremely beneficial in developing a sample. Primarily, I utilized Instagram, searching for specific hashtags such as ‘#twomoms’, #IUI (intrauterine insemination), #samesexparents, and selected participants for this study based on the response to my call out post. I also posted a call for participants in two private support groups on Facebook for LGBTQ+ couples who are going through fertility treatments and recruited additional participants there. All participation in the study was voluntary, and participants were aware of their option to leave the study at any time without question.

While I was able to recruit a sample for this study, there were systemic barriers that factored into who was selected and able to participate in the study, as explained above. Joey Sprague says that “systems of social power influence who becomes a participant in qualitative research projects. Researchers determine what type of interviewees they want to recruit...” (Sprague, 2016:154). The sample collected had to meet the specific criteria related to identity and fertility journey as outlined above. However, barriers to accessing fertility treatment such as cost, insurance access, and gender identity, prevented populations of queer people from being able to participate. With these barriers in mind, I hoped to create a sample that is representative of the larger population, and was inclusive people from various backgrounds including race, socioeconomic status, employment status, and gender identity.

My sample consisted of 22 participants. In total, I was able to interview eight couples in which both partners were able to be present and interviewed, and six people who are in relationships but due to time conflicts had to complete the interview without their partner(s) present (see Table 2 for full demographic information). The age ranged from 25 to 44, 19 participants identified as female, one identified as gender fluid, one as non-binary, and one as a trans woman. The racial makeup of the sample was primarily white, with one participant who identified as Mexican-American, and one who identified as Hispanic. 12 of the 22 participants identified as lesbian, three as gay, three as queer, and two as bisexual, one as bisexual or pansexual, and one participant identified as hetero-flexible. All 22 participants were married, and one was married and in a non-monogamous or polyamorous relationship with her wife. This participant, Kelsie, had a wife (who also had a girlfriend) and a live-in male partner named Andrew. Only Kelsie

was interviewed for this study. 12 of the participants identified as middle class, eight participants identified as upper-middle class, and two participants (one couple) identified as lower middle class.

Across the 22 participants, 16 of the participants were coupled and interviewed with their partners (eight couples), and six were participants who were married, but interviewed independently.

Table 2. Participant Demographics

Name	Age	Race/ Ethnicity	Gender Identity	Sexual Orientation	Relationship Status	Socioeconomic Status
Kelsie	32	White	Female	Bisexual/ Pansexual	Married non- monogamous	Middle
Elizabeth	35	White	Female	Lesbian	Married	Middle
Carla	34	Mexican- American	Female	Lesbian	Married	Middle
Wendy	25	White	Female	Gay	Married	Middle
Alex	25	White	Female	Gay	Married	Middle
Kelly	34	White	Female	Lesbian	Married	Upper-Middle
Rachel	30	Hispanic	Female	Lesbian	Married	Middle
Tegan	34	White	Female	Lesbian	Married	Middle
Leigh	34	White	Female	Lesbian	Married	Upper-Middle
Shelby	30	White	Female	Lesbian	Married	Upper-Middle
Cindy	37	White	Female	Lesbian	Married	Lower-Middle
Spencer	32	White	Gender Fluid	Gay	Married	Lower-Middle
Edith	35	White	Female	Hetero- Fluid	Married	Upper-Middle
Ingrid	44	White	Transgender woman	Queer	Married	Upper-Middle
Susanna	33	White	Female	Lesbian	Married	Middle
Amber	33	White	Female	Bisexual - currently in Lesbian Marriage	Married	Middle
Lucy	35	White	Female	Bisexual – currently in Lesbian marriage	Married	Upper-Middle
Allison	31	White	Female	Lesbian	Married	Middle
Karen	32	White	Female	Lesbian	Married	Middle
Jessica	33	White	Female	Lesbian	Married	Middle
Claire	28	White	Female	Queer	Married	Upper-Middle
Jesse	34	White	Non-Binary	Queer	Married	Upper-Middle

*Brackets indicate participants who are married to each other

ANALYSIS

Interviews collected were recorded with an audio recording app on an iPad Pro, and were later transcribed using an online program that slows down audio files, allowing me to accurately transcribe the interviews. Through the facilitation of interviews, both myself as the researcher, and the participants were active in discovering themes within the data.

Because of the nature of qualitative data and the use of open-ended interview questions, the transcriptions of respondents' interviews were coded for emergent themes that illustrate meaning within the responses (Babbie, 2007). When the data collection process was complete, I utilized a Qualitative Data Analysis Software, Dedoose, to uncover patterns in the themes. The software organized the data in accordance with the themes, which allowed me to quickly access excerpts based on codes, allowing me to quickly analyze the data to form a conclusion, using the theoretical framework of queer and feminist theory. I was then able to determine whether identity plays a role in the treatment of queer women receiving fertility treatment or not. During the coding process, it was important for me to be aware of any biases that I may have as the researcher in order to help me avoid researcher bias, which could have led to misinterpretation of the responses (Babbie, 2007). Once the data were coded, I was able to determine how the themes that were found relate to the research question and could then infer what the themes and subthemes told us about the marginalization of queer people seeking fertility treatment. In utilizing the narratives from the interviews to reinforce and highlight the themes found and was able to condense down the answers provided and find an answer to the research question, as demonstrated in the next two chapters, Findings and Discussion.

CHAPTER IV

FINDINGS

After reviewing the data for this project, the participants shared experiences that constructed three major themes: Fertility Experience, Identity, and Tension. Nuances within those themes, highlighted a necessity for subthemes. Under the first theme, Fertility Experience, are the subthemes insurance, clinic selection, treatment protocol, and inclusivity. Under the second theme, identity, are two subthemes: public assumptions and private assumptions. Finally, under the third theme, tension, there are three subthemes, which are family tension, invasion of privacy, and inadequacy.

FERTILITY EXPERIENCE

This main theme covers most of the details from the participant's entire fertility journey/process, starting with their insurance coverage, moving on to how the participants selected the clinic that they went to, what their treatment protocol entailed and how they felt it aligned with their sexual identity, and finally the inclusivity of the clinic, including the physical space of the clinic, the clinic website, language used on forms, etc.. This theme, comprised of the participant's responses, provides insight into how holding a queer identity influences the experience of going through fertility treatment.

Insurance Access/Coverage

A major finding created by the narratives of the participants, highlighted a problematic and cost prohibitive lack in insurance coverage for fertility treatments.

In asking the participants about their insurance coverage, four of the couples expressed that they were covered under their insurance, while the remaining eleven couples were not. The finding that is the most relevant in determining the role a queer identity plays in the context of healthcare, is that out of the four couples who were covered under their insurance, three were identified as having ‘situational infertility.’ The World Health Organization defines infertility as “a disease of the reproductive system defined by the failure to achieve clinical pregnancy after 12 months of unprotected sexual intercourse” (WHO-ICMART Glossary, 2018). This definition assumes that the people engaging in sexual intercourse are of the opposite sex and have the sex organs necessary to reproduce. While the definition does not explicitly mention heterosexuality, it highlights the necessity to create different categories of infertility to broaden the scope of the definition, specifically including situational infertility which is when there are “no biomedical fertility barriers” (Greil, 2010:143) to conceiving children.

Amber briefly discussed her lack of fertility coverage through her insurance, which she received from the military. She said “it’s all out of pocket. I have military insurance and they don’t care if you’re trying to get pregnant. But it’s like that for everyone.” Similarly, Jessica shared that:

IVF or fertility issues predominantly aren’t covered by insurance at all because they’re elective procedures. So, when it runs through insurance, part of [some] stuff is covered... some stuff isn’t covered at all depending on what it is. I think that’s with any couple going through IVF or IUI or anything.

These quotes illustrate the struggles faced by queer couples who are attempting to access insurance coverage and support in seeking fertility treatments.

There were many nuances presented by the participants when discussing fertility coverage. Kelsie shared one that she experienced:

We had to pay for the sperm completely ourselves, outright. Interestingly, if we had chosen a known donor, they would have covered the cost of that person going to a sperm bank and process[ing] that sperm, that would have been covered. I believe that we were covered under the umbrella term ‘situational infertility.’

Similarly, Edith shared, “[insurance] covers 100% of everything, no limits to how we can do this...as many IUIs as we want, it covers in-vitro” but then later shared that in order to get that coverage the clinic *had* to bill under infertility, even though the couple was not considered infertile. She said:

With the clinic that we didn’t pick, it was whether they were going to bill under infertility for the initial consult [that would lead us to pick them]. But because we had kids [previously] with no problems, we didn’t know if we would qualify as infertile, even though now we need help because we don’t have the right equipment. So, if they determined that we were fertile and they were billing under infertility, then we have to pay full price. Whereas the other clinic didn’t bill the initial consult under infertility, so we could go have a consult and then one day they were like ‘oh yeah, you’re infertile no problem... So they just billed it however it was going to work.

Similarly to Edith, Cindy explained that to get insurance coverage for her fertility treatments, “the doctor basically needed to sign off that we had at least been trying for six months naturally.”

Finally, Allison shared that in order to receive fertility benefits, she had to have undergone 12 unsuccessful IUIs, and only then would she be able to receive full coverage for IVF. She said “I guess I’ll say that my insurance has IVF coverage, but you have to have 12 failed IUIs, all of which are out of pocket. But all of my monitoring and medications were covered.” These experiences shared by the participants reflect the ways in which fertility coverage for queer couples is inconsistent and inapplicable to their situations. These inconsistencies and nuances led to the clinics having to process billing differently or resulted in a lack of insurance coverage for the couple.

Differently from the participants who did receive coverage, were those who did not. A lack of insurance benefits and coverage seemed to be narrowed down to two reasons: either fertility treatment was not offered to anyone under their insurance plan, regardless of sexual orientation, or the participants were lacking in a diagnosis of infertility, resulting in them not qualifying for their insurance benefits. Claire, who did not receive any insurance coverage for her treatments, discussed her experience with calling her insurance company to ask about coverage. She said:

Yeah it was pretty shitty to be told that we don't qualify for fertility coverage because we aren't infertile. The woman on the phone actually asked me why I needed fertility treatments if I wasn't experiencing infertility. I'm not even sure that she can ask me that.

When discussing the lack of fertility coverage, Rachel said “we both work at the same company and [the insurance] offered nil. It was horrible. And that's why we did IUI, we just forked out the money for that... we got new jobs, and the new job doesn't cover IVF, but they cover infertility which I don't have,” and Leigh said “My [insurance] company does help with infertility treatments, but I wasn't considered infertile.”

The significance in these findings lies in the heteronormativity of the healthcare system and insurance companies, specifically with Leigh, Cindy, Rachel and Claire, who were all denied insurance coverage because they could not get a diagnosis of ‘infertility’, as they could not biologically conceive a child with their partner. As a result, the clinics have to decide whether they are going to bill insurance inappropriately as ‘infertility’, which could be considered insurance fraud, or refuse services that the patient is entitled to, demonstrating the systemic nature of the insurance and healthcare systems.

Clinic Selection

An important part of all participants' fertility journeys involves the selection of the clinic. When asked about how/why a couple selected their clinic, the responses were varied. Some participants were required to go to a specific clinic based on their insurance coverage, some could choose anywhere but wanted to go somewhere that was inclusive of queer people, and other participants selected a clinic based on referrals and recommendations from others. Lucy said "I actually called a couple [clinics]. We only have...two reproductive endocrinologists and maybe one or two other doctors, OBs, who will do IUI," and ended up selecting the clinic with lower prices. Susanna said "We didn't really do any research. We just took my gynecologists advice." Similarly, Amber shared that they also did not do any prior research as they knew the clinic they were selecting was inclusive of queer couples; she said "I used the clinic that my wife used with her ex."

Some participants had to select clinics that were in network for their insurance companies. Kelly said "I guess if it wasn't for insurance purposes, we probably would have Googled the ones in the area." Edith said "we picked the two closest clinics to us, geographically, asked who would work with us and our insurance and we picked the one that was better and would work with our insurance." Elizabeth and Carla also expressed that they chose their clinic based on insurance purposes. Karen went into a little bit more detail, explaining how she and Jessica selected their clinic. She said:

I called them (a clinic) and another popular one here in [city], and kind of compared prices. I'm not sure about that though, why we went with the one we went with. Maybe just 'cause our friends did use them. We actually knew two families that used that [clinic].

Kelsie also began her search for a clinic based on who was in-network. She said:

I first checked to see who was covered by my insurance. So that was my first step was to see who was an in-network provider. And then I ended up speaking to another lesbian couple who I kind of met randomly, that also use the same clinic and were happy with their treatment. And then I think I also learned later on after we already decided to go with this center, that another friend of mine also used them. But to be honest there weren't a ton of options available to me. So, I basically chose the one that was like closest to me and seemed legit and then after already deciding that was getting positive feedback about them.

In sharing her selection process, Shelby said “I went to a group here that's highly recommended and [the doctor] was a just starting out with that group. She was younger which I feel more comfortable with one with the female and to someone of a younger generation especially being a lesbian”. This subtheme, ‘clinic selection’ emphasizes the process that guided participants to selecting their provider, but also demonstrated the ways in which insurance regulations removed choice from the decision for many participants. Clinic selection is one of the most important parts of the fertility process, and it is evident that many participants were unable to make that decision for themselves.

Treatment Protocol

Fertility treatment protocols experienced by the participants, often did not align with their needs. When asking the participants about their experiences with their fertility treatment cycles, I asked specifically about the treatment protocol at their clinic, or what they were asked to do for their specific situation or cycle. In some cases, participants reported that there were certain things that they were asked to do that did not apply to them when their identities were considered. Carla shared that she and her partner were required to attend a mandatory counseling session prior to undergoing treatment utilizing donor sperm. During that counseling session, Carla and her partner were asked whether

their child would have a positive male role model in their life, who that person would be, and what their relationship with the child would be. Carla said:

I definitely think it was kind of messed up. They wouldn't have asked it if we were a heterosexual couple. I just kind of felt like, why is it necessary? First of all, whether our child has a positive male role model or not is not standing in our way of going through this process, and I guess we shouldn't have to catalogue all the men that we know.

Susanna and her partner were also required to attend a counseling session and had to see the counselor referred by the clinic. They had to pay \$250 out of pocket for the session. Susanna said "we had to go to counseling and do one session of counseling. I wasn't pumped for it to start. I thought it was really stupid and regular couples don't have to do this." The participants who had to do mandated counseling were under the impression that everyone at the clinic who was using donor tissue (eggs or sperm), had to do the counseling regardless of sexual orientation. However, Claire felt that the counseling was unnecessary because "we are aware going into it that we have to use donor sperm, obviously there is no other option. It's not emotionally taxing for my partner that we have to use donor sperm, like it would be for a heterosexual couple who is using donor sperm because of male-factor infertility or something."

Like Susanna and Carla, Kelly and her partner were also required to attend a counseling session. She Said:

We had to go through mandatory counseling. Our clinic had mandatory counseling if you were using donor specimens of any sort. For us, it felt really demeaning, where I feel like for a straight couple, there is maybe some value in that like you are making a decision to not use your genes when you thought you were going to be able to initially but for us, we knew all along the use of our genes would not be involved already...It's supposed to be as a couple but my wife [couldn't make it] and luckily the social worker, I think he honestly kind of echoed my thoughts of this is kind of stupid...so he let me answer for [my wife].

While Allison and her partner did not have to attend counseling sessions mandated by their provider, she did say that she “talk[ed] to another couple that went to the same clinic but had a different provider, and they were told that they had to do [counseling] and they were very put off by it.” Allison went to a clinic that had five different providers and found it interesting that the providers had different protocols and rules even though they were in the same clinic. Allison and her partner were also required to sign specific paperwork determining parental status of any potential children, if the couple were to get divorced: “part of the consent that I signed was that my wife had to agree to custody. Like if we were to get a divorce, that we were both still in agreement with taking care of any children that could come out of our treatments. So that was really weird too.”

Other instances of heteronormativity were experienced within the treatment protocol for the participants. Spencer and her partner did reciprocal IVF. During this process, a reproductive endocrinologist harvested eggs from Spencer, fertilized them in a lab, and then implanted the mature embryos into Spencer’s wife, Cindy. Cindy would be considered the gestational carrier in this specific circumstance. Spencer was required to undergo a full gynecological exam, even though she would not be birthing or carrying the child; the clinic was following FDA protocol, which deemed the exam necessary. When I asked Spencer how she felt about that, she said “the entire time [the nurse] was up in arms and angry that she even had to do the exam and she kept saying ‘I’m so sorry we have to do this. You’re married to Cindy, this is your sexual partner, you shouldn’t have to do this.’ She was very protective.” Spencer also expressed that she was not aware that she would have to undergo the exam when she arrived at the clinic, and that due to past

trauma, felt extremely uncomfortable and emotionally distraught both during and after the exam. Spencer's experience reflects the incompetencies that queer people experience within healthcare spaces because of the care team's lack of knowledge and training on inclusivity.

Many of the participants were required to do pregnancy tests at the beginning of testing, and throughout their treatment journey, even though their care team staff knew about their status as being in a same sex relationship. In addition to pregnancy tests, Allison and Claire both went through additional procedures before starting their cycles. Allison said:

I was a little bit curious about the additional testing. For example, the HSG... it seemed like one of those things that if you're going there for infertility reasons, it does make sense to do that...it seemed like they had the same protocol no matter what. And I think that for same sex couples it should be a little bit more of an evaluation...it felt that we didn't have a choice, but they were like 'this is how we do things' and I didn't really feel like pushing back at that point.

On the other hand, Jessica expressed frustration in her clinic's lack of testing at the beginning of their process. Jessica and Karen went into fertility treatment not expecting the hard road they would have to face. Karen struggled with issues related to infertility, which were unknown at the start of treatment. Jessica believes that because of the clinic's lack of experience with same-sex couples, they missed out on undergoing certain tests that may have diagnosed infertility sooner. She said:

Obviously [with] a heterosexual couple...they kind of assume there's an issue and I feel like, I don't think they overtly did this, but I think they set us up in a way that was like 'Oh, well we don't expect there to be any issues' from the get go. It made it much harder at each stage.

When asked if there were tests or procedures or anything in the protocol that could be waived, almost all of the participants said that the majority of the tests were required, and

that they could only waive a few. Amber said “I think there’s some genetic testing that I could waive, maybe one or two other things. It wasn’t a large amount of things that I could waive,” and Susanna explained that even her wife was required to undergo blood testing, even though she was not contributing biologically to the process. Kelly said:

[the clinic staff] were being protocol-based and a lot of the protocols were not designed with gay couples in mind. And so, I caused a little bit of a stink because they kept making me do pregnancy tests, and she was not able to waive the actual pregnancy tests that were \$50 a piece. So I was getting really frustrated with the fact that I was taking my time to come in and do these and getting extra blood draws you know before any procedures could be done.

However, having to undergo unnecessary tests and procedures was not the experience of all participants. Edith said that she was “calling the shots” at her clinic: “I say ‘Okay, I’m here. Do what you gotta do’ and they just do it, you know? They don’t have to leave, or double check, verify, or I don’t have to prove, I just say ‘This is what I want’ and they’ve been doing that, which I like.” Lucy shared a similar experience, saying “at no point in our process did I feel like [our doctor] wanted me to spend more money on things I didn’t need or forced me to do procedures that [weren’t] necessary.” These different patterns indicate a lack of consistency across fertility clinics in treating members of the LGBTQ+ population, which shows a lack of experience in providing services to those individuals which is indicative of the heteronormative practices of some the clinics.

Amber shared another experience that actually led her to switch clinics due to the treatment protocol at her previous clinic. Amber and her wife were looking to do reciprocal IVF with an INVOcell device. She explained that the fertilized embryos are placed into this device, which is then implanted into a woman’s body, allowing her to incubate the embryos as opposed to them being incubated in a lab. Because of their issues

trying to conceive, the couple decided that they wanted to use Amber's wife's eggs, and Amber would incubate them. However, her clinic denied the request. Amber said:

She just said 'it's made for one person. The protocol is made for one person. This device is made for one person.' But there are other clinics who are doing it otherwise... I found out that there is a clinic a couple hours away that would do the INVOcell device reciprocal, and [my current] clinic won't and I don't understand why.

As highlighted in this theme, many of the participants experienced forms of homophobia and bias in their treatment protocol provided and mandated by their clinic. These experiences led to some frustration, accrued costs, and even to some participants switching to a new provider.

Inclusivity

While none of the fertility clinics selected by participants were exclusive of queer couples, meaning they did not refuse services to queer couples, more than half of the participants shared experiences that reflect less than inclusive practices at their clinics. First, I asked participants if they could describe the physical space of the clinic: what and who they saw. Tegan and Rachel reported seeing a black triangle, representing a 'safe zone' certified location on the window at their clinic. Tegan said "it's nice that we feel like we're just an average couple there. It's not that we're special because we're gay, we're just us."

Lucy and Allison both noticed that the clinic had queer couples represented on different media in their clinics. Lucy explained "There are lots of pamphlets for lesbian couples. Lesbian couples who are trying to adopt, lesbian couples who are trying to adopt embryos. There is, you know, a whole list of different scenarios for every sort of couple

going in there and trying to conceive a family in some way.” Allison said: “I think they have a couple of books that are geared towards same-sex couples and stuff like that.”

However, Amber and Claire both reported that there was no representation of queer couples in the media at their clinic. Amber said “there wasn’t same sex anything in there it was all you know, male/female,” and Claire said “I only ever saw stuff aimed at straight couples who were struggling with infertility.” Edith, who identifies as heterosexual and self-identified as being new to the queer community, said “I identify as a straight lady who is in a non-straight relationship, so that’s not on my mind.” She explained that she hasn’t had to be aware of inclusive materials before now, so she is not in the habit of looking for them as they have not historically applied to her. Edith’s wife Ingrid, who is a transgender woman, said “I haven’t seen anything representing anything else but straight couples there,” explaining that she probably would have noticed any inclusive media in the clinic.

Ingrid and Edith had different feelings about their experience after their first appointment. Edith felt that the appointment went great, and Ingrid felt like she had been ignored. Ingrid said:

The clinic that we chose, had a whole page on ‘oh we know about [providing services to queer couples] and we’re providing an environment and so on. And you know, they certainly handled the work competently, but not welcomingly. And it’s hard because I don’t exactly know what sort of treatment I was looking for. But it wasn’t invisibility and that’s kind of how I felt at first. Is it the trans thing? Is it the same sex couple thing? Is it just like ‘well you’re not the patient, we’re not going to ask you a whole lot.’ I didn’t know what it was.

Lucy also shared that her clinic lived up to their standards of being inclusive to queer couples. She said “He [the doctor] said that he was very gay friendly and didn’t have any biases towards same sex couples. And that’s absolutely true,” and Kelly said “I

think probably if they were not gay friendly that I would have definitely changed,” - hinting that she felt her clinic was inclusive of queer couples.

I then asked the participants if they recalled seeing any other couples that they perceived to be queer couples in the clinic during their time there. The responses were mixed. Lucy said, “I definitely saw several lesbian couples coming in and out of the office,” while Susanna said “I would say out of my...50 office visits, I saw another same sex couple maybe four times between the two different offices. *Maybe* five times.” Claire said that “it’s hard to know because some people go to all of their appointments by themselves, and you can’t tell by looking at a couple or an individual.” Amber said that she did not see any queer couples at her clinic, and Allison said, “I’ve definitely on a regular basis seen same sex couples there.” Karen said, “It was usually couples, straight couples. Occasionally maybe we would see a couple that we thought would be a lesbian couple. And of course, we always pointed out kind of when you see it like, oh they’re there. But only maybe once or twice. I don’t think much.” This subtheme highlights the experiences that the participants shared regarding the inclusivity of their fertility clinic. The selected quotes provide insight into the ways in which the fertility clinic engaged with and treated queer couples.

IDENTITY

The second main theme that was constructed through the experiences of the participants is the perceptions of identity. Out of the couples interviewed, all but three had either already had a child, experienced pregnancy, or were pregnant at the time of the interview. Of those couples, all of them expressed that people made assumptions about their sexual identities when they were in public with their child or while pregnant, or they

faced these assumptions while dealing with their fertility clinic and care team. This theme is broken down into two sub themes: Public Perceptions and Care Team Perceptions.

Care Team Perceptions

The first subtheme of perceptions of identity is care team perceptions, as the majority of participants shared experiences of clinic staff members making assumptions about their identity. Similarly, many participants reported the paperwork in the office being non-inclusive of queer couples. Karen said “all of the paperwork was obviously like if it was a heterosexual couple. We just crossed it out and put, you know, whatever term would be appropriate... [thinking] after they maybe experienced enough, they might change things.” Edith echoed Karen’s experience, simply stating “all the paperwork says husband.”

Many couples explained how the staff at their fertility clinic would refer to the father of the baby or a husband, even when both members of the couple were present at the clinic. Wendy said, “we did monitoring through an outpatient office and the lady did, she would be like ‘oh, well you know your husband’ or ‘the father of the baby’ or whatever. She actually did it once when Alex was with me, so that was awkward.” Shelby explained that when she had to attend appointments at the clinic alone due to schedule conflicts, providers would refer to her husband or father of the baby, briefly mentioning “the girl kept saying ‘you need to call your husband.’” Kelly shared that clinic staff referred to her husband “all the time and I present very non stereotypically, I guess you say. I mean every single blood draw, every single ultrasound ‘your husband can come back later.’” When asked how she handled those encounters, Kelly said “I always have to correct people. Usually they are like ‘oh, whoops, sorry.’” Lucy shared

her experience with a receptionist, stating “There was one incident when I was checking out with one of the girls who didn’t know who I was, one of the payment specialists, and I think she had referred to my husband.” Susanna, when attending an appointment with her partner, said “[the staff asked] ‘Oh, is this your sister or something?’ And I’m like, ‘no, that’s my wife’ and they were like ‘oh, I’m sorry, I’m sorry.’” Amber seemed the most frustrated by her experience with the staff assuming she had a husband. She said “I just remember being like, ‘on my chart it should say my wife.’ That’s all I remember thinking, like maybe if you familiarize yourself with my chart before I came in... I was kinda like, do you not look at shit?” Finally, Lucy said “I’ve had lots of experiences where people refer to [my wife] as a friend or whatnot. But they definitely treated us like spouses and not anything less.”

Allison explained a situation where she was in the bathroom, and her wife was assumed to be the patient, and in a heterosexual relationship:

At the beginning we had no problems, and not that there were really problems, we were just like everybody else. And then this time, I don’t know what’s changed, but there has been several instances. This last week, I was back in the bathroom and my wife was standing out with the paperwork and they go ‘oh, is your husband in the bathroom?’ and they just assumed that she was the patient.

Similarly, Karen detailed an experience she had with an outsourced lab technician:

I think she did say something about a husband and I said no, I’m married to a female. And then.. some people just shut up about it and some people just won’t stop talking about it. Well, she just kept saying ‘oh you know, when I was in high school, being gay was just so taboo and I had this girlfriend and she was gay and she wanted me to grow up and be her girlfriend. And I’m just not into that’ and just kept saying the say stuff and I’m just like, you should not be saying that.

Jessica, Karen’s partner, was quick to point out that the lab technician was not directly employed or connected to their fertility clinic, but the clinic outsourced their lab work.

Jessica said “I think Karen mentioned it to one of the doctors and they were really apologetic. You know [it’s] outside of their control”.

Allison shared some experiences that impacted her more than just having to fill out paperwork with non-inclusive language. When calling to schedule an ultrasound, she shared this conversation with the clinic staff:

They did ask me about pregnancy testing, and that was not something they used to ask... I was starting to explain to this person about how.. I’m in a same sex relationship, is it necessary that I have to do that? And basically she told me that when I called, I needed to announce that I was in a same sex relationship...I don’t know if she was just being standoffish in that moment because I pushed back on her, cause she was totally nice after that, she wasn’t weird about it. But it was weird to me that she told me to announce up front.

Allison also shared that after she experienced a miscarriage, she received a voicemail from the clinic. She said “so in this message, at the end of it they made sure to put in this note about how I should be abstaining from sex, and [should be] using condoms to make sure I don’t get pregnant.” Frustrated by this, Allison explained “I’ve been under their care for almost three years now,” and felt that there should be more attention given to a patient’s chart before a voicemail is left or instructions are given. Lastly, Allison shared that during one of her treatment cycles “[the clinic] said ‘yeah you should have sex between now and when you come in for the insemination. And I was like, once again, I mean I *can* but it’s not for the reason you’re telling me to do so.”

Throughout this section, the experiences of the participant’s that reflect their care-team’s assumptions of their identity, reflecting heteronormative assumptions. Their stories also reflect heteronormativity within healthcare spaces, as some of these instances of assumption were in the form of paperwork containing non-inclusive language, and recommendations for treatment that do not consider the participant’s identity.

Public Perceptions

In my sample, eleven of the couples interviewed either had a child or children before the interview took place, were pregnant at the time of the interview, or had experienced a pregnancy. All of the participants who took their baby out in public or were in public while pregnant, were assumed to be heterosexual at some point. This was especially true for Kelsie, who is in a polyamorous relationship. Kelsie detailed how people in public assume that her partner Andrew is the father of her baby, even when her wife Melissa is present. She said:

If I'm out with Andrew, 100% of the time people assume that he's the father and even sometimes when all three of us are out, or all four of us if Melissa's girlfriend is with us as well. I think [that Andrew] being the only male, they think he's the father... it has been passing comments that people will ask him like 'oh, how hold is he?' or something and Andrew just sort of answers. One other time I can think of is when someone said something that was kind of assuming was 'oh, yeah he's going to be tall like his dad.

Susanna explained that the assumption that she has a husband happens frequently. She shared one experience, saying:

Anyone who doesn't know you very well, they always say things about your husband or whatever. I have a student teacher and we went out to lunch today and I haven't really told her much, but...we were talking about kids and she was like 'what do [your husbands] think?' I think people just assume.

Karen shared that when she at a lactation group, the lactation consultant asked her if the baby got his dad's feet. She then detailed her response:

I said 'hmm, I'm not sure, why do you ask?' And she was like 'well, he looks just like you so I'm wondering what he got from his dad.' And I just [said] 'Well, I don't know we used a donor.' And then some people stop talking and then again some people ask like 50 million questions.

She goes on to share a similar experience:

I got my hair cut the other day with a new hairdresser, and we were talking about hair color and I was like 'yeah, the baby has my hair color.' And she's like 'oh,

what color hair does your husband have?’ at that point I should have just made something up because I said something about IVF and then same-sex marriage. And of course she would not stop talking about it.

Jessica, Karen’s wife, explained her experience when she was out alone with their son:

When I’m alone with him, people just assume that I’m his birth mom, it’s a different experience altogether than when the two of us are out. For example one time the two of us went out, we were at the art festival and Karen and I were out with [child’s name] and one of her friends from a mommy and me group was there with the baby [who] was the same age. And this woman approached us, and she was a librarian or something, and she came up and she’s talking to the two of them [Karen and the friend from the mommy-group], and I’m in the middle of them. [The woman] was talking to them about the baby group. And I engaged with her clearly like ‘oh that sounds great!’, you know, like part of the conversation. And at the end she was like ‘Oh, do you have a child?’ And I was like ‘Um, yeah. He’s our son’. And you know, she stammered for a second. I don’t think she was [meaning] to be offensive, but it’s obviously an assumption people make.

Kelly, echoing similar experiences, said “but even when I’m out with my wife, whoever’s pushing the stroller is kind of assumed as the mom and the other [person] is the sister, friend, whatever they decide.” When I asked Kelly how she felt in those situations, she said “I think it bothers both of us, but you know people just assume and I mean honestly the first time someday asks who the mom was, she just said ‘are you the mom’ and I said ‘yeah’ just not thinking that there’s another [mom].” She went on to say that she and her wife needed to get in the habit of correcting people now, before the baby is old enough to comprehend what is going on. Edith shared that when she and Ingrid and their children were at the grocery store, “in the check out, the lady bagging was like ‘so are you guys roommates?’ Wendy said “I like when people ask [questions], I find it’s an opportunity for us to educate some people about the LGBTQ+ community and all the different aspects of it.”

Finally, Ingrid shared:

People either have a hard time sort of deciding what precisely I am in terms of a parent or they'll say something about, and this is usually when they're talking to the kids or something, they'll say something about you'd have to ask your mom or something, your mom. And nobody calls me mom at all ever. So it's like this moment of dissonance for all of us and it's maybe, well she's not my mom she's my fama. And the other person doesn't know what that means. I'm under no illusion that anyone ever doesn't know that I'm trans. So that part of it, it's not as if they're outing me or something. But when one of the kids will say 'she's not my mom she's my fama', the reaction from the other person is... not a positive one. And it's not like awful either but you can see that kind of stiffening up about it.

To provide context for this experience, Ingrid is a transgender woman who is married to Edith. Together, they have children that they conceived traditionally before Ingrid's transition and are currently undergoing IUI cycles using Ingrid's frozen and banked sperm in an attempt to conceive another child. At the time of the interview, Ingrid and Edith had just returned home from taking their kids to a Minecraft Expo. She shared an experience of being in a big room and having to speak loudly so her kids could hear her. She said:

I'm already kind of hyper aware, but then because we would split up and then I would be talking loudly so the kids could hear me, which meant that other people around me could hear me saying 'well no, we have to go find mommy'. I'm sort of self-outing there that I'm not the real mommy or that we're a two-mommy family. But it's always this kind of putting out a little red flag every time I do it. I mean, what else are you going to do? She's mommy and I'm Fama, right?

While this research primarily focuses on the experiences that participant's had during fertility treatment, it is also important to highlight the ways in which queer families and parents are perceived in public, reflecting macro level systems of oppression at work. The macroaggressions and bias that my participants faced from others in a public setting, are reflective of the larger system of hegemonic heteronormative, that are the driving force of the heteronormativity within the healthcare system. If society was not

operating with a heteronormative lens, then the healthcare system and fertility clinics in general, would reflect more queer inclusive practices.

TENSION

The final main theme is tension. Many participants expressed feelings of tension in their responses. For the purposes of this section, tension refers to feelings of inadequacy, family interactions containing macroaggressions or bias, and feelings of discomfort the participant's experienced when being faced with personal questions. The tension experienced stemmed from family interactions before, during, or after fertility treatment, and multiple displays of bias from family members during those interactions. Feelings of tension were also experienced when participants were asked deeply personal questions about their fertility journey, creating the subtheme 'invasion of privacy.' Some participants expressed feelings of inadequacy during the fertility process and even into parenting. This was tension within the participants themselves.

Family Tension

More than half of those interviewed expressed experiencing tension with their family members regarding their pregnancy, their sexual identity, or their fertility treatment process. Cindy shared that because she was carrying her partner Spencer's biological embryo, her mother did consider Cindy to be the mother of the child, even though Cindy was the gestational carrier and would soon give birth the baby. Cindy said "[my mom and sister] said that they're happy for us but a little heartbroken because they won't be related to this child, and my mom was like 'you're basically the surrogate, you're not the mom.' And you know, that took a lot out of me." Two couples shared that the tensions with their family members stemmed from a religious background and a

general opinion about their sexuality, further emphasized by the pregnancy or child.

When asked about how her child was received by her family, Leigh said, “As far as my brothers go, there’s no difference. My father on the other hand – when I called and told him the news, I haven’t spoken to him since then... my brother has a daughter six months younger than [ours], so she came around the same time. [My dad] was elated for one and not the other.”

Lastly is Kelsie’s experience. Kelsie discovered after she had her child via a sperm donor, that she was conceived from donor sperm as well. She expressed frustration that her parents had never told her before as it seemed relevant to her medical history and sense of self. Kelsie shared:

I found out about a year ago that I was also a sperm donor baby. That’s like, 31 years old, I had never known this information. It’s a long and crazy story, but there was a little bit of a sense of betrayal for me. How could my mother have not told me this? She said she just didn’t feel like there was a right moment. I was like ‘Okay, so when I was picking out my own fucking sperm donor that wasn’t the right moment? Really?’

Amber experienced tension with her father when she came out to him. She said “when I came out to him, he was just like ‘you’re an embarrassment to the family.’” However, later when Amber disclosed her pregnancy to her father, she expressed that he was excited about the pregnancy. Karen also had a negative experience when coming out to her parents, but after a few years they accepted her identity and her partner, Jessica:

When I first came out maybe ten years ago, my parents were horribly upset and didn’t talk to me for months. But then by the time I met Jessica, they had known for a few years, so it had to sink in you know. From day one though, they liked her... we did meet online [though] and my mom was paranoid she was a killer and couldn’t believe I was going to meet her.

While Jessica's parents and the majority of her family were happy and excited when she and Karen announced their pregnancy, Jessica and Karen expressed feeling that one of Jessica's aunt and uncle were not happy for them:

Jessica: I have an aunt and uncle who are a little bit more conservative, but I've been very close with since I was a kid... they have two daughters. And I remember months after I told [my aunt and uncle] I ran into the daughters and they were like 'what's new with you' and I was like 'oh you know, just getting ready for the baby.' And they were like 'baby??' And I was like 'yeah, Karen is pregnant, I thought your mom would have told you.'

Karen: It's almost like they were embarrassed or ashamed to even tell that, I don't know.

Jessica: Yeah, I don't know that it was that way, but it definitely felt that way because like every other [piece of news] travels like wildfire. But other than that, I think everyone was happy.

When I asked the participants about the level of detail they shared with their families, if any, about their fertility process/journey, the responses were varied. Edith and Ingrid chose not to tell their families that they were going through fertility treatment. Edith said "we haven't mentioned any fertility treatments because if it doesn't work, it's like, well why get everybody all hyped up that maybe there's going to be a baby and you know, it doesn't work." Oppositely, Lucy said "[we were open with] literally every single person in my life about every step of the way during the whole process of IUI and IVF and they're all super supportive." Susanna shared "All of our friends and family have been very involved step by step through the process. We've been very open."

Family tension was a relevant part to the participant's overall experience with fertility treatment, whether there was tension experienced, like Amber and Jessica, or there wasn't, like Susanna and Lucy.

Invasion of Privacy

Another sub-theme under the theme ‘tension’ that I found, was invasion of privacy. Many of the participants shared details about exchanges that they had with family members in which the family members asked intimate, personal details about the couple’s fertility journey. This was met with a variety of responses from the participants. When asked how it felt to be asked such intimate questions, Amer said:

I think for me it depended on the person. When my mom was being super weird and prodding about the real intimate details of ‘why this’ or ‘why that’, I was more uncomfortable with that... it didn’t bother me to share it, but she [had other] motives for being that pushy about it.

When Claire announced her pregnancy online, many of her family members publicly commented on her post: “A few of my family members actually posted on our pregnancy announcement, ‘What? Did you use a turkey baster?’ or other jokes about how we made the baby.” She expressed how this made her feel, saying “it’s just dumb and rude. Would they ever ask that on a straight person’s post? No, because it’s obvious how the baby was made. But that’s such a personal question to ask.” Allison, who struggled with infertility resulting in multiple failed IUI cycles:

My mom, for example. Had a lot of questions about the donor... and other people, not as close to our family, were more curious about how many tries did it take? Most people have heard of IVF and that’s what they immediately go to in their minds. They don’t really realize that IUI is a thing, that it’s less invasive, and they kind of go off like ‘well why did it take so long, I thought IVF works most of the time?’ And it’s like, on man, you’re just completely wrong. And then the other people, not very many, but there were a few people that were truly interested in the actual process, like the difference between IUI and IVF.

Lucy also experienced people asking her questions about her conception process. She said “I’ve had several acquaintances or people say ‘well how does that work?’ ... I’ll say something silly like ‘you know, a lot of money and several doctors.’”

Kelly said:

We've been very open [about our process]. So any questions that people would have had, they would have had before we even conceived. So they don't really say anything. I don't think we've really had too many [questions] out in public either. They usually just say [the baby is] cute.

Some participants expressed frustration in response to the personal questions they would be asked. Jessica said "I'm just like, it's not always my job to educate you, like of course times when I feel like you should have a better understanding, or should maybe research this on your own" saying that she would sometimes take the time to educate people about the process, but often feeling like educating others is a burden. However, Susanna felt that people asking questions was a positive thing, saying "I think it also increases their understanding of the fact that we all can live a normal life even if we're married to the same gender, can have kids. It's not just for men and women, we can have kids and it's just a normal thing." Lucy also had a more positive reaction to questions. She said "I like to educate people 'cause you know, it's not their fault they don't know anything about it. I just like to educate them so in the future they can talk to somebody else in a different tone or type of verbiage that they use as far as asking questions."

Inadequacy

The last subtheme is inadequacy, on both the part of the gestational carrier (the person who carried the child or was attempting to get pregnant) and of their partner. Five of the partners of the gestational carrier, expressed feelings of inadequacy in not being able to be a part of that biological process. When asked if she had any feelings of inadequacy, Carla said:

I would say yes because of my role in the relationship. I am definitely the provider, the protector, and I want to give my wife everything she possibly wants and I definitely would want to see what our own biological children would look

like. I think also the fact that the process is different for heterosexual couples – heterosexual couples make love and oh, now you're pregnant and how special that connection and that intimacy is to now product this gift and this miracle. For us, it's very scientific and technical.

Carla also expressed concern for starting the process of IVF, and what that would entail for her wife. She said, "We obviously want a family, but I am not sure whether I want to put my wife through the fertility shots and everything that happens physically." Three couples also expressed feelings of unwelcomeness and inadequacy in their presence within the fertility community on Instagram. Wendy said, "Some people don't feel that our journey is valid. People write it off, you know, because we only had three cycles and people try for years and they're like 'oh well you know, it doesn't count if you haven't gone through years of disappointing negatives.'" Lastly, three of the participants expressed feelings of frustration in the process that they had to go through in order to conceive a child, as heterosexual couples (barring fertility issues) do not have to go through such extensive and costly treatments. Cindy shared, "It brought me back to when we had been trying and I feel like I failed. And I understand that there are things outside of my control, which unfortunately, infertility is." Jesse, Claire's partner shared "It's hard to watch my wife go through all of this medical stuff. I don't want to be a dude, but I wish that I could give her what she wants without going through all of this."

Other participants experienced feelings of inadequacy in less direct ways or felt frustration with having to undergo fertility treatments. Tegan expressed "Oh, this is really expensive. I guess [I have] emotional feelings of having to go through all of this and to spend so much money to be able to conceive a child." Elizabeth expressed frustration with people around her becoming pregnant spontaneously. She said "This random horrible person from high school or from college, you know is married with like three

children already and like I'm still working on number 1 and I'm 35. You know, it's just it's just super not fair, but at the same time it's like well, I mean it is what it is. There's no other way.” Claire felt similarly to Elizabeth saying “It really sucks having to undergo all of this just to have a baby. Straight couples without issues just get to, you know, and make a baby. But I have to get poked and prodded and spend thousands of dollars. But the same time, there is no other way so what are we going to do.”

Susanna shared:

It was hard [after my first failed cycle] cause nobody really understood. I think more just like the money aspect too. Like, of course I had friends who tried and it took some time, but nobody understood like okay, but you're just having some sex at home. Oh yeah, that's too bad that you had sex for a couple of days and it didn't work. You weren't poked and prodded and had to go through painful procedures and pay thousands of dollars. I just felt like nobody understood that.

Expressing her frustration with a lack of understanding from people who have not had to undergo fertility treatment. Lucy expressed similar sentiment but mentioned the financial aspect in a little more detail. She said:

It's never been like I feel angry that I didn't marry a man and have kids for free. But it is frustrating, you know, and your friends are getting pregnant on the first try and on accident or whatnot. I think its more or less during the process, me feeling like it better work because I just spend twenty grand when I could have you know, do something in the house. It sucks, but I think that I would never want to be with anybody but [my wife]. I'm more than happy to spend every penny we own to have these perfect kids.

Other participants expressed being frustrated by people around them getting pregnant when they were struggling to conceive, while Edith has been mostly interested in the treatment process. Edith and Ingrid had biological children together, prior to Ingrid's transition. When asked how she felt about having to undergo fertility treatment now, when she did not have to in the past, Edith did not seem too phased by the experience, saying:

I think it's just really interesting. I'm very interested in my whole fertility stuff, and I belong to these fertility boards and I've been here, doing my charting and the temperature taking and all that for nearly two decades now. And so going to the clinic and seeing what it's like and being part of the process, it's like Oh, we didn't do that last time. So now this is like another slice of the fertility pie I get to sample. But now it's like well this is kind of cool. It's something that we're doing. It's a little bit of a pain and there's some pressure, like there's only so much sperm, we can't you know, you have my ovulation tests and just be like oh, let's have sex tonight you know... so there's a little bit more pressure. You need to coordinate with a lot of people.

Edith's feelings about her fertility process differ from most of the other participants. She expressed that because she already had three kids prior to undergoing fertility treatment in an attempt to conceive another baby, that she already had a lot of kids so if fertility treatment did not work for them, it would not be as devastating as it would be if they did not already have children. Claire reflected in a similar way, expressing interest in the fertility process and journey, however she still experienced feelings of pressure and sadness. She said "it's cool to have a more in depth look at what is happening in my body and what needs to happen to make a baby, but it is terrifying because our financial resources aren't unlimited. So, once we are out of sperm, that's it."

Ingrid, reflecting on how she has felt during the fertility treatment process says:

My own personal relationship [with myself] has changed (referring to her gender identity and transition), but not in a very clear [way], I can't sit here and say I'm pining to be pregnant myself, but I'm sort of grieving that it's not possible too, for this whole consolation of reasons...you know, she's having this baby and I'm not, but I could, but I'm not, not because she's having this baby and I can't and I don't know what to think about that.

The two participants who seemed to struggle the most with feelings of inadequacy were Ingrid and Jessica. Jessica explained feelings of being negatively impacted by other people asking her or her wife Karen about the baby's father, or assuming that Jessica was not the baby's other parent. When I asked her what specifically impacted her, she said:

It's just pointing out that this child didn't come from me and it's just one more alienating step away from me from the idea that [child's name] was my child. So, it's like a reminder of that. I'm aware of that, but it's almost like an acknowledgement from them that I'm somehow less important, and that this person who isn't anything to my child [the sperm donor] is more important. I think that's what is difficult for me. I think, to be fair, he does look a lot like my wife. He's spot on her. But I don't care, part of me is like would they say that so much if they knew we weren't a heterosexual couple? Cause like, what else do you say? That's one of the things you say: Who do you think the baby looks like? Well, obviously, they're not going to be like oh he looks like your donor. But those things are difficult in general.

Ingrid shared feelings of stress/pressure during the fertility treatment process, directly related to her transition, she uses the word awareness to describe her feelings. Prior to her transition, she and her wife Edith decided that they wanted to freeze and bank Ingrid's sperm to use in the if they wanted more kids. They are currently undergoing medicated IUI cycles. Ingrid shared her feelings:

You know, I have this mental image of whatever rack my [sperm] vials are sitting in and getting shorter and shorter each time...[Edith] is the one handling all the regional logistics [shipping sperm from storage to clinic], but [I'm] aware of those being necessary because of me. I don't think it's exactly guilt, but it's awareness. If not for me, we would not be doing this and that makes this process all feel a lot more high stakes and more than I think it would if none of this had happened, you know, if we were just a straight couple trying this one more time, I don't think I'd feel the same intensity.

Fortunately, none of the participants that have children, reported feeling inadequate or less than as a parent because of their lack of biological relationship to the child, or the method of conception utilized.

This section reflects upon the experience's and feelings of the participants in relation to the ways in which their parenting status is perceived by others, feelings of stress and inadequacy relating to the fertility process they had experienced, and general feelings of frustration at the process and the amount of money and resources necessary to utilize fertility treatments. In the next section, I will be utilizing a queer and feminist

theoretical lens to analyze the data and determine what role sexual orientation plays, if any, in the experiences of queer couples going through fertility treatment processes.

CHAPTER V

DISCUSSION AND CONCLUSIONS

The data collected during this study demonstrate the ways in which sexual orientation influences how some people who identify as queer or under the LGBTQ+ umbrella are treated while going through fertility treatment. More specifically, I was interested in looking at how people who hold queer identities experience that identity within healthcare spaces (Meer & Müller, 2017), focusing this case on fertility clinics. Throughout the three main themes and many subthemes, heteronormativity and the resulting biases, prejudices, and microaggressions, were highlighted and explained by the participants. I will be discussing and analyzing the findings in the following section from the themes that are relevant to answering my research question.

HETERONORMATIVITY IN THE FERTILITY EXPERIENCE

The theme ‘Fertility Experience’, discussed detailed aspects of the participant’s experience with fertility treatment. Participants shared information about their insurance coverage, how they selected their clinic, what their treatment protocol was throughout their process and how they felt that protocol aligned with their identity, and lastly the overall inclusivity of the clinic they selected.

Insurance

Many participants reported that while fertility coverage was offered through their insurance provider, they did not qualify for coverage because they do not have a

diagnosis of ‘infertility.’ The World Health Organization defines infertility as “a disease of the reproductive system defined by the failure to achieve clinical pregnancy after 12 months or more of regular unprotected sexual intercourse” (WHO-ICMART Glossary, 2016). This definition of infertility assumes that the people engaging in sexual intercourse are of the opposite sex and have the sex organs necessary to reproduce. While the definition does not explicitly mention heterosexuality, it highlights the necessity to create different categories of infertility to broaden the scope of the definition, specifically including situational infertility which is when there are “no biomedical fertility barriers” (Greil 2010:43) to conceiving children. Biomedical fertility barriers would be an issue of infertility, this could be low ovarian reserve for a person who was assigned female at birth, or low sperm count for a person who was assigned male at birth. Queer people who are seeking fertility treatment do not always have a biological issue that has led them to the fertility clinic.

The case for my participants was that they all sought out fertility treatment because they wanted to start a family and only after beginning treatment, some discovered underlying infertility issues. As Edith described, they “don’t have infertility, [they] have a point A to point B problem” meaning that the issue is getting the sperm into the person who will be carrying the fetus. According to the data provided by the participants, many insurance companies require an official diagnosis of infertility for the insurance holder to qualify for infertility/reproductive services. Requiring a diagnosis of infertility in order to qualify for benefits is a barrier to queer couples accessing their fertility benefits (providing they have them) because of a heteronormative definition of what infertility is and who qualifies for coverage. Denying queer couples their insurance

benefits because of an incomplete definition of infertility reflects an incompetency within both the healthcare and insurance systems (Hayman et al., 2013; Malmquist & Nelson, 2014; Meer & Müller, 2017, Rossi & Lopez, 2017). A lack of insurance or inability to access fertility benefits results in financial pressure for queer couples seeking fertility treatment, as they are forced to pay for their treatment out of pocket and with IVF costing on average \$12,400 out of pocket (Bell, 2010; Taylor et al., 2008), thus creating a systemic barrier for queer couples to access fertility treatments. This insurance coverage oversight could be solved by expanding the definition of infertility to include situational infertility, which would result in insurance coverage for people experiencing situational infertility. The significance in these findings is exposed in the heteronormativity of the healthcare system and insurance companies, specifically in the cases of Leigh, Cindy, Rachel, and Claire, who were all denied insurance coverage because they could not get a diagnosis of ‘infertility,’ as they could not biologically conceive a child with their partner.

In the experiences of Susanna, Kelsie, Spencer, Carla, and Allison, insurance coverage was inconsistent and unclear. Susanna explained her experience with trying to access her fertility benefits, which resulted in an ongoing, back and forth battle between her, her fertility clinic, and her insurance company. Susanna read in her insurance packet that artificial insemination was covered per her benefits. In disbelief, she called her insurance company to verify and was told that yes, artificial insemination and IUIs are covered. Still in disbelief, she followed up via email with her fertility clinic, asking them to run the treatment through her insurance to make sure. Later, she got an email back

again confirming that her treatment would be covered by her insurance. However, once she started her treatment cycle, she was handed a bill at the end of her first appointment.

She said:

Of course I freak out because we're ready to start this next cycle. Over Winter we saved up and we bought four vials of sperm, but we didn't save for the cycles because it was going to be covered. And then I call my insurance... and he's like 'I'm sorry, it's a little confusing. The person you talked to didn't click over to the next page, but you are in a large group, and you are not eligible so it is not covered'. And I [say] 'This is terrible, I have paperwork stating that it is covered' and he was pretty much like 'well you can file an appeal, but that will take a while' so we had to pay out of pocket for everything.

While this experience reflects flaws within the insurance company itself, it is also relevant to this research as the participant was negatively impacted, as a result of fertility treatment coverage not extending to people with situational infertility.

Allison also explained that she had to undergo twelve failed IUI treatment cycles, paid for out of pocket, before her insurance would cover IVF treatments. When looking at the cost of IUIs and the emotional distress of undergoing twelve failed cycles, it is unclear how requiring that amount of failed cycles is beneficial to the insurance company. This requirement also bars queer couples who are hoping to undergo reciprocal IVF treatment, as they would not get coverage without doing IUIs first. If a queer couple wanted to conceive a child using the process of reciprocal IVF, they would have to pay completely out of pocket under that insurance requirement, which may result in the couple deciding not to pursue fertility treatment. Queer couples choosing not to seek fertility treatment is an example of the population resisting seeking healthcare due to their identities affecting the level of care they receive (Bonvicini & Perlin, 2003; Cant, 2005).

Clinic Selection

Participants were asked to share their reason for seeking out fertility treatments, and then share how they selected a fertility clinic to work with. All participants shared that they sought out fertility treatments because they wanted to conceive a child with their partner. In looking at how participants selected their clinics, it was discovered that insurance policies dominated the selection process. Because many participants had to select a clinic based on what clinic was in their insurance network, they were not able to choose a clinic that valued inclusion or a clinic that stated their stance on serving LGBTQ+ patients in this capacity or choose a clinic that was referred to them. Referring back to the American Society for Reproductive Medicine (2013), fertility clinics do vary in their willingness to treat queer couples and while none of the participants were refused services by a clinic, the chances of them ending up at a clinic and being refused services is likely to be higher when they have to choose a clinic mandated by their insurance company. Some participants, like Lucy, Kelsie, and Claire, were also limited by the number of clinics that were available in their area. This demonstrates another barrier to selecting a queer inclusive provider, as participants have to choose a clinic that is within a reasonable driving distance, due to the frequency of testing and monitoring appointments throughout the treatment process.

Treatment Protocol

It was demonstrated by the majority of participants, that the treatment protocol designated by fertility clinics for each patient, is not inclusive of identity and that the protocols reflect heteronormative assumptions. Many participants were required to do testing and procedures that did not seem relevant when considering their sexual identity.

An example of this is having the person who is going to be going through the medical process, undergo an HSG test without any history of fertility issues. This test is done as a way of diagnosing issues, but also flushes the fallopian tubes which can be a treatment for someone experiencing infertility issues. However, because many of the participants who sought treatment were only seeking it because they were queer and cannot conceive a child on their own, there was no indication of that procedure being necessary. Other tests were more minor and many were covered by insurance in some cases, such as bloodwork and pregnancy testing. The data showed that many of these tests were mandatory, and the participants were not given the option to waive certain tests – the reason given being ‘it’s protocol’. This shows that heterosexual couples are the main client base at these clinics. A lack of inclusive paperwork also reflects this, as many of the forms that participants filled out assumed heterosexuality, utilizing terms such as ‘husband’ or ‘father’ as opposed to more inclusive language such as ‘spouse’ or ‘parent’. A lack of inclusive protocol and paperwork demonstrate how heteronormativity is reinforced in this setting.

Inconsistency and confusion, similarly to that experienced when dealing with insurance policies, is reflected in the services provided by clinics and specific providers. In more than one instance, participants reported hearing the experiences of other couples at the same clinic where providers were following different protocols. Some patients were even able to access different types of treatment at different clinics that were not offered at their original clinic of choice. While this seems as if it could be an issue with inconsistencies across fertility clinics in general as opposed to being related to sexual orientation, I am specifically referring to Amber’s situation, in which she could access

reciprocal IVF utilizing the INVOcell device at another clinic, after being denied that protocol at her original clinic. This demonstrates heteronormativity as the original clinic denied reassessing the protocol to make it more inclusive for queer couples, and instead refused the treatment to the participant.

Inclusivity

The findings in the subtheme ‘inclusivity’ are also reflective of heteronormativity experienced within healthcare spaces. When the participants were asked if they saw any couples at their clinic who they perceived to be queer, some said that they saw a queer couple a few times, while others said that they never saw another queer couple. For the participants who did see couples who they perceived to be queer at their clinic, they may have experienced an assumption of community which could lead to them feeling more comfortable and included at the clinic, and would at the very least know that the clinic provides services to queer couples. Some participants who were not receiving fertility coverage from their insurance, were able to research different clinics, or get referrals in order to help them choose a clinic to go to. Referrals and recommendations from queer friends who have utilized a clinic reflect a sense of community and trust within the queer community. There is also a reduced chance that the participants would encounter microaggressions at the clinic, and that the clinic would have more inclusive policies on the assumption that they have experience serving the LGBTQ+ community. This is reflected in Karen’s experience when she shared that she and her wife would change the information on forms to correctly reflect their identities, saying that “all of the paperwork was obviously like if it was a heterosexual couple. We just crossed it out and put you

know, whatever term would be appropriate...after they maybe experienced enough, they might change things.”

The majority of participants reported that they did not see any representation of queer couples in any of the media at the clinic (pamphlets, books, magazines, posters, etc.). The significance of this finding, like many others, also lies in heteronormativity. One couple, Karen and Jessica, reported seeing a Safe Zone sticker at their clinic, leading them to feel included as opposed to othered. Ingrid and Edith had a different experience. Ingrid explained that the clinic they chose had a very lengthy page on inclusivity on their website, but then later said that they handled the work “competently, but not welcomingly.” She also said:

I think what has kind of been missing is, I didn't realize how much I wanted somebody to be able to say 'this is all a big mess for you and we get it, but we've seen it a bunch of times and we'll be your shepherd' and 'here are some things you have permission to feel or that we're even going to guide you towards feeling because they're okay to feel' and just to give me some sort of handle to grasp from, or you know, something. [But] instead what I've got is this sort of blankness or this 'all of your feelings are fine, go have them', and that's not helpful.

Ingrid expressed frustration in the lack of engagement she perceived from the staff. However, it is hard for both the participant and myself to pinpoint whether that lack of engagement is queer related bias, or if that clinic is just generally bad a patient support. Ingrid continues:

[It] feels really complicated, you know, I think if we were to challenge them, they would say 'well, tell us what you need and we'll do it'. Part of the point is 'well, no, you guys are professionals. We're coming to you for a top to bottom service. So it's not our job to tell you'. You know, every patient, it is their job [healthcare professionals] to tell them what they need. I get being an advocate for yourself, but it's your [healthcare professionals] job to know. I don't want to have to teach you how to do it so that then you do it, [or] I'll just go do your job by myself, alone. That piece has been frustrating, and it's a clinic that made a point of saying that they are welcoming. If they hadn't said that at all, I wouldn't feel half as

bothered as I do. [But] I think if the system is going to say that it's branching out and it's accommodating, that it's supportive, than it needs to be those things and not just a written page on the website.

Ingrid's feelings reflect previous research addressing how queer people are impacted by heteronormativity in the healthcare system. She demonstrates first-hand how queer people may feel discomfort while accessing healthcare, or they may resist seeking healthcare in general (Bonvicini & Perlin, 2003; Cant, 2005, Smith & Turell, 2017).

IDENTITY

The data presented in the findings section under the theme 'identity' is also relevant when considering my research question. This theme highlights the ways in which the identities of the participants became relevant in their treatment experiences.

Care Team Assumptions

The experiences participants shared demonstrate how many fertility clinics operate under an assumption of heterosexuality, reflecting heteronormativity more broadly. This representation of heteronormativity proved to be harmful to queer families, as some expressed feelings of inadequacy and frustration at their health care providers. The question Carla and her wife Elizabeth were asked regarding whether their child would have a positive male role model or not, shows bias towards queer couples, as it is reinforcing the concept of the nuclear family, suggesting that a child needs to have both male and female role models. These findings echo Bell (2010) and Steinberg (1997), who discuss how the medicalization of infertility and treatments contributes to the regulation of sexuality and the reinforcement of heteronormative ideas related to the concept of the nuclear family. Heterosexual couples who are bringing a child into the world generally do not have to consider if there will be a positive male role model, and if they do consider it,

they most likely are not asked to justify who the role model is to their medical staff. It is also likely that single women who are utilizing artificial reproduction technologies to conceive a child, aka single-moms-by-choice, are not asked this question.

The findings demonstrate that in most cases, the clinic care team frequently assumed heterosexuality through using language that does not align with a queer person's identity. This includes but is not limited to, not having inclusive forms and paperwork, making comments to the patient about a 'husband' or 'father', or referring to someone's spouse as their sister or friend. These microaggressions perpetuate heteronormativity and create a healthcare environment that excludes queer people.

CONCLUSION

Overall, the findings of this study demonstrate that heteronormative expectations within healthcare, specifically within the context of fertility clinics and treatment, further marginalize queer people. Sexual orientation impacts the experiences and treatment of queer couples receiving fertility treatment through a fertility clinic; it affects their ability to access insurance benefits or receive fertility coverage due to an incomplete definition of infertility, queer couples experience heteronormativity within their fertility clinic spaces, family encounters, and personal internalizations, and creates feelings of inadequacy, frustration, further marginalizing the queer population. Some issues that queer couples face because of heteronormativity within fertility clinics are that in some cases it literally costs them extra money in the form of unnecessary tests and procedures as well as the inability to access insurance coverage, impacts the quality of their care, and can foster feelings of discomfort. Haymen and colleagues (2013) discussed the different ways in which lesbian women experience homophobia when seeking healthcare services.

These demonstrations of bias and homophobia included exclusion, the assumption of heterosexuality, and the asking of inappropriate questions. Of these forms of homophobia, all were experienced by all of the participants in this study while they were undergoing fertility treatments in a fertility clinic. By utilizing feminist and queer theory as frameworks for the analysis, it is possible to examine gender and sexuality, allowing for a look into larger social issues that exist and are reinforced/demonstrated by the treatment of queer women within the context of fertility treatment.

By considering and analyzing the narratives of queer couples and the marginalization that queer people experience in healthcare, we are able to determine that sexuality does play a role in the treatment of and experiences of queer people seeking reproductive services. In order to create a more inclusive environment within not only fertility clinics, but within the healthcare system as a whole, diversity, as well as equity and inclusion training, needs to be provided to the staff and doctors working within these offices.

Some data from the findings are not included in this discussion section. This is because while the participant's narratives constructed the themes and subthemes, some of those themes were not directly or indirectly answering my research question which was specific the context of fertility clinics. However, the findings are important and needed to be included as they are representative of different aspects of queer people's experiences with the entire fertility treatment process. Different aspects of queer fertility not included in this discussion include how queer people going through fertility treatment interact with family members/friends and the biases and microaggressions they are likely to face, how they handle personal or invasive questions, and how their identities are perceived in

public situations during pregnancy or parenting while queer. These themes could guide future research that looks at queer families, or further examines the queer fertility experience.

Some limitations of the study were time, and a lack of diversity within the sample. Due to the internet-based recruitment method selected, I found that my sample was “likely to underrepresent populations that have low access to the internet” (Nosek et al., 2002:12). Acknowledging this and being aware of sampling error that could occur, ultimately allowed me to select participants from the target population (queer, experiences with fertility treatments) and have a more representative sample that accurately reflects the population (Schutt, 2019).

A brief note about my identities as the researcher as it relates to this research: I identify as a queer, white, cis-gender woman, who is married to a trans and nonbinary person, and who has undergone fertility treatment. My partner and I successfully conceived our beautiful twins through three rounds of medicated IUIs at a fertility clinic local to us. It was our experience in that space that prompted this research. We experienced microaggressions and more explicit acts of bias from our clinic staff, and our clinic heavily reflected heteronormativity in their policies, procedures, and treatment. During and after our experience, I could not help but wonder ‘does this happen to other people?’, a question that created this project. Holding many of the same identities as my participants did not only impact this research but deepened and enhanced it. Because I have been through the experience and am very familiar with the terminology and treatments that my participants were detailing, I was able to spend more time listening to their lived experiences as opposed to trying to decode the medical terminology.

My experiences with heteronormativity and homophobia within the context of a fertility clinic were, not surprisingly, reflected in my participant's experiences as well. Overall, this strengthens my findings and reaffirms what we already know about heteronormativity within the healthcare system.

Although I held many of the same identities as the participants, this was not something that was disclosed to them during interviews. In order to remain open to discovering new data and being open to the direction the data would take me regardless of whether it aligned with my experiences, I maintained a professional boundary with my participants, choosing to not disclose my identities or aspects of my experience with fertility treatment and clinics. My familiarity with the clinic experience as well as my in-depth knowledge of social justice, specifically in identifying bias and microaggressions as they occur, allowed me to see the microaggressions in the participant's experiences that they might not have identified themselves. An example of this is some participant's expressed how accepted and welcomed they felt at their clinic, saying that they did not experience any heteronormative reflective practices or procedures, but then went on to explain how their paperwork listed 'husband' as opposed to spouse. Because of my identities, knowledge, and experiences, I was able to identify those key moments as a representation of heteronormativity or bias which ultimately informed my research findings.

Future research on this topic needs to address the lack of diversity amongst the population of people being interviewed. Because of the extremely high cost of fertility treatment, and the lack of insurance coverage for those treatment, especially for queer couples, the sample for this study was overwhelmingly white and middle/upper middle-

class individuals. It would be beneficial to take a more in depth look at the members of the queer community who are not receiving fertility treatments and go deeper into understanding the reasons why.

From my research and experience with the topic and in finding participants, I discovered that many queer couples who cannot afford or access fertility treatment in a clinic setting, chose to do their own inseminations, at home, with a known sperm donor. While this route is definitely more cost effective, there are higher risks in doing inseminations this way. A person could contract a sexually transmitted infection from using fresh sperm from a known donor who is not tested in advance or who is not honest about their status. There could also be future custody battles if the known donor and the person trying to conceive did not go through the correct legal processes to remove parental rights from the donor. One participant who used a known donor had a legal contract drawn up by a lawyer; all parties involved signed the document and it was notarized accordingly. However, according to Sarah Tipton, a legal writer, in some states a court will not honor a contract between a sperm donor and the recipient, even if it was drafted by a lawyer and both signed and notarized (2018).

Other future research could involve doing a comparative study between heterosexual couples and their experience with fertility treatments and queer couples and their experience. Because my study only looks at the experiences of queer couples, there is no comparative analysis to be done. It would be beneficial to compare the two experiences and hopefully be able to provide a more detailed analysis about the differences in their experiences, allowing researchers to more clearly explain the ways in which sexual orientation and identity play a role in the treatment of queer people in the

fertility clinic setting. This type of comparative analysis would also be beneficial to taking a more intersectional approach, and specifically looking at the experiences of couples of color going through fertility treatment and comparing those to the experiences of white couples.

This research is limited to couples who were receiving treatment at fertility clinics. It would be valuable to look at the ways in which queer couples or queer people create families in ways other than through the utilization of artificial reproduction technologies. Situations such as adoption and surrogacy could be explored using similar methods in order to see the ways in which sexual identity and orientation could affect the way that people going through the adoption or surrogacy process are treated.

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APPENDIX A
INSTITUTIONAL REVIEW BOARD APPROVAL



Institutional Review Board

DATE: April 24, 2019

TO: Caitlin Ortis
FROM: University of Northern Colorado (UNCO) IRB

PROJECT TITLE: [1383617-2] QUEERING FERTILITY: Experiences of Queer/Lesbian Women Seeking Fertility Treatment within a Heteronormative Healthcare System and Society

SUBMISSION TYPE: Revision

ACTION: APPROVAL/VERIFICATION OF EXEMPT STATUS

DECISION DATE: April 24, 2019

EXPIRATION DATE: April 24, 2023

Thank you for your submission of Revision materials for this project. The University of Northern Colorado (UNCO) IRB approves this project and verifies its status as EXEMPT according to federal IRB regulations.

We will retain a copy of this correspondence within our records for a duration of 4 years.

If you have any questions, please contact Nicole Morse at 970-351-1910 or nicole.morse@unco.edu. Please include your project title and reference number in all correspondence with this committee.

This letter has been electronically signed in accordance with all applicable regulations, and a copy is retained within University of Northern Colorado (UNCO) IRB's records.

APPENDIX B

PARTICIPANT INFORMED CONSENT FOR INTERVIEWS



CONSENT FORM FOR HUMAN PARTICIPANTS IN RESEARCH
UNIVERSITY OF NORTHERN COLORADO

Project Title: Queering Fertility: Experiences of Queer/Lesbian Women Seeking Fertility Treatment in a Heteronormative Healthcare System

Researcher: Caitlin Ortis, Sociology MA Graduate Student
 Phone: 419-344-9359 E-mail: Caitlin.ortis@unco.edu
 Supervisor: Dr. Cliff Leek
 Phone: 970-351-4780 E-mail: Cliff.leek@unco.edu

Purpose and Description: The primary purpose of this study is to determine the role, if any, sexual orientation plays in the experiences of and treatment of queer couples who are receiving fertility treatments/assisted reproduction through a fertility clinic.

By signing this form, you are consenting to participate in a 30-90 minute recorded phone or video interview.

At the end of the study, I would be happy to share my data and findings with you, upon your request. Your personal information will be kept confidential – only myself and my supervisor will have your name and contact information. In the final report, your name will be replaced with a pseudonym in order to retain anonymity. All data collected and analyzed for this study will be kept on a private computer, only accessible by the researcher.

The risks in participating in this study are minimal. However, participants may be asked to speak on topics that are of a sensitive nature, which may bring up negative feelings for the participant. If at any time you experience emotional discomfort, you may wish to contact the National Suicide Prevention Lifeline at 1-800-273-8255, or follow up with a mental health professional.

Participation is voluntary. You may decide not to participate in this study and if you begin participation you may still decide to stop and withdraw at any time. Your decision will be respected and you will not be asked any further questions and your data will not be used. Having read the above and having had an opportunity to ask any questions, please sign below if you would like to participate in this research. A copy of this form will be given to you to retain for future reference. If you have any concerns about your selection or treatment as a research participant, please contact the Institutional Official for the Protection of Human Research Subjects, Linda Black, Ed.D. at 970-351-1907 or at linda.black@unco.edu.

Subject's Signature _____ Date _____

Researcher's Signature _____ Date _____

APPENDIX C
INTERVIEW GUIDE

Interview Guide

Demographic Information:

- Name
- Age
- Sexual Orientation
- Gender Identity
- Relationship Status
- Race/Ethnicity
- Socio-economic Status/Class

Questions:

1. How did you first come across fertility treatment?
 - a. What led you to seek fertility treatment?
 - b. What treatments have you received/are you receiving?
 - c. How long did you receive treatments?
 - d. Are you currently pregnant? Have you already had a child conceived through fertility treatment?

2. How did you select a provider?
 - a. Were there any factors that you took into consideration regarding your sexual orientation when researching providers?

3. Tell me about your first visit to this provider.
 - a. Did you feel welcomed by the staff/doctors?
 - b. What kind of things did you see in the office? Posters on the walls, magazines, books, etc
 - c. Were there any other people there?

4. How was your sexual orientation was accepted and respected? How was it not?
 - a. Was there any language used by anyone in the office that did not align with your identity?

5. If you have successfully conceived, have you faced questions regarding how you conceived?
 - a. How have those made you feel?
 - b. If currently pregnant or have a child already conceived via fertility treatment, do you feel that people make assumptions about your identity because of this?

6. What insurance coverage, if any, did you have for treatment?
 - a. If yes, were there any conditions that needed to be met in order to receive coverage?

7. In what ways have you felt that your fertility journey has been perceived by the support groups you are involved with? (ie Instagram, Facebook, the Bump, etc)
8. (Partner who did not carry/attempt to become pregnant): Can you tell me about any feelings that you had about yourself during the process, and your feelings about utilizing donor sperm to conceive your child?
9. If pregnant or parenting: How do you feel your sexual identity is perceived when you are in public (either as visibly pregnant or with child)
10. How open have you been with your family(ies) about your fertility process/conception process?
 - a. How has your family reacted to your specific fertility journey?