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"Made of Queer Magic": Understanding the experiences of pregnancy for queer women

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“Made of Queer Magic”: Understanding the experiences of pregnancy for queer women

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PsyD Clinical Dissertation Signature Page

This Clinical Dissertation, written under the direction of the student’s Clinical Dissertation Chair and Committee and approved by Members of the Committee, has been presented to and accepted by the faculty of the Clinical Psychology PsyD Program in partial fulfillment of the requirements for the degree of Doctor of Psychology. The content and research methodologies presented in this work represent the work of the student alone.

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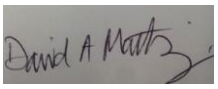

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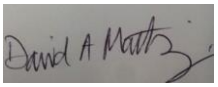

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Dedication and Acknowledgement

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Abstract

Queer families are deciding to use donor insemination or medically assisted reproductive treatments to become pregnant and start their families. Previous research indicates that the process of using medically assisted reproductive treatments may be a stressful experience for queer families due to cisheteronormativity within the system. In addition, research has also revealed that stress during the process of conceiving can impact mental health experiences during pregnancy. However, there is a lack of research on the specific mental health experiences of pregnancy for queer women. The present study used a qualitative research design guided by constructivist grounded theory to examine the experiences of pregnancy for queer women. Eight pregnant, queer, cisgender women were interviewed regarding their experiences of pregnancy. Initial and focused coding were used to analyze the interviews and resulted in major analytic categories and a substantive theory/conceptual model that reflects the experiences of participants in this study. The study revealed that the challenges and experiences specific to queer women’s process of becoming pregnant impacts their physical and mental health experiences during pregnancy. Results from this study have clinical implications and suggest the need for assessment and interventions that target the specific, unique stressors queer women experience during the process of trying to conceive.

“Made of Queer Magic”: Understanding the experiences of pregnancy for queer women

It has been estimated that as many as 2 million to 3.7 million children under the age of 18, living in the United States, may have a lesbian, gay, bisexual, transgender, and/or queer parent (Gates, 2015). Gates (2015) suggests that about 200,000 of these children are being raised by same-sex couples. Historically, homosexuality and the family have been viewed as conflicting or exclusive categories, primarily due to heterosexism (Allen & Demo, 1995). However, there have been significant changes over the last several decades when it comes to queer family formation, specifically in the ways queer couples go about building their families (Goldberg, 2010).

Same-sex female couples have been using Medically Assisted Reproductive (MAR) technologies for years and, in 2013, the Society for Assisted Reproductive Technology released a statement that sexual orientation and marital status should not restrict access to reproductive technologies. It has been hypothesized that advances in reproductive technologies, societal acceptance, and access to medically assisted reproductive treatments (MAR) over the last decade have increased the number of same-sex female couples utilizing this process to build their families (Carpinello, et al., 2016). Despite the reported increases in utilization, data representing the numbers of same-sex female couples using MAR services do not exist. In 2014, only 60.2% of clinics belonging to the Society for Assisted Reproductive Technology reported treating female couples (Carpinello, Jacob, Nulsen, & Benadiva, 2016).

On a similar note, research on same-sex female couples’ experiences using MAR treatments to become pregnant and build their families is limited. Navigating the journey to parenthood presents challenges for most parents. Slade, Cohen, Sadler, and Miller (2009) state that pregnancy can be disruptive for an individual even when it is planned and wanted. Same-sex

female couples choosing parenthood often experience additional challenges when deciding to build a family and become pregnant. Already facing stigmatization, discrimination, and heterosexism in daily life, being pregnant in a heteronormative society can bring about additional stressors in many contexts, creating an even more vulnerable experience.

Definition of Terms

The terms queer, lesbian, gay, bisexual, transgender, and queer (LGBTQ), sexual minority, as well as, same-sex female couples will be used throughout this research proposal. The researcher would like to acknowledge that the list and use of these terms is imperfect and may not represent the variability and diversity in the experiences of the participants and the communities in general. This researcher uses language that is inclusive and reflects the diversity of sexual identities and gender identities of the participants in this study.

Family Building Processes and Terminology

Zegers-Hochschild et al. (2009) aimed to develop an internationally accepted set of terminology for assisted reproductive technologies practiced worldwide. Below are their proposed definitions for ‘assisted reproductive technology’ and ‘medically assisted reproduction’ which will both be used throughout this study.

Assisted Reproductive Technology (ART): All treatments or procedures that include the *in vitro* handling of both human oocytes and sperm, or embryos, for the purpose of establishing a pregnancy. This includes, but is not limited to, *in vitro* fertilization and embryo transfer, gamete intrafallopian transfer, zygote intrafallopian transfer, tubal embryo transfer, gamete and embryo cryopreservation, oocyte and embryo donation, and gestational surrogacy. ART does not include assisted insemination (artificial insemination) using sperm from either a woman's partner or a sperm donor.

Medically Assisted Reproduction (MAR): Reproduction brought about through ovulation induction, controlled ovarian stimulation, ovulation triggering, ART procedures, and intrauterine, intracervical, and intravaginal insemination with semen of husband/partner or donor.

Assisted Insemination/Donor Insemination: Insemination that uses donor sperm to become pregnant. Assisted Insemination/Donor insemination reflects the processes of insemination without implying that the medical system was involved. This can include DIY/In-home insemination, IUI, IVI, etc.

Intrauterine Insemination (IUI): Intrauterine insemination (IUI) is a type of medically assisted reproduction insemination in which sperm in placed inside the uterus to achieve fertilization and pregnancy. IUI is sometimes referred to as assisted insemination or artificial insemination.

Intravaginal Insemination (IVI): Intravaginal insemination (IVI) is a type of assisted insemination in which donor sperm is inserted into the vagina using a syringe.

In Vitro Fertilization (IVF): In Vitro Fertilization (IVF) is an assisted reproductive technology procedure that involves extracorporeal fertilization. It often includes a series of procedures including, egg retrieval, sperm retrieval, egg fertilization in laboratory dish resulting in an embryo, and embryo transfer to uterus.

Critical Literature Review

LGBTQ Populations and Sexual Orientation in Research Literature

Research on lesbian, gay, bisexual, transgender and queer (LGBTQ) persons and communities continues to emerge in the literature, especially in the last several decades. The themes represented in the literature have largely been influenced by clinical, social, and political contexts as well as an increased visibility and positive representation of LGBTQ persons in our popular U.S. culture (Goldberg, 2010; Holley, 2017).

Early research on LGBTQ populations in the psychological literature went through a major shift following the removal of the term homosexuality from the Diagnostic and Statistical Manual of Mental Disorders (DSM), 3rd edition in 1973 (American Psychological Association, 1980). Prior to this, research on LGBTQ communities was rooted in the societal belief that homosexuality was a psychological disorder and same-sex relationships were therefore viewed as deviant. The removal of homosexuality from the DSM set into motion a shift from a clinical diagnosis and pathological view of homosexuality to a non-pathological emphasis and this shift was representative of a larger movement to de-stigmatize homosexuality (Conger, 1975; Rothblum, 1994).

Research in the 1970s and 1980s, following the removal of homosexuality from the DSM, included themes of coming out, establishing gay identities, sexual exclusivity versus openness in relationships, and "sex role" identity and behavior (Blasband & Peplau, 1985; Cardell, Finn, & Marecek, 1981; Coleman, 1981; Jones & de Cecco, 1982; Lewis, 1984; Troiden, 1979). Research continued to perpetuate an "othering" of LGBTQ communities as studies began comparing homosexual and heterosexual relationships (Holley, 2017). Research designs utilized heterosexual relationships as control groups while LGBTQ relationships were the "other" group. Reflected in these trends of between group comparisons, is the notion that heterosexual relationships are the "norm."

Research in the late 20th century began to identify the similarities and differences between homosexual and heterosexual relationships. Literature reviews reveal that both relationship types appear to operate in a similar manner and have similar relationship satisfaction rates (Kurdek, 2004; Peplau & Fingerhut, 2007). Differences were also found, shedding a positive light on same-sex relationships, including greater emphasis on equality within same-sex

relationships and more effective conflict resolution behaviors (Gottman, Levenson, Swanson, Swanson, Tyson, & Yoshimoto, 2003; Kurdek, 2005). Although these themes continue to be explored in the current literature, a greater emphasis on the diversity within LGBTQ communities and experiences has recently begun to be demonstrated in the research literature (Goldberg, 2010; Holley, 2017).

LGBTQ Experiences in the United States

Considering Multiple Identities

It is important to consider the broader sociopolitical climate, including cultural norms and practices in the context of time, and place, when examining the experiences of queer families (James & Murphy, 1998). Additionally, it is important to acknowledge that individual cultural identities may impact an individual’s internal and external experiences of heterosexism and oppression (Goldberg, 2010). An individual’s sexuality and gender identity do not operate in a vacuum. Other identities such as one’s age, race, ethnicity, religion, class, family of origin, and location of where they grew up, create overlapping and interdependent systems of disadvantage and discrimination. The intersectionality of these identities may influence their experience of heterosexism from the broader society as well as their levels of internalized heterosexism. These individual characteristics and cultural memberships may also have implications for their membership in intimate relationships (Goldberg, 2010). Cultural differences exist between individuals of a couple, as well, and may play significant roles within relationships.

It is critical to acknowledge the diversity within LGBTQ communities and the implications of multiple oppressed identities that exist for individuals and couples. These oppressed identities have implications for mental health and well-being. This researcher proposes

that pregnancy and the transition to parenthood, should be considered as additional identities that may intersect with other identity memberships.

Research has demonstrated that becoming a parent for the first time is a challenging life transition for queer families as it requires a process of renegotiation of personal roles and identities to fit those of a “parent” (Cao, Mills-Koonce, Wood, & Fine, 2016; Cast, 2004; Cowan & Cowan, 2000). New parental identities are worked into the existing identities (e.g. spouse, worker, queer, femme) at a time where traditional gendered divisions of labor are amplified (Katz-Wise, Priess, & Hyde, 2010 ; Strauss & Goldberg, 1999). In addition, the transition to parenthood is also a time where new parents may experience changes in their social networks and primary supports (Bost, Cox, Burchinal, & Payne, 2002). Cao and colleagues (2016) utilized identity theory to discuss the potential stressors same-sex couples face during the transition to parenthood as well as the coping strategies they use. They used identity theory framework to understand the way in which same-sex couples develop a sense of self that merges the “conflicting” identities as parents and lesbian women. They explain how the prevailing heteronormative model of family and parenthood impacts their ability to integrate their “sexual minority identity” and their parent identity at the same time. In result, this attempt at integration can result in tension between their marginalized queer identity (historically viewed as childless) and parental identity (historically regarded as a heterosexual privilege), which may cause distress and anxiety. The authors also suggest that it is important to consider how other social structural factors such as social class, race/ethnicity, family structure, geographic location, and associated social and cultural contexts independently and intersectionally, inform the identity transformation process for queer parents. Finally, they also discuss how same-sex couples cope with this distress in order to alleviate these negative feelings and achieve a “verification state”

which they refer to as “the process of bringing one’s perceived self-relevant meanings in a situation into agreement with the actual self-meanings one holds in identity standards by modifying one’s output to the environment” (Cao, Mills-Koonce, Wood & Fine, 2016, p.6).

Minority Stress

Same-sex female couples experience unique stressors due to their stigmatized and marginalized status in a predominantly heterosexual society (Heron, Braitman, Lewis, Shappie, & Hitson, 2018). Meyer (2003) and Hatzenbuehler (2009) have developed theories explaining how sexual minority stress impacts mental health and well-being. Taking their theories together, they suggest factors such as actual or anticipated rejection and discrimination, disclosure, or concealment of sexual orientation, as well as internalized negative messages about homosexuality (heterosexism), may impact distress levels for sexual minority individuals. Other research has acknowledged the impact of sexual minority stress on health disparities between non-heterosexual and heterosexual women, reporting that non-heterosexual women have higher rates of mood and anxiety disorders (King et al., 2008; Marshal et al., 2011), increased risk for substance use (Cochran et al., 2004), suicidal ideation (Fergusson et al., 2005; Hill & Pettit, 2012), and suicide attempts (Gilman et al., 2001; Herrell et al., 1999; King et al., 2008).

Queer families’ experiences of family building operate within the social context in which they exist. As queer families transition to pregnancy and parenthood, their new identity as a parent also intersects with their other cultural identities.

Pregnancy

Pregnancy is an extraordinary time in life for many individuals who experience it. It is a complex experience that involves biological, emotional, and social factors and it is a critical time for the mental health of all primary caregivers and their new baby. Pregnancy often brings

transition, transformation, and reorganization for individual and family identities, and can be disruptive even when it is planned and wanted (Slade, Cohen, Sadler & Miller, 2009). Culturally, pregnancy is often stereotyped as a time of bliss and serenity (Leifer, 1980). However, research suggests that these states do not typify the experience for most women and that affective instability is a more common experience for even the most stable women during pregnancy (Bibring, Dwyer, Huntington, & Valenstein, 1961; DiPietro, Novak, Costigan, Stella, & Reusing, 2006; Moses-Kolko & Feintuch, 2002). The period of pregnancy involves a shift and reorganization of one’s sense of self at an internal, psychological level, as they begin to incorporate a new identity of becoming a parent. Regression, conflict, anxiety, depression, emotional lability, and ambivalence are all natural consequences of this shift and reorganization (Slade, Cohen, Sadler & Miller, 2009). Additionally, a woman’s experience of pregnancy is strongly affected by her social context, including her most immediate relationships as well as the larger society and cultural memberships to which she belongs (Slade, Cohen, Sadler & Miller, 2009).

The transition to parenthood for heterosexual couples has been studied extensively in the literature (Cowan & Cowan, 1988; Gjerdingen & Chaloner, 1994; Goldberg & Perry-Jenkins, 2004). The literature examining the transition to parenthood for heterosexual couples has revealed that the process can be challenging and stressful. This literature identifies specific challenges in relationship quality, work and family responsibilities, and emotional well-being (Ballard, Davis, Cullen, Mohan & Dean, 1994; Belsky & Rovine, 1990; Costigan, Cox, & Cauce, 2003; Krieg, 2007; Matthey, Bartnett, Ungerer, & Waters, 2000; Shulz, Cowan, Cowan, & Brennan, 2004). Protective factors for heterosexual couples that facilitate the transition to parenthood have also been identified in the literature and include a strong preexisting marital

relationship, and social support from family and friends (Feldman, Sussman, & Zigler, 2004; Goldberg, 2010; Morse, Buist, & Durkin, 2000). Very little research has examined this transition for same-sex female couples and the research findings specific to heterosexual couples cannot be generalized to same-sex female couples (Goldberg, 2010). Goldberg (2010) states,

> In becoming parents, lesbians and gay men destabilize the associative interdependence of ‘the family,’ heterosexuality, and reproduction and therefore serve as vivid examples of the socially constructed nature of families. Furthermore, they directly challenge the necessity of conventional (hetero)sexual relations for reproduction. (p. 1033)

Although similarities may exist, queer couples and their families are inherently different from cisgender heterosexual couples and their families. They have unique strengths and challenges that may translate to their transition to parenthood and specifically, experience of pregnancy, that have not yet been demonstrated in the literature.

Queer Pregnancy

Few, if any, studies have examined the pregnancy period for queer women. However, there has been some research regarding motivation to use medically assisted reproductive treatments to become pregnant for same-sex female couples. This research has identified motivating factors in using medically assisted reproductive treatments, including the importance of experiencing pregnancy and childbirth (Chabot & Ames, 2004; Daniels, 1994; Goldberg, 2010; Harvey, Carr, & Bemheine, 1989; Kranz & Daniluk, 2006; Reimann, 1997), ability to control their child’s genetic background and prenatal care (Wendland, Byrn, & Hill, 1996), and the desire to raise a child from infancy (Herrmann-Green & Gehring, 2007). Queer couples have also identified pursuing biological parenthood because they felt their family members were more likely to accept their child and their decision if the child was genetically related to them

(Goldberg, 2010). Furthermore, some queer couples anticipate less barriers and discrimination in the MAR treatment process than in the adoption process (Goldberg, 2010; Kranz & Daniluk, 2006).

Medically Assisted Reproductive (MAR) Treatments

There are multiple routes in family building for queer families including, but not limited to, donor insemination, surrogacy, foster care or adoption, or heterosexual intercourse (Goldberg, 2010; Lev, 2004). Advancements in reproductive technology in addition to social and political progress in terms of LGBTQ tolerance and inclusion, have led to an increase in family building options and consequently a rising number of queer parent families (Carpinello, Jacob, Nulsen, & Benadiva, 2016; Gates, 2015; Goldberg, 2010). The family building process for same-sex couples often requires a great deal of conscious effort, planning, and discussion. It is a process that includes interpersonal, intrapersonal, social, cultural, ethical, and financial factors.

The current dissertation study aimed to understand the experiences of pregnancy for pregnant queer, cisgender women, who use donor insemination or medically assisted reproductive treatments to become pregnant. However, it is important to preface the pregnancy period with a discussion of the events that led up to it. Research has sought to capture the experiences of same-sex couples who use medically assisted reproductive treatments, most often indicating that the process itself can be extremely difficult and stressful for a variety of reasons. Factors such as cost, duration, and lack of control over outcomes have been identified as stressful factors in the MAR process according to heterosexual couples (Burns & Covington, 2006; Williams, Marsh, & Rasgon, 2007). Literature has reported rates of stress that mirror those of patients with heart disease, cancer, or HIV (Domar, Zuttermeister, & Friedman, 1993). Holley and Pasch (2015) propose that same-sex couples using medically assisted reproductive services

may face similar stress as well as additional stress related to factors such as discriminatory clinic policies and procedures, barriers to insurance access based on non-hetero status, or expectations of rejection by healthcare providers if their sexual minority status is revealed. Additional research has also identified the harmful long-term effects of distress during the family building stage including, treatment drop out and distress continuing into pregnancy and postpartum periods (Eisenberg et al., 2010; Smeenk, Verhaak, Stolwijk, Kremer, & Braat, 2004). The process of donor insemination or MAR treatment may have implications for mental health and wellbeing during pregnancy. The following sections will present literature on mental health vulnerability during pregnancy and the repercussions these challenges may pose for postpartum health.

Mental Health During Pregnancy

Pregnancy is a vulnerable period for mental health and well-being of parents. The psychological processes of pregnancy have been mentioned in previous sections and are influenced by physiological and social factors. These processes in conjunction with donor insemination and MAR treatment experiences may create even more vulnerability for queer families during pregnancy. While published research and peer reviewed studies do not exist for queer women, research conducted with heterosexual women suggests prior psychiatric disturbance, substance use, early or ongoing trauma and domestic violence, prior pregnancy loss, and the absence of relational, familial and social supports during this time may be risk factors for mental health challenges during pregnancy (Slade, Cohen, Sadler, & Miller, 2009).

Psychological distress during pregnancy has been noted to carry over to the postpartum period and impact the development of the baby. Several studies have linked anxiety symptomatology during pregnancy to difficulty adjusting to negative expectations about

motherhood (Hart and McMahon, 2006), difficulties adjusting to the demands of the maternal role (Barnett et al., 1991), and the development of other forms of psychological distress, such as postpartum depression (Austin et al., 2007; Heron et al., 2004; Matthey, 2004; Matthey et al., 2003; Sutter-Dallay et al., 2004). Additionally, research has noted the impacts of psychological state during pregnancy on the neurobehavioral functioning of the child, development of difficult infant temperament, developmental delays, and other emotional and behavioral disturbances in childhood (Grant, McMahon, & Austin, 2008).

Mental Health During Pregnancy for Queer Women

A hetero-normative view of childbearing exists in today’s society which creates challenges for those who choose to build their families outside of a heteronormative, nuclear norm. It is likely the case that queer families experience distress surrounding pregnancy due to heterosexist discrimination (Sigal, 2008). Research has acknowledged the impact of sexual minority stress on health disparities between non-heterosexual and heterosexual women, reporting that non-heterosexual women have higher rates of mood and anxiety disorders (King et al., 2008; Marshal et al., 2011) are at increased risk for substance use (Cochran et al., 2004), suicidal ideation (Fergusson et al., 2005), and suicide attempts (Gilman et al., 2001; Herrell et al., 1999; King et al., 2008).

These trends are perpetuated through heterosexism and may transfer over to the pregnancy period. Research on mental health and well-being for queer women during pregnancy is scarce; however, one study identified discrimination, financial struggles, mental health history, and lack of social support, as risk factors for perinatal depression (Ross, 2005).

Significance and Proposed Impact

As the legal and social climate has become more accepting of queer individuals, an increasing number of same-sex couples are planning and creating their families through donor insemination and medically assisted reproductive technologies (Carpinello, Jacob, Nulsen, & Benadiva, 2016; Gates, 2015; Goldberg, 2010). Although there have been advances in the social climate in regard to queer visibility and inclusivity, these advances may benefit certain individuals or groups within the community more than others. It is important to observe the individuals frequently highlighted in these movements (e.g. figures in popular culture) and notice that, most often, these are White, upper class, individuals or couples, who do not necessarily represent the diversity of the LGBTQ community. In alignment with this trend, the research on the process of MAR treatments has come out of European countries such as Sweden and Norway, where same-sex couples have fewer barriers to accessing health care compared to couples in the United States. The Commonwealth Fund International Health Policy Survey (2016) indicates that the percentage of people who experienced access barriers to health care due to cost in the United States was 37% versus in Norway (10%) and Sweden (6%). The representation in the literature may also be indicative of a health care access issue.

Regardless of the rationale behind the lack of literature on same-sex couples using medically assisted reproductive treatments to build their families in the United States, existing literature on related topics highlights the importance of better understanding this experience. Research has demonstrated that queer women experience mental health disturbance at greater rates than heterosexual women (King et al., 2008; Marshal et al., 2011). Additionally, research has revealed that prior mental health disturbances are risk factors for mental health challenges during pregnancy. Given the rates of mental health disturbances in queer women in general and the risk factor of prior psychiatric challenges to psychological well-being during pregnancy, the

research suggests that pregnancy is an especially vulnerable period for same-sex female couples. The need for this research and the importance of this proposed study are made clear here. Given the potential vulnerabilities of queer women during pregnancy it is critical to understand the actual lived experiences of queer pregnancy during this time. This dissertation study seeks to inform future research areas and its results have implications for future culturally responsive services for this community, as well as for informing healthcare providers who are involved in these processes.

The Present Study

The purpose of this dissertation research study is to understand the physical and mental health experiences of pregnancy for pregnant, queer, cisgender women who have decided to build a family through donor insemination or medically assisted reproductive treatments. Research is needed to understand these experiences in an effort to provide supportive, and culturally accountable mental health and medical treatments. Through semi-structured interviews, participants had the opportunity to share their experiences, including their mental health and wellbeing during pregnancy. This clinical dissertation seeks to inform future research and has implications for mental health clinicians and medical providers, as well as inform future scholarship, trainings, and research.

Expected Outcomes

In accordance with grounded theory, the researcher did not make hypotheses about the data prior to data collection. The nature of grounded theory analysis is inductive, and the researcher typically begins with no preconceived hypothesis about the phenomenon being studied (Glaser & Strauss, 1967). Entering data collection with no prior hypothesis allows the researcher to stay as objective as possible when interpreting and analyzing the data.

Methodology

Rationale for Qualitative Research Design

Qualitative research provides the opportunity to explore experiences in a complex, detailed, and in-depth manner (Creswell, 2013). It situates the social contexts in which participants address a certain experience, or phenomena, and enables participants to share their processes, thoughts, feelings, emotions, and behaviors in a way that quantitative research may not allow for. Creswell (2013) explains that qualitative research has been recommended for use with populations who are typically under-represented in the research and for phenomena that are not adequately captured in the literature. Qualitative approaches can be used to develop theories when partial or inadequate theories exist for certain populations. Additionally, qualitative approaches provide an opportunity to give voice to individuals and minimize power relationships that often exist between researcher and participants (Creswell, 2013). Queer individuals are an underserved community and their experiences of pregnancy are an under-researched phenomenon. Utilizing a qualitative approach, this study aids in illuminating the voices and shared experiences of pregnancy for queer women.

To ensure a strong research design, qualitative research literature suggests that researchers select a research paradigm that is congruent with their beliefs about the nature of reality and fit the research questions and aims for the study (Charmaz, 2014; Creswell, 2013). A social constructivist paradigm was selected for this study. Social constructivism denies the existence of an objective reality and, instead, suggests that realities are social constructions of one’s mind (Guba & Lincoln, 1989). As individuals, our views of the world and the ways in which we make meaning of our experiences are influenced by our history and our cultural contexts. For this reason, social constructivism views the existence of as many constructions of

reality as there are individuals (Guba & Lincoln, 1989). Utilizing a social constructivist paradigm will ensure the representation of multiple realities and the honoring of individual values of the participants in this study. This is important as the experiences of queer women who use donor insemination and medically assisted reproductive treatments in the United States to become pregnant have rarely been heard or represented in the literature. Additionally, social constructivism acknowledges the interrelationship between the researcher and participants and highlights the co-construction of meaning in the research process (Creswell, 2013). A researcher brings in her own processes, personal values, experiences and priorities (Charmaz, 2005). When working with marginalized communities it is not uncommon for biases or stereotypes these communities face in society to show up in the research process, even inadvertently. For this reason, it is imperative that this study include an in-depth reflection of the researcher’s personal assumptions, values, and beliefs on the construction of meaning, which are offered in the “Researcher Reflexivity” section of this chapter.

Rationale for Social Constructivist Grounded Theory

Grounded theory was utilized as the methodology for this study. Grounded theory is a research method which seeks to construct theory about experiences and phenomena (Charmaz, 2014). Corbin and Strauss (2007) assert that grounded theory moves beyond mere description to generate or construct a “unified theoretical explanation” (p.107) for a process. It provides an opportunity to learn about the worlds of the individuals we study and a method to develop a theory to understand their experiences. Creswell (2013) describes the data collection process as a “zigzag process” in which the researcher enters into the field to collect data, returns to the office to analyze the data, goes back out to the field to gather more information, returns to the office to incorporate the new information, and this process continues until the data is “saturated” and the

theory is captured in its complexity. Charmaz (2014) considers data to be saturated when collecting new data no longer generates new theoretical ideas or reveals additional information about the researcher’s theoretical categories. This process is referred to as the “constant comparative method” and involves data analyses to be constantly revisited and re-informed by new data and compared to new emerging categories (Parry, 1998).

Grounded theory was developed in 1967 by Barney Glaser and Anselm Strauss who felt that existing theory did not appropriatly capture the experiences of participants under study (Creswell, 2013). They proposed developing theories that were grounded in the direct experiences of participants, rather than deducting hypotheses from existing theories. Since its creation, different researchers offered their own perspectives on grounded theory, applying their philosophical and interpretive frameworks to develop their own approaches, and moving away from the positivism direction that its creators began with. Three major approaches to grounded theory exist today: classic, Straussian, and social constructivist grounded theory. Of these three major approaches to grounded theory, Charmaz’s (2006) social constructivist grounded theory approach was utilized in this study, because of the inclusion of diverse perspectives, multiple realities, and the complexity of experiences. Charmaz’s approach assumes that any theoretical constructing offers an interpretive portrayal of the studied world, not an exact picture of it. Charmaz also places emphasis on the co-construction of reality and asserts that what the researcher brings to the study (e.g., her interests, biases, and assumptions) influences what she can construct. While Charmaz’s approach emphasizes the importance of gathering rich data, coding the data, memoing, and utilizing theoretical sampling, it also places further emphasis on the views, values, beliefs, feelings, assumptions and ideologies of the individuals involved in the research. In doing so, this approach aims to minimize the hierarchical power dynamics of

researchers and participants while at the same time highlighting the researchers’ reflexivity in the process.

The goal of using a grounded theory methodology in this dissertation was to construct a substantive theory that is grounded in the data. A substantive theory is grounded in the data of one particular substantive area (e.g., queer cisgender women’s experiences of pregnancy). It is a “theoretical interpretation or explanation of a delimited problem in a particular area” (Charmaz, 2014, p. 344). A substantive theory is a stepping stone, providing an initial direction for a formal theory. Formal theory, in contrast, is often thought of in research as “a theoretical rendering of a generic issue or process that cuts across several substantive areas of study” (Charmaz, 2014, p. 343). Formal theory has often been tested and re-tested and based on validated, generalizable conclusions across multiple studies (Gasson, 2009).

As the experiences of queer women who decide to become pregnant through donor insemination are not sufficiently represented in the literature, utilizing grounded theory provides an opportunity to give voice to these experiences and construct a substantive theory in collaboration with this population. Additionally, using social constructivist grounded theory, this study aimed to give voice to the research participants who, because of their sexual identity status, have historically been oppressed and marginalized.

Trustworthiness

While quantitative studies use terms such as “reliability” and “validity” to examine the quality of their data, qualitative studies often use the concept of “trustworthiness” (Williams & Morrow, 2009). Williams and Morrow (2009) propose three major categories of trustworthiness for qualitative research: integrity of the data, balance between reflexivity and subjectivity, and clear communication of findings.

Integrity of the data refers to the “adequacy” or “dependability” of the data (Morrow, 2005; Patton, 2002). Williams and Morrow (2009) offer some contributing factors to achieving integrity of the data. A clear articulation of the research methodology and analytic strategy is one factor in achieving integrity of the data. Clearly articulating and referencing the research design allows for the replication of the procedures (Patton, 2002). Additionally, integrity of the data involves assuring that sufficient quality and quantity of data have been gathered (Williams & Morrow, 2009). The authors state that quality and quantity of data gathered goes beyond the sample size and suggest that researchers “collect rich data that are purposefully sampled” (p. 576). Williams and Morrow (2009) suggest using “triangulation” to increase data quality. Triangulation of data refers to the use of multiple methods of data in effort to develop a comprehensive understanding of the phenomena being studied (Moran-Ellis et al., 2006; Patton, 1999). Approaches to triangulation may include using different methods to collect data, examining the consistency of different sources of data within the same method, using multiple analysts to review findings, or using multiple theoretical perspectives to interpret the data (Denzin, 1978; Patton, 1999). Triangulation, was used in this study, through “checks” with participants, checks with the literature, and discussions with colleagues, at different time points throughout the duration of the study.

The second criteria of trustworthiness identified by Williams and Morrow (2009) involves the balance of reflexivity and subjectivity. In other words, the data should represent a balance of participant narratives and researcher interpretation of participant narratives. Two main processes for assuring this balance are utilizing member checking and researcher reflexivity (Williams & Morrow, 2009). Member checking is an important process in constructivist grounded theory research as it attempts to bridge the gap between the researcher’s interpretations

and the participant's actual meanings (Lincoln and Guba, 1985). This study utilized member checks after tentative analytic categories were established. Tentative analytic categories are focused codes that demonstrate potential analytic strength. A discussion of tentative analytic categories will be presented later in this chapter. The primary researcher conducted follow-up interviews with six out of eight participants to gather their feedback about the tentative analytic categories and receive any other general thoughts about the study.

Researcher reflexivity refers to the researcher's awareness of biases and assumptions that they bring into the research process. Rennie (2004), defines reflexivity as an "awareness of the self." In practice, this entails the researcher remaining self-reflective in effort to identify what comes from the researcher and what comes from the participant. The following section will include more on the importance of reflexivity as well as a discussion of this researcher's potential biases and assumptions that may impact the research process.

The third criteria of trustworthiness identified by Williams and Morrow (2009) involves the communication and application of the results of the study. Researchers are encouraged to provide support for their interpretations of the data. This study utilized extant literature, as well as direct quotes from participants, throughout the data analysis process and to support the study findings.

Researcher Reflexivity Statement

Qualitative research acknowledges the role of the researcher in shaping the data. Qualitative research, especially grounded theory research, emphasizes the interactive process and co-construction of theory between the researcher and participants (Creswell, 2013). Creswell (2013) states, "how we write is a reflection of our own interpretation based on the cultural, social, gender, class, and personal politics that we bring to research. All writing is 'positioned'

and within a stance” (p. 215). For this reason, it is imperative that researchers attempt to acknowledge their biases through engaging in reflexivity. Charmaz (2014) states that reflexivity includes examining how the researcher’s interests influenced the research topic, as well as how the researcher relates to the participants and how she presents them in written work. In this section, this researcher will acknowledge her presence in the research process and highlight some pieces of her identity that may impact the ways in which she interprets the data.

To begin, this researcher would like to recognize her identities and acknowledge that the ways in which she identifies may play a role in how she is perceived/how she percieves her participants, as well as bring about certain power differentials between her and her particpants. As a White, cisgender female, the researcher holds certain priviledges and power dynamics that may differ from her participants. As a queer woman, the researcher acknowledges a connection to the queer community. She has a strong interest in hearing the stories of her participants, and holds a desire to ameliorate any distress that this process brings about for this community. As the researcher feels she may identify with some of her participants in this way, she would like to highlight that often times when we feel we can relate to others on a certain identity it may also cause us to be less objective of another’s experience. It may be important to note that this researcher has not gone through the process of assisted reproduction, nor has she ever become pregnant or parented a child.

Through her clinical interests in infant mental health and the transition to parenthood, commitment to the queer community, and research experience with new parents, this researcher became further interested in studying the transition to parenthodd for queer families. As a research assistant, this researcher had the opportunity to hear the stories of same-sex female couples who were utilizing medically assisted reproductive treatments to build their families.

The stories that these couples shared caused her to wonder about how these experiences for same-sex couples may impact their pregnancy, their new identity as parents, and their mental health during this transition.

The researcher anticipated inquiries from participants about her sexual identity and membership to the queer community as well as her relation to motherhood and assisted reproductive treatments. This researcher felt it was important for her to self-disclose these pieces of her identity if asked by participants. In doing so, the researcher paid attention to the impact this disclosure had on the data, paying close attention to instances in which participants may feel the researcher understood a certain experience as a member of the queer community. In these instances, the researcher asked for clarification about participants’ experiences.

The researcher would also like to share some reflections from the experience of conducting this research study. Throughout the process, the researcher found herself deeply engaged in the narratives of her participants. During interviews, the researcher often had an emotional reaction to her participant’s stories. The researcher found herself feeling heartbroken, angry, and elated throughout the interviews. She was struck by the challenges the participants faced in their process of becoming pregnant and moved by the resiliency of each family. During the data analysis process and when reporting or sharing the results, the research felt compelled to make sure she did not leave any parts of her participants’ experiences out. All of the data felt so meaningful and it was important for the researcher to share the data as it had been intended to be shared by the participants.

Procedures

Participants

Participants in this study included eight adult, queer identified, cisgender, pregnant, women, who had used donor insemination or medically assisted reproductive treatments to become pregnant. Individuals were in their second or third trimester of pregnancy at the time of the first interview. Individuals were still eligible for participation if they had experienced pregnancy loss. Additionally, participants were fluent in English. Participants were compensated with a $15 Amazon gift card for their participation.

The researcher originally attempted to recruit participants who had received medically assisted reproductive treatments in the San Franscisco Bay Area. However, due to time constraints of data collection and difficulty based on the specificity of the recruitment criteria, the researcher lifted this criteria to include participants from across the country.

Sampling Strategies and Recruitment

Purposeful sampling was used to select individuals who met the study criteria. Purposeful sampling involves selecting participants who may decisively inform an understanding of the research aims of the study (e.g. queer pregnant women) (Creswell, 2013). Specifically, homogenous sampling strategies were utilized in an effort to focus on a specific subgroup, reduce variation, and simplify analysis (Palinkas, Horwitz, Green, Wisdom, Duan, & Hoagwood, 2015). Homogenous sampling is recommended for grounded theory research as this sampling strategy allows for the selection of participants who can contribute to the development of the theory.

Participants were recruited through online social media platforms that targeted queer family building (e.g., Facebook and Reddit). The researcher shared her flyer with social media administrators and personal contacts. The flyer for the study briefly detailed the goals of the study, criteria inclusion, and the study procedure (see Appendix A).

Participants were instructed to contact the researcher by phone or email. Upon initial contact, the researcher confirmed participant eligibility, briefly reviewed the study, and scheduled the initial individual interview. Following this initial contact, the researcher sent the informed consent form (see Appendix B) by email and the demographics questionnaire (see Appendix C) using Qualtrics.

Data Sources

Demographic Questionnaire

A demographic questionnaire (see Appendix C) was administered through email using Qualtrics. The demographic questionnaire asked participants to respond about their age, biological sex, gender identity, sexual identity, racial identity, ethnic identity, religious preference, education level, and income level. Additional questions were asked about assisted reproductive treatments and pregnancy.

Initial Interviews

Data was collected through initial intensive, 60-90 minutes, semi-structured interviews with each participant. All eight initial interviews were conducted and audio recorded using Zoom video conferencing software. The primary purpose of the semi-structured intial interviews was to ask open-ended questions, which allowed for an interactive space in which both the researcher and participant’s views and insights could emerge (Charmaz, 2013). Interview questions were designed as a guide to explore participants in-depth, detailed experiences of pregnancy. The semi-structured interview guide can be found in Appendix D. Sample items include, “Can you tell me about your journey of becoming pregnant?” and “Do you feel any parts of your pregnancy experience have been particularly stressful because of your queer identity?”

Follow-Up Interviews

Follow up interviews were offered to every participant and were conducted with six out of eight participants as a means of member checking (see Appendix E). In accordance with the constant comparative method, follow up interviews were conducted in order to present tentative analytic categories, serving to “member check” and elicit participants feedback about preliminary data analysis (Charmaz, 2014). In addition, follow up interviews provided the researcher an opportunity to ask participants any clarifying or additional questions that emerged during analysis.

After all eight initial interviews were coded and tentative analytic categories were identified, the researcher emailed participants to assess their willingness to participant in follow-up interviews. Of the eight participants, six participants chose to participate in follow up interviews. One participant did not respond to the email and due to scheduling conflicts one participant did not participate in the follow-up interview. Follow up interviews were 15 to 30 minutes long and occurred over Zoom and regular telephone (according to participants’ preference). The researcher shared a Microsoft Word document by email with each participant which outlined the tentative analytic categories and their properties. The researcher completed a brief check in with participants about how their family was doing, elicited feedback on the tentative analytic categories and asked for any additional feedback or thoughts about the study. The researcher also answered any questions participants had. Using this new data gathered from the follow-up interviews, the researcher used the participant feedback to guide the final stages of analysis.

Memos

Memo-writing was used throughout this research project to support the analytic process. Memo-writing refers to the process wherein the researcher writes down ideas and thoughts about

the evolving theory throughout the research process (Creswell, 2013). Charmaz (2014) states that, “Memos catch your thoughts, capture the comparisons and connections you make and crystallize questions and directions for you to pursue” (p. 162). Memos offer the researcher an opportunity to further explore the data as they encourage the development of ideas, fine-tune succeeding data gathering, and support the reflexivity process (Charmaz, 2014).

As suggested by Birks, Chapman, and Francis (2008) memos for this research project were categorized as *operational*, *coding*, and *analytic* memos. Operational memos were used to capture steps in the research process, as well as for the researcher to write out her reasons for decisions and actions. Coding memos were used to explore codes and categories in the data, while analytic memos were used for “examining, explaining and conceptualizing data” (Charmaz, 2014, p. 169). The researcher wrote memos throughout the research process in the context of these three proposed categories. Microsoft Word was used to complete and store operational memos. Coding and analytic memos took place using the memo function in Atlas.ti software.

Data Analysis

Coding Process

Coding is the first step in grounded theory data analysis and is the process of defining what the data are about (Charmaz, 2014). It involves breaking down large chunks of data from participant interviews into smaller components for data analysis. Coding assists in understanding the experiences of the phenomenon being studied and in developing additional questions about the analytic issues we are defining in our theories (Charmaz, 2014). In accordance with constructivist grounded theory data analysis procedures, data coding in this study occured in two phases: initial coding and focused coding.

As interviews were completed, the researcher had each intervew transcribed by an external transcription company, Rev.com. The transcriptions were uploaded into Atlas.ti and coded using the software.

Initial Coding

According to Charmaz (2014), initial coding is the first step in filling the gap between concrete events and descriptions of events from participants to theoretical insight and theoretical possibilities. “Initial codes are provisional, comparative and grounded in the data” (Charmaz, 2014, p.). Charmaz (2014) reminds the researcher that during the initial coding process of data analysis, answers to the following questions are sought: “What is this data a study of? What do the data suggest? Pronounce? Leave unsaid? From whose point of view? What theoretical category does this specific datum indicate?” Initial coding allows the researcher to begin defining what is happening in the data and begin to understand what it means.

Four methods of initial coding were used in this analysis: line-by-line coding, open coding, in-vivo coding and pre-existing coding. Upon receipt of interview transcriptions, the

researcher uploaded the document into a qualitative analysis software program, Atlas.ti. Atlas.ti allows the researcher to interact with the data and offers several functions which aid in data organization and analysis. The researcher began the intial coding process by using line-by-line coding. Charmaz (2014) suggests that line-by-line coding provides the opportunity to “bring the researcher into the data, interact with them, and study each fragment of them” (p. 121). Line-by-line coding involves going through each line of textual data and providing a code name for that line. It allowed the researcher to take events apart and analyze what makes them up and assign a label. Within each line of textual data the researcher assigned an open code, in-vivo code, or a pre-existing code to the text. Open codes are general codes that define and label what a certain segment of data is about. An in-vivo code captures participants’ language and involved taking direct language from the participant to name the code. Pre-existing codes were assigned during line-by-line coding when a data segment was representative of a concept captured by an exisiting open or in-vivo code. Focused coding was the next step in the coding process. The purpose of focused coding was to advance the theoretical direction of the data (Charmaz, 2014). At the completion of line-by-line coding the researcher had almost 3,000 intial codes!

Focused Coding

Focused coding is a selective phase that uses the most significant and frequent initial codes to sort, synthesize, integrate, and organize large amounts of data (Charmaz, 2006). In order to create focused codes, the researcher reviewed the initial codes and attempted to concentrate on what the codes imply or reveal about the data shared by participants. The researcher then chose original initial codes that represented analytic categories, compared initial codes between each other, re-named initial codes, or merged codes that may represent one category. Charmaz (2014) proposes six questions to determine which codes may serve best as focused codes:

1. What do you find when you compare your initial codes with data?

2. In which ways might your initial codes reveal patterns?

3. Which of these codes best account for the data?

4. Have you raised these codes to focused codes?

5. What do your comparisons between codes indicate?

6. Do your focused codes reveal gaps in the data? (p. 141).

Functions in Atlas.ti were used to support the focused coding process. The software allowed the researcher to view the frequency of each code. This made it possible to identify the most frequently applied codes in order to raise them to focused codes. Atlas.ti also assisted in merging together similar codes and creating ‘code families’ of codes that fall into similar categories. Similarly, the software had the ability to identify codes that may be redundant or codes that may reflect concepts that are closely related. The researcher arrived at about 70 focused codes. Atlas.ti identified the co-occurrence of multiple codes in the data as well. This function is critical in data analysis as it enabled the researcher to examine possible relationships between codes. Contreras (2002) highlights the importance of identifying co-occurring codes and suggests three questions to support the researchers understanding of their relationships:

- What is the co-occurrence telling us about our research problem?
- How do these concepts relate to each other in the context of the study?
- How is this particular concept helping us understand this other particular concept?

After the most frequent and/or significant initial codes were raised to focused codes the researcher utilized memo writing and reflection with the dissertation chair to raise focused codes into tentative analytic categories.

Memos in the Analytic Process

Memos were used to define each code and raise focused codes into categories. Glaser and Strauss (1967) define a category as a “conceptual element in a theory” (p. 37). Categories reflect the codes that have prevailing significance or abstract a common theme or pattern from the data. Focused codes can be understood as a description of the data while categories represent an abstract, theoretical level of the data (Charmaz, 2014). The researcher used the memo function within Atlas.ti to define conceptual categories, explain the properties of each category, detail the conditions of which the category develops, is sustained, and changes, and demonstrates how categories relate to each other.

Theoretical Sampling and Data Saturation

After collecting and beginning to analyze data from the first five intial interviews, the researcher had identified preliminary categories of analysis. Using memos and reflection with the dissertation chair, the researcher revisited the interview guide, made minor changes, and incorporated those changes into the final three intial interviews. Theoretical sampling is the strategy used here to return to the field to collect data that may elaborate and enrich these categories (Charmaz, 2014). The researcher then conducted follow-up interviews with six out of the eight participants, during which she presented the tentative analytic categories to check in with participants to ensure that she had interpreted the data in alignment with their experiences. The new data from follow up interviews was considered in the final analysis.

Data Saturation

Theoretical sampling advances the analysis of data. The process prompts the researcher to generate new questions to gather data that will enrich existing categories, developing the properties of each category. It supports the delineation of the properties of each category and illuminates the relationships between categories (Charmaz, 2014). After the first five interviews

were completed, transcribed and analyzed the researcher used the final three interviews to gather data needed to inform existing categories. Data was gathered until the properties of each category and the data, overall, were saturated. Charmaz, (2014) defines data saturation as occurring when gathering new data no longer inspires the generation of new theoretical insights nor provides new properties of theoretical categories. Glaser (2001) states,

> Saturation is not seeing the same pattern over and over again. It is the conceptualization of comparisons of these incidences which yield different properties of the pattern, until no new properties of the pattern emerge. This yields the conceptual density that when integrated into hypothesis makes up the body of generated grounded theory with theoretical completeness (p. 191).

The researcher established saturation of categories after eight intial interviews.

Developing an Emerging Theory

Corbin and Strauss (1990) state that grounded theory approaches are designed to develop a theoretical explanation that illustrates a basic social process. This involves the researcher identifying a “core category” or “central phenomenon” of which all other categories from the data can be subsumed (Strauss & Corbin, 2008). Charmaz (2006) advocates for the inclusion of diverse perspectives, multiple realities, and the complexity of experiences. Charmaz’s approach assumes that any theoretical constructing offers an interpretive portrayal of the studied world, not an exact picture of it. Additionally, the developing of an emergent theory should not solely represent a single phenomenon (Charmaz, 2006). In moving through the analysis to the constructed theory of this study, the researcher followed Charmaz’s (2006) ideologies that constructivist approaches understand the emerging theory as *one* interpretive lens that the participants experiences could be understood.

Through an iterative process of refining codes, categories and subcategories, reviewing initial analysis and memos, integrating follow-up interview data, as well as reviewing supporting literature, major conceptual categories were identified (Page, 2012). Major conceptual categories are categories whose concepts capture abstract, theoretical ideas about the phenomenon being studied (Charmaz, 2014). Upon identification of major conceptual categories, the next step in analysis was to move from major conceptual categories to a substantive theory.

Strauss and Corbin (1998) have suggested that grounded theory analysts work to “uncover relationships among categories…by answering the questions of who, when, why, how and with what consequences…to relate structure with process” (p.127). To support this process, the researcher used the Conditional Relationship Guide, to understand the relationship among major conceptual categories (Scott & Howell, 2008). A conditional relationship guide is created by answering each of the following questions for each of the major conceptual categories:

- What is [the category]? (Using the informant’s words helps avoid bias.)
- When does [the category] occur? (Using “during ...” helps form the answer.)
- Where does [the category] occur? (Using “in ...” helps form the answer.)
- Why does [the category] occur? (Using “because ...” helps form the answer.)
- How does [the category] occur? (Using “by ...” helps form the answer.)
- With what consequence does [the category] occur? (Using “by...” helps form the answer) (2004, p. 116)

The process resulted in a theoretical model that is grounded in the participants’ experiences.

Results

The purpose of this study was to understand the physical and mental health experiences of pregnancy for queer, cisgender women who have decided to build a family through assisted

reproductive treatments. In this chapter, I will discuss the major categories as well as their properties, dimensions, and how they interact with one another.

Participants

Participants in this study were eight pregnant, self-identified queer, cis-gender women. All participants were in their second or third trimester carrying their first child. Participants were living in different geographic regions across the United States including the San Francisco Bay Area, the Northeast and the Southeast. They ranged in age from 27 to 38. Seven out of eight participants identified their race as white while one participant identified as white/Hispanic. To protect confidentiality of participants, their names and other major identifying information was removed or changed. The participants are briefly described below.

- P1 was 32 years old and 31 weeks pregnant at the time of the first interview. P1 identified as a white, queer/lesbian, cisgender queer femme. P1 and her partner completed multiple rounds of fresh, self-administered, in-home insemination then began doing IUIs at home with a midwife’s support.
- P2 was 32 years old and 20 weeks pregnant at the time of the first interview. P2 identified as a white, bisexual/queer, cis woman and/or femme. She and her husband utilized at least 6 IUI attempts at a medical clinic before becoming pregnant.
- P3 was 34 years old and about 25 weeks pregnant at the time of the first interview. P3 identified as a white, queer/lesbian/gay, woman. She and her wife completed about eight fresh, self-administered, in-home inseminations and then began doing IUIs at home with a nurse practitioner. She reported doing 10 cycles of IUI which led to her pregnancy.

- P4 was 36 years old and about 29 weeks pregnant at the time of the first interview. P4 identified as a white, queer, cisgender female/femme. P4 and her partner tried multiple rounds of self-administered, in-home insemination, IUI, and became pregnant on their first round of IVF.
- P5 was 36 years old and about 27 weeks pregnant at the time of the first interview. P5 identified as a white, queer, female. She and her partner completed two rounds of IUI in a doctor’s office and became pregnant on the second insemination.
- P6 was 38 years old and about 38 weeks pregnant at the time of the first interview. P6 identified as a white/Hispanic, lesbian, female. P6 and her partner completed 7 rounds of IUI and became pregnant after 1 round of IVF.
- P7 was 32 years old and 34 weeks pregnant at the time of the first interview. P7 identified as a white, queer/bisexual, cis female. P7 and her husband reported doing one in-home, self-administered, IUI which resulted in her pregnancy.
- P8 was 27 years old and 28 weeks pregnant at the time of the first interview. P8 identified as a white, lesbian, female. P8 and her partner completed one round of reciprocal IVF and became pregnant.

Major Analytic Categories and Subcategories

Given the participants’ experiences, the major analytic categories are presented based on two timepoints; Section 1: trying to conceive/the process of becoming pregnant and Section 2: pregnancy. Eleven major analytic categories emerged from the data with subcategories that define and support them (Table 1). Each participant’s experience was unique; however, they shared many commonalities among them. Participants did not necessarily experience all of these categories and subcategories and they did not experience them in any particular order.

Table 1
Analytic Categories with Subcategories

Analytic Categories and Subcategories
Section 1: Mental Health while Trying to Conceive
1. Intentionality
a. Positive Impact
b. Mixed or Negative Impact
2. Conducting Research
3. Decision Making
a. How do we want to start our family?
i. Adoption
ii. Who will carry?
iii. Sperm donor
iv. Choosing clinics and providers
v. Method
4. Interactions with healthcare providers
a. Interactions with providers
i. LGBTQ+ Affirming Care
ii. Fertility Counseling
b. Procedures and Treatment
5. Financial burden
6. Life Events
Section 2: Mental Health During Pregnancy
7. Physical and Emotional Aspects of Pregnancy
a. Physical aspects/complications
b. Emotional aspects
8. Queer identity and pregnancy
a. Validating Queer Experiences
b. Queer invisibility
9. Gender related items - Intersection of gender and queerness – Rejecting the binary
a. Sex of baby – Rejecting the binary
b. Gender expression and gender identity
c. Considering the experience for non-cis gendered individuals, non-binary, GNC
10. Connection to Community

Section 1: Mental Health while Trying to Conceive

The process of becoming pregnant is defined by the events and experiences of participants from the time they decided to start building their family to the day they found out they were pregnant. Although the purpose of this study was to understand the experiences of

pregnancy, it became clear that for most participants, the process of becoming pregnant impacted their mental health and overall experiences during pregnancy.

There were many factors that impacted participants’ mental health and wellbeing during the process of becoming pregnant including the processes and challenges shared in this section. In addition to the categories that are shared in depth in this section, previous or existing mental health conditions seemed to be exacerbated for a few participants. Two participants shared that their depression and anxiety symptoms increased during the process of becoming pregnant. One of these participants attributed this increase in depressive symptoms partly to taking Clomid to increase fertility. As mentioned in the previous section, P2 lost her mother just as she was starting insemination. The quote below demonstrates how this loss along with other factors of the process, including taking Clomid, impacted her mental health.

> So, I did three unmedicated, and I did one with Clomid, and I hated Clomid. Clomid made me even more depressed. It was October when I did the Clomid, and I had a week or two ... And it wasn't immediate, so I didn't immediately connect it to the Clomid, but sometime in early November, I was like, ohh, I just feel so bad. And it was like, that makes sense. My mom just died. There're so many reasons to feel depressed right now … Yeah, it was hard. It was very hard. I knew it was ... I felt like we were prepared for it to take a long time and to be difficult, but it was a lot harder than I thought it would be emotionally. Which also made, there was this huge confounding factor with my mom, but- I think it's the two hardest things I've ever done at the same time. (P2)

Even during pregnancy, the journey to becoming pregnant was always in the background. Understanding the process of becoming pregnant sets the context for which the pregnancy exists and is experienced.

Category 1: Intentionality

For participants in this study, the process of becoming pregnant included many deliberate decisions, beginning with the initial intent to start building a family. To this extent, all eight participants discussed intentionality: directed efforts towards an outcome (becoming pregnant), which includes the participant’s desires, thoughts, beliefs, hopes and wishes about the process. Intentionality is shared here as its own category; however, it overlaps with many other categories and subcategories.

Positive Impact

For two participants, the intentionality required had a positive impact on their experience. For example, after doing extensive research on the experience of becoming pregnant for queer women, P8 and her partner decided to surpass doing IUIs and other methods and begin with reciprocal IVF. During their interview, she shared their intentionality behind this decision and how it had a positive impact on their experience,

> We also had friends of mine that I knew from college that had two kids, but they had them via IUI. And I knew their struggles and how many times they had gone through IUI at home. Because they tracked their own ovulation and all that jazz, and how much time consuming and frustrating and heartbreaking that their experience was. And then later involving a clinic to do IUI, to get their two kids. So, after looking at all of that, looking at SART [Society for Assisted Reproductive Technology] data too, which just says live birth rates and stuff, we just said, "Hey, we don't want to waste our time with IUI…" Just

> knowing from all that background research, because I love to research things, I was like, "No. I don't want to... Even though an IUI can run you $100 to $2,000, I was like, "I'd rather just put that money towards IVF. That has a higher statistical rate of getting pregnant and let's just do it and get it done. And hopefully it works. And if it doesn't, it doesn't, but I'm going to take my odds." And here we are. One cycle later. Boom. Pregnant. (P8)

Mixed or Negative Impact

For six other participants, the consequences of decisions carried more weight and the intentionality of the process contributed to exhaustion, anger, sadness, and disappointment (i.e., when an attempt did not work the disappointment felt more painful). Factors such as the waiting and anticipation of an attempt, the time-consuming nature of having a successful attempt, and the lack of control participants felt they had over the process contributed to making the process of becoming pregnant more challenging. For all participants, even those who were successful on their first or second attempts, there was a lot of waiting and anticipation involved in the process of becoming pregnant. Many participants described the process as an “emotional rollercoaster.” Participants had to constantly be tracking their menstrual cycles in order to know when they were ovulating and when to inseminate. Many participants did this every month, tracking and inseminating and waiting a few weeks to take a pregnancy test. This pattern involved excitement and hope and also stress, anxiety, and disappointment. P3 describes this process.

> You sort of live your life in two-week increments, and are constantly either waiting to see when you're going to ovulate, or waiting to see whether you got pregnant, and then being disappointed that you're not, but then gearing up to do it all over again. (P3)

P2 describes how she felt physically and emotionally during an in clinic IUI.

> But yeah, it hurt. I felt like garbage. I felt like emotional tissue paper, where I was just so fragile and, and ... I cried on the table in the clinic, and then I cried in the car, and then we went out for brunch and I cried at brunch. It was not a good day, and I had no hope that it would work. And then I went to the zoo that afternoon. That was a good idea. That helped. (P2)

P1 discussed the exhausting nature of having to be so intentional during the process of becoming pregnant and the weight it carried after experiencing pregnancy loss,

> Straight women have early miscarriages all the time, don't even know. It's like, "Oh, that was a really heavy period and came a couple weeks late. Huh." So many people aren't even aware that that happens. Especially for queer people or anyone that's struggling with getting pregnant, you're just tracking it so closely that obviously you know if you're pregnant. The level of vigilance that you have to have gets really tiring. (P1)

For participants in the study, the process of becoming pregnant took anywhere from just under one year to seven years. The process not only can take many years, but it is also time and energy consuming on a weekly/monthly basis. From the decision to start a family to actually getting pregnant there are so many aspects of the process that require additional time and attention and contribute to the overall length of time it takes.

All eight participants discussed giving up activities, hobbies, and lifestyle choices to increase their chances of becoming pregnant. Participants also discussed the additional appointments, procedures, and activities they engaged in to increase their chances of getting pregnant (such as acupuncture, yoga, therapy to reduce stress, etc.). In addition, most participants who were not pregnant after their first assisted reproduction attempt, discussed needing to take a break from trying at some point in their process due to the all-consuming nature of the process,

the distress it was causing, and for some, the medical complications from treatments such (i.e. cysts). Breaks to travel, enjoy a family members wedding, a vacation, or reasons related to work were all mentioned.

> So then last summer was balancing that the whole summer where I was essentially every cycle, and my cycles are pretty short, so it was like every three, four weeks, basically being like, "Okay, are we just going to keep trying again? Are we going to keep trying again?" And by like the third one that didn't work, we were pretty bummed and needed to take a month off because it was just a lot of money and a lot of hormones and a lot of ups and downs. And even though you're not pregnant, it's kind of like you are because you're already limiting so many things because you're like, "Well if coffee is bad for fertility and I'm paying all this money and going through all these ups and downs, I should quit coffee. And if this thing is bad and that thing is bad." It's like all of this stuff that you already start losing your sense of self and your identity and even the light hormones that they give you for IUI still change your body to clothes, like everything that all the really hard stuff about pregnancy that kind of is already happening, but you're not actually pregnant. (P4)

At the end of every interview, the researcher asked participants if they had any advice for people just getting started with the process. At least three participants had advice related to the time-consuming nature of the process. P2 shared, “allow more time than you think you need. Be flexible. Be prepared for it to not do what you hoped on the first try.” P6 also advised people to have patience because the process and timing is out of your control,

> And then, advice for anybody going through it is just patience. Because it's going to take 10 times longer than you think it's going to take. And you don't have a lot of control over

> your body. Especially when it comes to your infertility. Just kind of got to go with the flow. (P6)

Five participants discussed the lack of control they felt over the process of becoming pregnant. Some participants identified the lack of control over the process to be stressful and to contribute to mental health challenges.

> I was a pretty avid runner for a while, and ran a couple of marathons and a lot of half-marathons, and had been an athlete. I was very used to asking my body to do something specific, like training and preparing to do it, and then to perform, and do what I wanted it to do. This was a very different experience. I think that's another element of it, of just ... Yeah, you think you have control over these kinds of things, but you really have very little. For sure you can do your research and put your best foot forward, and there are things that you could do to either help or hinder the process, but you can't ultimately dictate everything the way you exactly want it to go…That might have been my personality in the past. I am someone who wants to have a lot of control over things. But I think if nothing else, this has really taught me about the fact that you have very little control over. Even when it's physically your own body. That was I think definitely something that was so hard throughout all of it, was, this is my own body. Why can't I make it do what I want it to do? (P3)

P1 expressed her anger and frustration about the lack of control during the process:

> I had over the years just had a ton of rage at straight people basically. I just felt like, what the fuck? The narrative is that you just get pregnant, and people get pregnant by accident every single second of every single day. I was just like, "Well, what the fuck? Why is this going this way?" At that point, there was no ... I have had of course gone to the

> gynecologist, done all of the tests and the medical things, and there was nothing quote/unquote wrong, so it just felt like really shitty luck or something. (P1)

Other participants saw the lack of control they had over the process as a protective factor, as something that was outside of them, so they had to accept it. P6 describes how she felt after experiencing a miscarriage during the process:

> I mean it was sad but it was also ... I handle stuff like that pretty well because it's out of my control. Things that are out of my control, I'm okay with. Not necessarily okay with. I felt sad and all that stuff, but at the same time, I was like, it wasn't meant to be. And just focused on moving forward. And it was more physically painful than I had anticipated, which was odd. (P6)

Despite the challenges faced in the process of becoming pregnant, participants did eventually become pregnant. They carried with them their experiences of trying to conceive. The next section presents the categories that emerged related to the experiences of pregnancy.

Some participants experienced the intentionality of the process as having both positive and negative impacts. P3 and her partner completed over 10 inseminations before they became pregnant. During her interview she shared the emotional rollercoaster of every failed attempt; however, she also discussed how the intentionality of the process contributed to her gratitude for the ability to reach the point of pregnancy,

> I think that already adds a level of intentionality into having a child, and bringing someone into the world. But I think added on top of that for us is, just a sense of being really thankful that we are where we are now. It doesn't mean that I still don't complain when my body hurts, or when I feel ... I had pretty awful morning sickness in the first trimester. That was not fun. I wouldn't wish that on anyone. But on the other hand, I feel

> like, am I going to be as upset about how sleep deprived I am, or am I going to be as worried about every little thing that I could decide to obsess over if I wanted to? Probably not. I think that I'm just going to be a little bit more laid back and appreciative of even getting to the point where we're parents, because we worked at it for so long, and because there were so many parts to the journey, that I think it just gives us a broader perspective on even getting to the point where we are. I think will hopefully give us that sense of gratitude in the bigger picture when the baby's actually here. (P3)

Category 2: Conducting Research

Queer family building methods are not common knowledge even among the queer community. Conducting research is defined by the participants’ process of systematically investigating and studying different sources of information in order to inform decisions about the process of starting a family and getting pregnant. All eight participants discussed having to do research about queer family building to inform their own processes. Participants conducted research for a number of different decision-making processes including financial decisions, methods of conception, choosing providers and clinics, sperm donor decisions, inducing lactation, finding support, and 2nd parent adoption. All eight participants discussed using social media platforms and online groups to connect with others who have already gone through the process.

> So that's where the Facebook groups really came in helpful, because there was a lot of people, and there was a lot of talk about sperm donors…And then on Facebook groups, there was just a lot of conversation about known donors, where they had said one thing, "I don't want to be involved," and then later on in life, they show up and say, "Oh yeah, I

> want to be super involved with the kid's life." Or we saw a really extreme case where some sperm donors sued for parental rights. (P8)

Some participants had queer family members or friends who shared their experiences. Others mentioned that they had a difficult time finding the information they were looking for and turned to utilizing resources on “infertility” for guidance. One participant spoke to navigating several unfamiliar processes, having to learn these processes as they went, and how time consuming that can be.

> I don't want to be 36. I wanted to be 33, 34. I wanted to get that shit done like anybody would. But I mean, what can you do? And you don't know. So, every little thing that comes your way when you're queer and you don't know this process, you're like, "Wait. How do I get sperm? Wait. What do I do?" (P4)

Several participants expressed desire for a more centralized resource on queer family building that was accessible.

> But there [were] also things like some clinics we looked at like [name of clinic], they have websites there. They have pages just for LGBT family planning. So that was helpful to click that. But it's just very basic information like, "We welcome you. Please contact us for more information." That's nice to see and you know the clinic's open to it. But I guess, I don't know, I still crave, instead of getting bits and pieces from all these places, there was one place and it was super widely publicized. (P8)

Two participants discussed how their job or their partner’s job was helpful in regard to knowing where to start or knowing a little more about the process and not having to do as much research. For example, P7 works as a veterinarian and has completed numerous intrauterine inseminations on animals. P7’s husband was a nursing student at the time and together they were able to

complete an at home, self-administered, IUI and became pregnant after their first insemination. P7 reported doing some research on the difference between inseminating certain animals and humans but for the most part utilized her knowledge from her work in the process. P5’s wife enjoys doing research and was knowledgeable about insemination prior to their journey,

> My wife works in family planning reproductive health abortion rights and has a joint MSW MPH. So she knew a lot of this beforehand. She knew a lot about ICI versus IUI and medications and all of that. So there was less research that needed to be done, but also she loves doing this research. (P5)

Category 3: Decision Making

For participants in this study, decision making is defined by the process of making choices related to family building by gathering information and assessing possible resolutions. The decision-making process is intentional and often involves conducting research. Participants had to make numerous decisions during the process of becoming pregnant. Some of the decisions participants had to make included how they wanted to start their family, who would carry, what methods to use, decisions around use of sperm donor, and choosing clinics and providers. One participant discussed how there were so many decisions to be made that it felt overwhelming and caused her to wonder if there was a right way to approach the process, “…am I doing it right? They did it this way, they did it that way.” She continued by stating that it is important to remember that, “there’s no right way to do it.” (P8)

The subcategories discussed below are not an extensive list of all the decisions participants needed to make in the process, but rather are ones that were discussed most frequently as well as ones that seemed to significantly impact the experience.

How do we want to start our family?

Adoption. Two out of the eight participants mentioned that they considered adoption to start their family before deciding to use assisted reproductive treatments to become pregnant. One participant (P7) discussed how she and her partner ideally wanted to adopt to start their family. They talked with numerous adoption agencies, both domestic and international, and tried everything they could to make adoption work. They faced hurdles for a variety of reasons, one being their queer identity.

> It's really just been ... there's the practicality like when we were doing adoptions and literally every time we were talking to anyone about adoption our first question had to be, ‘So, do you adopt to queer couples?’ And as soon as they said no we were like, ‘Cool, glad we screened that one out. Let's go to the next one.’ So that took some time. (P7)

Ultimately, they decided not to pursue adoption due to a combination of factors in their lives and timing. She shared her disappointment over realizing they were not going to adopt and about their decision to move on to using assisted reproductive treatments.

> So a lot of the heartache a lot of people experience when it comes to starting families, especially queer couples, for us was in the discovering that adoption was not really going to work for us…And my personality is such that I think that once I realize a plan has gone sideways I tend to very heavily and quickly pursue plan B. So it did, I guess, kind of help in that particular sense that as I started seeing the writing on the wall for the adoption stuff I was already like, ‘Okay, next step is I'm going to get myself a fertility appointment and then we're going to figure out what sperm bank.’ So I was already part way down plan B before I knew for sure plan A had fallen apart. For me that's just how I am in general. That's how I try to get through disappointment… Maybe I shouldn't call it plan B. It was more like plan R. It was a lot further. Again, like I said, one whose worked

> in reproduction. I just remember helping out with all of these various animal births, but just births. And I just remember thinking, "God, why would anybody ever voluntarily do this?" And now I'm 34 weeks pregnant and I still have the same opinion like, "Why does anyone do this?" (P7)

Who will carry? Deciding who would carry was another decision that five participants discussed having to make. Factors such as desire to carry, gender identity, gender expression, health, age and fertility impacted this decision. Some participants identified neither partner having a desire to be pregnant but doing so for the purpose of starting their family. Other participants reported that their partners did not have an interest in becoming pregnant.

> There was never a question that I was physically going to be the person to have both of those children, because my wife has never been interested at all in the physical aspect of this. She's very excited to be a parent, sometimes more so than I am even. But physically has not been interested in it. (P3)

P5 shared that she and her partner both had somewhat of an interest in carrying but that her age was the major factor in decided to be the first of the two to become pregnant.

> A lot of people will ask, oh why did you decide, or how did you decide who's going to go first? I was like, well I'm five and a half years older than her, so that wasn't a hard decision. If I was going to have a baby, it made sense for me to go first. (P5)

Sperm Donor. Due to the fact that participants and their partners did not produce their own sperm, making decisions about using a sperm donor is one that every participant discussed. The first decision participants needed to make was whether to use a known donor or an anonymous donor. This was an important decision for many participants that involved a lot of intentionality, research, and time. Once deciding on a known donor or an anonymous donor there

were other decisions and attention to details that were needed. For those who chose to use a known donor, they often needed to involve a lawyer to draw up legal agreements for protection over parental rights. When choosing a donor, there were often certain traits participants were looking for in a donor such as sexual orientation, health and genetic information, race, ethnicity, and views on politics and social justice. P3 shared she and her partner’s decision-making process around choosing a known donor,

> We then started talking about, "Okay, well who would that be?" Who are people in our lives that maybe we would ask to see if they would be a donor? It just felt really right for us to be able to have someone that we would know. Both personality wise, relationship wise, whatever, was someone that was important to us and that fit with us as a family. But also that then the child would know, from the very beginning, that this is where they came from, this is how they were created, and that it wouldn't be this sort of secretive person that we couldn't know or they couldn't know until they were 18 years old, and it wouldn't feel like their whole life was growing up waiting until the moment where they could find this out. That just really felt right for us. I certainly recognize that there are a lot of reasons why using an anonymous or at least an unknown donor makes a lot of sense for people, and why they would never want to have another person involved in the process the way we have done it. But it just felt really right for us to be able to say we would know from the very beginning this would be an open sort of part of this child's story about how they came to be. That they would know who that person is, and that they would be in their life to a certain extent. (P3)

Choosing clinics and providers. Participants needed to make decisions about which sperm banks to use, which medical providers to use, and in some instance’s other alternative

providers. Most participants mentioned the importance of choosing providers that were queer affirming. Sometimes there was no choice due to insurance, some participants chose intentionally not to interact with the medical system and rather use alternative providers such as midwives/doulas that would come to their homes. As P3 described,

> So I was like, “Look, I don't need to put all these hormones in my body and have that whole part of it be an experience, and we can still kind of just keep trying for a little while longer…” Another person that we had met at a group at the LGBT center was someone who is sort of like a midwife. She's a women's health nurse practitioner…But she also is queer and has her own family and helped other people create families, and she has a practice on her own, where she does inseminations at people's homes. Without medication, and just sort of based on the same kind of process we were going about, like tracking your cycle, and kind of getting a sense of what your body's doing, and then timing things based on that. That ended up seeming like the perfect next step to go to, because we could still be at home. We could still be kind of having as much control over the process as we could, and just feel like we were still doing it on our own. (P3)

Method. Once participants had identified their sperm donor and were ready to begin assisted reproductive treatments, they were faced with another decision of deciding what method they would like to use. Participants in this study discussed three different methods to become pregnant; in-home insemination, intrauterine insemination (IUI), and/or in vitro fertilization (IVF). For participants in the study, in-home insemination involved intravaginal insemination (IVI) completed by the participant or their partner. IVI is completed by inserting donor sperm into the vagina using a syringe. Intrauterine insemination (IUI) is typically, though not always, performed by a medical professional in the home or in a clinic. IUI is completed by inserting

donor sperm directly into the uterus. In vitro fertilization (IVF) is the process of fertilization by extracting eggs, retrieving sperm, and manually combining an egg and sperm in a laboratory dish resulting in an embryo. The embryo(s) are then transferred to the uterus.

In-home insemination. Three out of eight participants chose to begin with doing things on their own through self-administered, in-home inseminations. This often-included Intravaginal Insemination (IVI) in which sperm is inserted into the vagina. For these participants, having an intimate experience of insemination was important. As P3 described,

> I think another thing that had been really attractive about the known donor piece of it was so we could do it on our own, and that we could kind of have this more intimate experience around it, like it was really just us. I felt like if a heterosexual couple gets to try on their own for a certain amount of time before they decide that they need help, why shouldn't we be able to do that as well? (P3)

Unfortunately, the three participants who began by using self-administered, in-home inseminations ended up having to use other methods due to multiple unsuccessful attempts. All three participants ended up turning to IUI. Two of the three participants chose to continue trying at home and had a midwife or nurse practitioner come to their homes to perform the IUI procedure. The third participant tried multiple rounds of IUI and eventually turned to IVF.

Intrauterine Insemination (IUI). Seven out of eight participants chose to use intrauterine insemination (IUI) at some point in their process. Participants needed to decide where they would have these procedures done and who would do them. Some participants identified the importance of interacting with the medical system as little as possible. For these participants, at home IUI was where they started. Participants identified beginning with IUI because it was less invasive and less expensive than IVF. In addition, participants mentioned that their medical

insurance would not cover IVF until they attempted a certain number of IUIs. P6 and her partner started with seven rounds of IUI in a medical office because their insurance would not cover IVF,

> Just do a couple of IUIs before we did IVF because it's so much more expensive. IUI, while it was expensive and buying sperm every time was expensive, was at least 50% covered by insurance. So it was okay. Just googling the price of IVF, we're talking tens of thousands of dollars. So we were trying to put that off as much as possible. (P6)

In-Vitro Fertilization (IVF). Three out of eight participants used In Vitro Fertilization (IVF) to become pregnant. Two of the three used IVF after multiple attempts of IUIs. One participant out of the eight intentionally chose to start with IVF. This participant and her partner decided to go with IVF right away for a few reasons. One reason was because they had done a lot of research on the experience of becoming pregnant and decided because the chances are higher with IVF they would eliminate additional time trying, money, and stress. Another reason they wanted to use IVF was because they wanted to use reciprocal IVF. This participant described both she and her partner wanting to have a connection to the baby and felt reciprocal IVF was a way they could do that.

> And then we thought, "Oh, with reciprocal IVF, I can carry one, and then [name of partner] can carry the second one." And then we both get to experience birth and pregnancy like we both experienced proposals to each other. Oh, yeah. We did both propose to each other because we're those types of girls… So, logically we're like, "Why not do this really cool connection, biological / physical thing?" And then we'd be able to have that bonding experience. (P8)

Category 4: Interactions with the Healthcare System

For all eight participants in this study, the process of becoming pregnant involved visits and procedures with health care providers. The category of Interactions with the Healthcare System has two subcategories: interactions with providers and procedures and treatment. Some participants identified involving medical providers from their decision to start their families while other participants discussed the importance of trying to conceive on their own without medical interventions and interactions. Participants discussed appointments or procedures with primary care doctors, gynecologists, obstetricians, fertility clinic doctors, nurses, and counselors, as well as alternative health care providers such as acupuncturists and naturopaths.

Interactions with Providers

LGBTQ+ Affirming Care. All eight participants mentioned the importance of having queer affirming health care providers. This included providers having at minimum a basic knowledge of working with queer individuals and families, a familiarity with the family building process for queer families, an awareness of potential outward homophobia, transphobia, and heterosexism, and the inclusion of participant partners in the treatment. P1 discussed the intentional positioning of herself within queer community in the context of her providers and supports,

> I'm very grateful to live in a place where there are tons of queer families and parents. So, I have been able to create a context in which I do not interact with any health care providers or people who are not either queer themselves or 100% queer competent and affirming. My midwife is queer, and she's really great … My partner and I are doing this queer prenatal group that's 10 sessions every other week, and it's community-building but also birth education and breastfeeding and education around particular topics. That's run

> by a queer midwife and a queer therapist who are both parents. So, that's been really great. (P1)

Inherent in most participants’ discussions of choosing and interacting with health care providers was a worry, fear, or concern of interacting with providers as a LGBTQ+ identified person or family. P3 directly addressed this,

> And definitely for sure with fear in the back of my mind. Each time we did go to a new doctor, or a new provider of any sort. As much as you can vet them, or kind of try and get a sense of what it's going to be like. Sometimes for sure, you could end up somewhere where someone isn't understanding or isn't supportive. There's always that little bit of I think fear, sometimes in the back of my mind. I definitely I think will probably feel that again to a certain extent throughout the whole child's life. Will there be someone at the hospital who won't ... We're planning to bring a copy of our marriage certificate to the hospital, just because we don't want there to be any question that [partner’s name] name and my name can both be on the birth certificate. (P3)

Participants from this study reported experiencing both validating, affirming experiences with providers and interactions which were not queer affirming. One participant mentioned having to “teach” or “explain” the process of becoming pregnant to some of her providers. Four participants spoke about providers generalizing their experience to the experiences of an “infertile cis-heterosexual” couples. P3 had already completed at least 8 in home inseminations as well as 6 cycles of IUI with a Nurse Practitioner in her home. She and her partner attended a medical appointment and she shared the following experience,

> We unfortunately had one negative experience going to someone where it just didn't feel like she really understood or respected the way that we had been going about it up until

> this point,... She sort of brushed off what our process had been up until this point and was like, "Oh, it doesn't seem like you're that desperate to get pregnant, if you've been trying for this long." It really felt like she was just not in-sync with what was important to us.... As someone who practices that, their job is to get people pregnant as quickly as possible, so I understand why they want people to use medication and want to kind of push an aggressive process that's going to get the result that someone wants. But philosophically, it just felt like she wasn't going to be the right fit. (P3)

Fertility counseling. There were some unexpected processes that came up during the process of becoming pregnant. Three participants discussed being required to attend fertility counseling. Some participants described fertility counseling to be a waste of time and money while others shared that they found it to be helpful. P8 and her partner were required to attend before they began IVF.

> At first, we thought it was kind of offensive because we're like, "Oh, it's because we're a lesbian couple and we don't know what we're doing or something to that nature." But what it actually was after talking to the counselor was more because we were using donor sperm and how to best talk about that with our future child, how to explain that, how to if they want to know more information about that, how are we going to like tell them, and it was really, really helpful because she reassured us. She's like, "Well, people with a donor typically they don't find that they want to have a relationship with that person. They just want to know who they are, and that after they find that out, it's typically, it's null and void from there.” (P8)

P2 and her husband also were required to see a fertility counselor because they were using a known donor. The clinic also required their donor to see a counselor. P2 explains her experience

with the fertility counselor and how the counselor was not queer affirming and asked questions about her husband’s transition that did not feel relevant. She mentions how she and her husband answered the questions against their will due to power dynamics at play in the relationship.

> The only part of the getting ready process with this clinic that I didn't like was that they made us see a counselor, and they made our donor see a counselor, and then they made us meet to see a counselor together, all three of us. And his counselor was awesome and totally not a waste of time and asked us some questions that we hadn't actually talked about yet. We were a little bit like, this whole thing is a waste of time because we have contract, we have talked about stuff, we communicate well. This is why we're doing it like this. But there were some things that we were like, oh, actually, we don't have an agreement about that, and maybe we should consider it, and okay. The person at our clinic I think had never met a trans person before, and it was ... It would've been terrible I think no matter what, but because this clinic, we only found them because they were deliberately advertising their queer friendliness, it's like, you can learn this. This is not that hard. She asked a lot of invasive questions about milestones on his [transition] …and we were like, this is not really relevant - and we answered all of it because she was potentially in a position to tell us we couldn't move forward. (P2)

Procedures and Treatment

Participants shared many medical procedures and treatments to improve fertility, prepare their bodies for reproduction, or to complete IVF. Three participants discussed having to undergo a Hysterosalpingogram (HSG) X-Ray. The HSG x-ray is an outpatient procedure done to evaluate the shape of the uterus and determine whether the fallopian tubes are blocked. Providers insert an iodine-based dye through the cervix and take x-rays. Participants mentioned that this

procedure was uncomfortable, and one participant said it hurt worse than IUI procedure. At least three participants mentioned being prescribed Clomid or another medication for the purpose of increasing fertility during the IUI process. Multiple participants mentioned Clomid causing significant physical discomfort and one participant added that she felt it contributed to feelings of depression.

Participants described IUI and IVF procedures as invasive and uncomfortable. P4 describes her experience of IUI’s at a new clinic she and her partner tried, “Like it's hard enough to have people in your vagina three days a week for two weeks of each month. But to have it be totally different people every time was just like, I couldn't handle it.” P4 and her partner eventually decided to use IVF after many unsuccessful IUI attempts. She explains the IVF process in detail,

> So it's like 10 days of these really timed shots because you're stimulating follicles to be able to retrieve a bunch and then turn them into a bunch of embryos. And you're just trying to get quantities to improve your chances. So it's just this crazy mind-fuck of really intense hormones, knowing that this surgical procedure is coming up. So it's 10 days of all these shots, being super bloated. I was already in maternity leggings because anything I wore hurt my body to have anything pressing against me. And then had this surgery to the egg retrieval surgery where they do put you under anesthesia and they go in through your vagina and poke two holes in your vaginal walls to be able to retrieve with a super tiny catheter the eggs, the follicles from your ovaries from the outside … So they poke holes in your vagina, so there's little wounds in the top of your vaginal cavity. And then they pull them out and you just sit there for 20 minutes. They make you leave. And there's no like... You just go home, and you bleed a little and are sore for a couple days.

> And so in that time period, they tell you how many egg follicles they got, how many were mature, how many were fertilized and then eventually how many make it to a five day blastocyst. And that's like an embryo developing for five days is usually the sign that it would be healthy and strong enough to continue developing. And then we chose to have them frozen at five days, and then have genetic testing where they test chromosomes to make sure whatever embryos are chromosomally "normal," and then you plan to transfer an embryo in. From the embryo transfer on, I had to do two progesterone shots per day because the progesterone keeps the embryo in. And your body starts making its own progesterone at eight weeks pregnant. And the doctors recommend you do the shots until 10 weeks pregnant. So the shots were huge. They're intramuscular. They're super painful. They cause bruising, keloids, and I had to do two a day, and that was for 12 weeks every day. And it was horrible. And that was probably the worst part of this whole process, like worse than the IVF, worse than the surgery getting the eggs out. It's just these really painful shots twice a day because they pump you full of progesterone, and the progesterone is what makes you sick. It's the hormone that makes all day morning sickness. So by having this extra progesterone to make sure that the embryo is staying, I mean I was just dizzy and nauseous every second of every day with no relief and throwing up every day a couple times for like 10 weeks. (P4)

Four participants mentioned using alternative medical providers during their process to support fertility. Three participants mentioned using acupuncture to regular their cycles and improve fertility. P1 discussed how after a length of time trying to get pregnant and interacting with the medical system, she felt as though typical western medical providers were not helpful to

her. She sought support from alternative providers which she believes contributed to her becoming pregnant.

> Then I ended up going to a series of alternative health care providers, which is how I think it got pregnant. Medical doctors were not doing shit for me. So, I went to an acupuncturist who suggested that I go to a ... She did all these labs, and my thyroid ... I had slight hypothyroidism. My thyroid wasn't clinically out of the range, so a Western medical doctor, if they look at it, even though it was on one end of the scale, they would just be like, "Oh, it's fine. It's in the range." That's something that I had actually brought up before, because I have had lots of hypothyroid symptoms and chronic fatigue and depression stuff over the years. Anyway, it took going to this acupuncturist who then sent me to this naturopath who ... This is all over many months. But who prescribed thyroid medication. So, I started taking thyroid medication and got pregnant the first time trying after the miscarriage with doing another IUI. She also prescribed progesterone suppositories because my progesterone was, again, low but not so clinically low that an OB/GYN would even notice. Anyway, so I was using progesterone suppositories, taking the thyroid medication, and I got pregnant the first try. (P1)

Category 5: Financial burden

All eight participants mentioned the financial burden of becoming pregnant. Throughout the process there are many things that participants had to spend money on. For example, participants needed to purchase sperm, pay for the shipping, pay for health care providers, appointments and procedures, medications, and lawyer fees to name a few. Some participants shared having to take out loans or having to open credit cards in order to pay for their procedures. P8 compared the experience to being in debt for a car payment, “It was like just

being in debt for a car payment. Which, we luckily don't have a car payment. We paid off our cars before this happened. So that was a justification, too.” For some, medical insurance covered parts of these process but for most participants, they still had to pay money out of pocket. Many participants shared that their insurance would only cover IVF if they completed a certain number of IUI’s and sometimes a certain number of medicated IUIs.

> Just do a couple of IUIs before we did IVF because it's so much more expensive. IUI, while it was expensive and buying sperm every time was expensive, was at least 50% covered by insurance. So it was okay. Just googling the price of IVF, we're talking tens of thousands of dollars. So we were trying to put that off as much as possible. (P6)

The financial burden of the process caused stress and anxiety for many. On top of worrying about the success of each additional attempt, many participants expressed the financial burden each additional attempt brought.

> And it just sucks. And then each month is a new disappointment. And each period, you're like, "That was a $1,500 period... There's $1,500 going into my organic tampon…So it was just a lot of anxiety and a lot of stress and trying not to think about it, but because... I think if insurance had covered it, or if we had had the cash, it would not have been as stressful. But being that we knew we were taking on credit card debt, I was like, "If I end up with nothing at the end of this, I'm going to fucking freak out." (P4)

P4 shared how as a queer family she and her partner felt already at a financial disadvantage:

> And being queer is also a financial setback. You don't necessarily have the same job opportunities, or your life trajectory is a little delayed because there's a lot of self-discovery that happens and it's not this normative... And especially we came of age in the early 2000s, so it's different than now. It was harder then, and there was the stupid

> Depression crash thing in 2007 and 8. So when we graduated college, not only was there still a lot more overt homophobia, but then there were no jobs and all this stuff. So it was just a long time where it's just, even though it's only 10 or so years ago, it's really different than it was. And having a trans partner, insurance didn't cover top surgeries 12 years ago. So that was $10,000 out of pocket. And all that stuff that now is totally different. Like when we got married, gay marriage wasn't even legal yet. And that was only eight years ago…So we're just starting at this financial disadvantage where it's like, yeah... Student loans, no jobs, insanely expensive health care for trans people. And just being queer people... Job stuff... Whatever. So whatever. So then to have to take on $25,000, we basically had to talk about it and be like, "Okay, we have really good jobs now. And we make really good money now. And we will just have to take out new credit cards and pay them every month." And we looked at personal loans and medical loans and all of the interest rates were pretty high, and the credit cards were like no interest for 18 months, and then high interest rates. But then you can just transfer the balance. So we did all this stuff. We did all this research, and we just felt like IVF was inaccessible, but we were trying to figure out how to make it accessible. (P4)

Financial considerations impacted decisions made during the process (i.e. IUI verse IVF, to have or not to have certain procedures, alternative providers, taking breaks between inseminations, etc.) Taking on the additional financial burden also caused the process to draw out longer for some participants.

> And let's see, we did three cycles unmedicated, and then we did ... they recommended, and I think also my insurance required, two medicated cycles before ... So my insurance required six IUIs, two of them medicated, before they would cover IVF. And that was

> kind of the plan, but after six, you sort of hit diminishing returns in doing more IUIs, so you might as well do something that's going to be more definite. At that point, you've been trying for a while, and it's expensive, and you're paying for it out of pocket. So if insurance will cover IVF at that point, then we sort of felt like okay, might as well. So I did three unmedicated, and I did one with Clomid, and I hated Clomid. Clomid made me even more depressed. (P2)

P4 shares some of her thoughts on why insurance does not cover the process more adequately for queer families,

> There are grants for IVF, but it's still such a really heteronormative space that I'm like, okay. If there were funds that were just more accessibly managed... You know how there's abortion funds and all this stuff that we need desperately. Queer fertility funds also would be valid and super helpful. “Or how can queer fertility be worked into education in high schools? I don't know because if you're gay, you have to have a surrogate. And if you're two gay, cis gay men, you have to have a surrogate, and that's almost $100,000. Which is crazy. Or just at the very base level, insurance coverage because right now the fertility industry is not really regulated because it's so taboo that nobody talks about it or complains about it. And so they just benefit from that by having it be as expensive as they want, almost totally privatized and just no one would complain about it. It's like until you complain about the EPI pens, prices just skyrocket. So it's also going to take a mass protest against the fertility industry as it is in that it needs to be covered by insurance. And they automatically disqualify you as an LGBT person because they're like, "You're not actually infertile. There's nothing wrong with you. You just don't have sperm." And

> you're like, "Well, I know that I'm not infertile. But no matter what I do, I'm going to need this medical intervention." (P4)

Category 6: Life Events

Life does not stop while trying to get pregnant and most participants shared events that happened during the course of their process to become pregnant that impacted their experiences. Three participants discussed significant moves during their journey that were impacted by the process and/or impacted their experience of the process. Almost all participants mentioned their work being impacted by their process or the process impacting their work in some way. P7 shared about her work and how her job requires her to travel often. She and her husband had hoped to start their family through adoption but in part because her job had a planned move for her and her family, they ultimately decided to have their first child through assisted reproductive treatments.

> My job has us moving internationally quite a bit. And as we started our adoption journey we basically ... The very short version is that we found out that there wasn't going to be a judge around who was going to grant us a kid, because we moved countries so often. We went hard on that for a long time. We tried a lot of different angles. We looked into a lot of different choices. Ultimately the only one that was probably going to work out was going to be domestic infant adoption. And we knew that that was an arena where it was really competitive for a lot of the parents. (P7)

Two participants shared about the impact of losing loved ones either during the process or the impact of having lost someone special to them prior to the process but being reminded of them. P2’s mother passed away just as they were about to complete their first IUI. P2 shared how just

after they had their sperm donor arrangements and were finally ready to begin inseminations, her mother passed away unexpectedly.

> And this might not be strictly relevant to my queer experience, but I think it's an important part of the story. So yeah, we were gearing up for the first IUI last June, and my mom died really suddenly on June [date] with basically no warning. She went into the hospital on a Monday and died on a Wednesday. And- I had to rush down to [name of state] and it was horrible and it sucked, and ... not very quotable quotes there. It sucked when my mom died. (P2)

P2 continued sharing her journey and how losing her mother impacted the experience:

> So, we finally started trying. The first one didn't work. That was July 1st, I think. And then I did a second one, and that one also didn't work. And then I was having panic attacks about what would happen ... about just everyone dying. What if I got hit by a truck while I'm riding my bike right now? And just imagining in vivid detail exactly how my family would react, which I knew now because I had seen it happen, that sense of safety not being there anymore because I couldn't really tell myself that that doesn't happen, because it did, so. So, we decided to skip a month so that maybe I could relax a little bit and not ... Because being pregnant while having that level of anxiety also sounded hard. I felt that would probably just ratchet it up. And I was right. From here, I can tell you now, it totally did. (P2)

Three out of eight participants experienced a miscarriage during the process of becoming pregnant. Having a miscarriage significantly impacted mental health and wellbeing during the process of becoming pregnant and during pregnancy. Many participants shared a general worry or concern about losing a pregnancy and for those who had experienced pregnancy loss, they

expressed a heightened sense of fear, worry, concern, and sadness. P6 shared about her experience after her pregnancy loss. Throughout her interview, she also discussed losing her brother nine years ago and how she carries that experience with her always, even during her process of becoming pregnant.

> I think, probably the more difficult part was right after the miscarriage, my sister-in-law got pregnant. I think she was pregnant at the same time. We were about the same amount of time along. So, then my niece was born and then somebody else got pregnant too. There was a little twinge of like, oh, that's not fair, but it'll happen. I lost my little brother about eight years ago. Actually, it's almost exactly eight years ago. Nine years ago, I'm sorry. And I think having that experience helps me to sort of put things in perspective and manage stress better. (P6)

The participants who experienced pregnancy loss discussed how lonely and isolating the experience can be. They continued to carry and hold that experience with them through the process and well into pregnancy.

> We definitely felt very different trying after having had a loss. I mean, there was always the anticipation and wanting it to work every time we did it regardless, but the stakes felt so much higher after having a loss, and it was both like, "I really want to get pregnant but I'm also scared to get pregnant again, because then what if that happens again?" You know, you kind of experience that you're going to lose it again, or that it's not going to work out. Obviously, you still really want it to happen, but it feels more complicated. (P3)

P1 shared her thoughts about being queer and having a miscarriage.

> I think miscarriage, from what I have heard, I think is an incredibly isolating experience for anyone. I think just being queer and the stakes of how much time and money and energy queer folks often have put into the process just makes it ... Someone who's straight who just had sex with their husband, not that a miscarriage wouldn't be devastating. I'm sure it is. But you just sleep with your partner again the next month. I just feel like the stakes are really different for queer people, and I think the level of kind of isolation is more so than for straight folks typically, I would imagine. (P1)

Section 2: Mental Health During Pregnancy

The purpose of this study was to understand the physical and mental health experiences of pregnancy for queer cisgender women. As mentioned previously, all eight participants were in their second or third trimester of pregnancy at the time of the interview. The categories and subcategories presented in this section represent the experiences of pregnancy up to that point for participants as well as other thoughts and topics that emerged for them related to their pregnancy and identities.

Category 7: Physical and Emotional Aspects of Pregnancy

Participants shared triumphant and challenging physical and emotional experiences during pregnancy. Often the physical and emotional aspects did not exist independently, and all participants expressed mixed feelings regarding their pregnancy.

Physical aspects of pregnancy/complications

For participants in this study, it was common to have a physically challenging first trimester. Six participants reported feeling physically ill during the first trimester. Of the six, the three participants who used IVF mentioned having to administer themselves progesterone shots for 10 weeks post embryo transplant for the purpose of increasing the likelihood of the embryo to

stay implanted. These shots caused significant physical discomfort and sickness. P4 discussed the physical symptoms she experienced post embryo transplant as well as a mixed emotional experience due to feeling so ill,

> So that was really hard. And so then basically I was pregnant, but it was so new. It's really scary. Going to the doctor every week to check on the ultrasound and make sure that the embryo is growing, and it was. And it was super exciting every time. It was super, super exciting. But I felt so physically horrible. It was like having a chronic illness. I never had one, but I was like I feel like I've contracted a thing that makes you ill all the time. And I was just... I would cry every night. And I was like, "Why did I do this? Can I abort this $25,000 embryo?" I was just so sick... So, so sick. And then it's really exciting, and I want to go around saying, "I'm pregnant," but I'm like four weeks, six weeks, eight weeks pregnant. It's so new that it's really scary. So then I just tried to get through the shots and through this period of feeling really sick and having all the first trimester symptoms super intensely because of the extra progesterone. (P4)

Emotional aspects of pregnancy

Participants in the study shared a range of emotional experiences during pregnancy. The researcher observed that emotional difficulty in the first trimester correlated with a challenging process of becoming pregnant. Other factors influencing emotional difficulty included physical complications (including pregnancy loss), life events, and expectations of pregnancy. For the three participants who experienced pregnancy loss, there was a shared feeling of fear, worry, concern, and sadness during their pregnancy. P3 elaborates on this,

> My pregnancy has not been easy on me, and it's been I think ... At first in large part because of having had a miscarriage, I just was very fearful in the beginning, and sort of

> was ... It was like every day or every week felt like, "Okay, is this going to be when it happens? Am I going to lose this again? Am I prepared for that?" On the one hand I've experienced it before so I know that I can get through it, but on the other hand, more so emotionally, how would I handle going through that again? What would that mean for what we might do moving forward? I definitely was just very very scared of losing the pregnancy again, especially early on. But I still feel that way to an extent. I have not come to a place where I'm completely, even now, convinced that I'm going to have a baby in the end of all of this. I think there's still a little part of me that is like, "Well, yes, we've made significant progress, but there's still a chance that this might not work out." I think it was definitely a lot more fear very early on, especially as I was approaching the time period in which in the previous pregnancy, I lost the pregnancy. (P3)

Two participants discussed an increase in depression and/or anxiety during pregnancy. P1 had a history of depression in addition to experiencing two chemical pregnancies, pregnancy loss, and an extended period of time trying. She discussed her experience with prenatal depression,

> I also experienced really extreme prenatal depression in the first trimester ... I have a history of depression and have been seeing psychologists and therapists most of my adult life, and no one ever ... And obviously talking about the process of trying to conceive. Every person I've worked with has known that, and no one ever suggested that I could really have … a hard time during pregnancy itself. I actually stopped taking antidepressants a couple of years ago, in part because we were going to start trying again. I now realized that that was a huge mistake and that oftentimes providers either encourage folks to stop taking antidepressants or just don't raise any concerns with that

> choice when, in my case, that was when I needed them the most. It was really, really bad. I was having really intense suicidality, in a way that I had not had ever/in a long time. It just hit me just totally out of nowhere … So, I started taking [Zoloft] again I think towards the end of my first trimester and started seeing a therapist and a psychiatrist and just was needing to get as much support as I could, which was hard because I was so sick that I couldn't just drive to visit friends … I think that the experience of that miscarriage, the blow would have been softened a little bit. So, that's just something I have been sharing with people and especially in that field. I think, especially when there's been such a tumultuous fucking journey to get pregnant, choosing to stop taking antidepressants in order to get pregnant doesn't always make sense. (P1)

P2 experienced the unexpected passing of her mother while she was trying to become pregnant. She shared how the process of becoming pregnant impacted her mental health during pregnancy. P2 described the increase in anxiety she felt during her pregnancy,

> I had a lot of anxiety about miscarrying or just something going wrong. It had taken such a long time for it to work, I didn't really think it was going to work, and I was afraid of believing that this was really it, and it was really going to stick. And the same kinds of catastrophic thinking that hit me last summer also have been a real struggle this whole time, with just anything, like oh, this plane's going to crash. I don't know. (P2)

P7 shared a history of anxiety prior to pregnancy as well a physically difficult first trimester; however, discussed that her anxiety symptoms significantly reduced during her pregnancy.

> I swear I feel more stable now. I don't really know, maybe this is what I always needed, a lot of progesterone flowing through is the solution, I don't know. I can't possibly explain

> to you why this has not been horribly anxiety producing. Maybe once I actually hold the kid in my hands, I'm going to have a total panic attack. We'll see. (P7)

P6 shared that her due date happens to be two days before the anniversary of her brother’s passing. She discussed how the pregnancy and expecting the baby has helped her to feel more hopeful and excited for the month of her brother’s passing than she ever has before,

> So it's like, March has always been for my family. Over the last nine years it's been difficult. And we always do something to ... We do something together on what we call his D day … We go see him at the cemetery and we go to lunch and do a thing but it's not going to happen this year and I haven't really been thinking about it too much. Like I've been thinking about it. Like I know that the day's coming up and all that stuff but it's like ... It's almost like if I believe in anything, it's almost like fate that the baby's due right around this time, so sort of ... My brother would not have wanted me to dwell on anything. He would have thought that was ridiculous. So it's almost like, everything happens for a reason. You know what I mean? It's going to change one of the worst months of my life into one of the best. So I haven't really figured out how I feel about that yet. (P6)

Category 8: Queer Identity and Pregnancy

Participants described the ways that their queer identities and their pregnancies were intersecting. Participants discussed ways in which their queer identities were validated during their pregnancy as well as ways in which their queerness had been “invisible,” dismissed, or invalidated in pregnancy, often due to pregnancy being seen as a cisheteronormative experience.

Validating Queer Experiences in Pregnancy

P4 describes her joy of attending Pride and embracing her queerness during pregnancy,

> But we went to the Pride parade. We went to the Reclaiming Pride protest march, and I wrote on my belly... My big pregnant belly, "Made of queer magic" in magic marker, and that felt really good. That was the most exciting, for sure ... So yeah, but I think mostly it's exciting and physically, I feel pretty sexy as a queer femme. Like my boobs are big, my belly is round. Yeah, I feel pretty sexy. (P4)

Queer Invisibility and Femme Invisibility

Along with feelings of queer validation, pregnancy has also at times shed light to queer invisibility. Four participants described the experience of having people in society ask about the “father” of the baby. These participants shared that when asked this question, they are put in a place of either having to “lie” or avoid a larger conversation or having to “come out” and reveal how their pregnancy was conceived. For participants who had transmale partners, this question was also frustrating because of course their husband is the father of the baby; however, they also described having to make a decision about how much detail of the process they wanted to share. All participants described their gender as cisgender female; however, discussed different gender expression. Regardless of gender expression, there seemed to be a common experience of queer invisibility. Three participants touched on “femme invisibility.” P4 describes pregnancy as the “pinnacle of straight womanhood” and highlights her experience of queer femme invisibility both in the larger society as well as within queer spaces,

> But as also a queer femme, people really, really read you as straight when you're pregnant because they don't assume that you're having a baby with a not-cis male partner. And so all of that queer identity stuff just really goes out the window, and I think then also in queer spaces, if you're visibly pregnant, people probably also assume maybe that you're straight. (P4)

P1 explained why queer-specific spaces were critical sources of support for her during her pregnancy, as they validated her queer identity,

> I think that’s part of why queer-specific spaces are so important for me, because I am seen as a queer femme. I’m seen as a queer person, whereas I think in straight spaces I would just be seen as a straight woman or a straight-looking lesbian or something like that. I don’t think my gender would be legible to people. So, I think that is actually a big factor. (P1)

Category 9: Rejecting the Binary – Gender Related Topics

The topic of gender was discussed by all eight participants. Gender came up in speaking about the fetus/baby, participant’s own gender identity, their partner’s gender identity, or other queer individual’s gender identity.

Sex of baby/Rejecting a gender binary for baby

All eight participants brought up the importance of not placing a gendered pronoun on their fetus/baby and expressed feelings of “annoyance,” “frustration” and/or “anger” when other people asked, “what are you having?”

> The thing that is really annoying to me is strangers asking ... Or, anyone really, but especially strangers, neighbors, everyone asking, "Do you know what you're having?", and wanting to know the sex of the baby. For the most part, with strangers I'll just be like, "I don't know," which I do know the sex, the assigned sex. (P1)

Gender expression and identity

Two participants mentioned that finding maternity clothing that matched their gender expression was almost impossible. This played an impact on their emotional wellbeing during pregnancy. P5 shares about her experience,

> I've had two big times where the word that comes to mind is dysphoria about clothes. I strongly identify as a woman, and the changes in my body abstracting from what they've done to my clothing really have felt weird or great. They haven't felt like problem. I like to dress ... My usual outfit when I'm not pregnant, my work or synagogue outfit, is nice slacks, men's slacks, men's button down, a tie and a vest. When those things stopped being able to fit was hard, and I knew it was coming, but part of the thing was that I just started feeling really shlubby in what I was wearing. It just felt really bad. I had two days in particular, moments in particular, where it was just like I can't do this anymore. (P5*)*

P5 also discussed gender identity/expression and how other’s perceived who should be carrying the baby based on her and her partner’s gender expression.

> “So [my partner] had a text convo with her cousins where she was like, guess what, [P5] is pregnant. Her cousin was like, oh you mean you're pregnant? She's like, no, [P5] is pregnant. But we've had actually, in a couple medical settings, them assume it was [partner’s name] and not me. Which was not fun.

Considering the experience of pregnancy for non-cis gender individuals, non-binary, or gender non-conforming (GNC)

All eight participants also either asked if the researcher was including non-cisgender individuals in the study or reflected on what the experience of pregnancy may be like for non-cisgender individuals. P1 reflected about her gender identity/expression and about how those who identify as gender nonconforming or do not identify as cisgender may experience pregnancy,

> I think in terms of my gender, the experience of folks who are pregnant who are visibly gender nonconforming, whether they identify as cis women or not, I think that is an

> experience that I am not familiar with. Being pregnant really does not feel contradictory to my gender presentation nor experience. In terms of just navigating the world, I imagine ... I mean, I know just from talking to people that trans men or just folks who are gender nonconforming I think would have a lot to say. (P1)

Category 10: Connection to Community

Connection to community was another topic that all eight participants discussed. Connection to community had two subcategories: social support and resiliency.

Social Support

All eight participants discussed support from their partners being important. All eight participants also mentioned receiving support from online queer communities and social media platforms.

> I love the fact that we know so many queer parents. There's this Facebook group, I think it's called the Queer Parent Network or something like that, that's just full of lots of folks who are ... in general they're people that have a really similar outlook to just how we talk about gender, sexuality, and identity. And raising kids, it turns out, is a huge ... it feeds and flows very nicely from that. So there's been so much, what I would consider, really good advice that I'm seeing circulating out there. So I think that having that community structure has been really, really amazing. (P7)

All eight participants also mentioned the importance of seeking support from people who have gone through the process, most frequently this was other queer families,

> Then I think just to just be specific, not everyone who's queer had a really hard time getting pregnant, but I think there's just a shared understanding around the fact that this

> journey has been different for us than for people who are coupled in a [cis]heterosexual configuration. I think that feels just ... That shared experience feels safer and better. (P1)

Resiliency

Despite the challenges that existed for participants during the process of trying to conceive and during pregnancy, all participants demonstrated resiliency throughout their journey. Some examples of this resiliency include reclaiming the experience of pregnancy as a queer one, as well as giving back to community through advocating for injustices in the process, sharing their stories, supporting others in the process.

One example of this is giving back to the community. For example, all eight participants discussed their motivation to participate in this study largely due to the challenges they faced in their experience. They wanted to inform the process for future queer families trying to conceive and starting their families.

> Oh, absolutely. That’s why I’m so glad that you were doing it. And I was like so passionate about helping because I’m just like, “Oh my god. Nobody knows.” (P4)

Many of the participants discussed staying active in trying to conceive Facebook groups in order to offer support to other families in the process. In addition, each participant offered ideas for future research based on parts of their experience that were especially challenging or salient for them or even for their partners,

> I think in terms of my gender, the experience of folks who are pregnant who are visibly gender nonconforming, whether they identify as cis women or not, I think that is an experience that I am not familiar with. Being pregnant really does not feel contradictory to my gender presentation nor experience. In terms of just navigating the world, I imagine

> ... I mean, I know just from talking to people that trans men or just folks who are gender nonconforming I think would have a lot to say around gender. (P1)

Inherit in participant’s narratives was a desire to claim pregnancy as a queer experience. Two participants discussed attending Pride while being pregnant and embracing their queer pregnancy. The title of this dissertation is pulled from a quote from P4 who shared her experience during pride in which she wrote “made of queer magic” on her pregnant belly. She went on to share how she felt sexy as a pregnant queer femme.

Follow-Up Interviews

Six women participated in follow-up interviews. All six participants stated that they resonated with the categories shared and each elaborated on categories that felt particularly relevant for them. Many participants commented on how similar the experience had been overall for all participants despite minor differences in how each experienced the categories.

The researcher also asked participants if they felt anything from their experience was not covered in the tentative analytic categories shared. Two participants mentioned second parent adoption as an additional part of the process they found to be challenging and extensive. They mentioned that the process involved having to get a lawyer and having to pay additional fees in order to assure that both the carrying partner and the noncarrying partner had parental rights to the baby. In addition, three participants shared that they had an emotionally challenging time postpartum. They mentioned that an idea for a follow up study would be to explore mental health experiences postpartum for queer women. Finally, all six participants referenced the unexpected impacts COVID-19 had on their postpartum experience. At the times of the follow-up interviews, one participant was still pregnant, and five participants had babies ranging in age from a few months to about 9 months. All the participants had to navigate the postpartum period

during a global pandemic, creating a unique experience that brought challenges as well as opportunities to be closer to their baby and family.

Discussion

This study aimed to understand the physical and mental health experiences of pregnancy for pregnant, queer, cisgender women who have decided to build a family through assisted reproductive treatments using a constructivist grounded theory approach. In this section, the researcher will discuss the main findings of this study and explore how each of the study’s categories supports, differs, or adds to prior findings in the literature. In addition, the following section will include a substantive theory that has emerged from the data.

Section 1: Trying to Conceive/Process of Becoming Pregnant

Discussion of Category 1: Intentionality

This category explored the concept of intentionality, which is defined as directed efforts towards the outcome of becoming pregnant which includes the participant’s desires, thoughts, beliefs, hopes and wishes about the process, and the impact intentionality during the process had on mental health experiences while trying to conceive. All eight participants discussed the intentionality of the process and how it impacted their physical and emotional experience during their process of becoming pregnant. Intentionality was comprised of the following subcategories which represented the impact intentionality had on their experience of becoming pregnant: “Positive Impact” and “Mixed or Negative Impact.”

Six out of eight participants in this study described intentionality as either having a “negative impact” or “mixed impact.” Factors that influenced the impact included the waiting and anticipation of attempts, the time consuming nature of the process and the lack of control

participants felt. The two participants who described intentionality as having a positive impact became pregnant on their first inseminations and their processes took about one year.

The researcher did not find any studies which examined the concept of intentionality of pregnancy for queer women. However, a study conducted by Greil, Shreffler, Schmidt, and McQuillan (2011) examined the variation in fertility-specific distress (FSD) according to different experiences of infertility among heterosexual women. They utilized the medical definition of infertility which categorizes women as infertile if they have experienced a year or more of unprotected intercourse without conception (Zegers-Hochschild et al., 2009). The researchers examined the impact of intentionality on fertility-specific distress by comparing women who were actively “trying” to become pregnant at the time of their infertility (infertile with intent) with those who met the medical definition of infertility but were not actively trying to become pregnant (infertile without intent). They measured intentionality as “planfulness to become pregnant” rather than a general desire for a child or those who are “okay either way” (Greil, Schreffler, Schmidt, & McQuillan, 2011). Their findings revealed that women who were intentionally trying to become pregnant experienced significantly higher levels of fertility-related distress than women who did not describe themselves as explicitly trying to become pregnant. They concluded that assessing for and determining intentionality of pregnancy is useful and needed for mental health and fertility counselors working with women who are experiencing infertility.

Although the constructs of infertility and queer women trying to conceive may be thought of or experienced differently, the findings of this dissertation are consistent with this literature and reveal additional clinical implications for working with queer women who are trying to conceive through assisted reproductive treatments. Sperm and insemination procedures often

cost too much money for participants to be “okay either way” about an attempt. The nature of the process requires queer women to be constantly intentional. Taken together, these findings suggest that the intentionality of trying to conceive for queer women may contribute to distress during the process.

For participants in this study, the process of becoming pregnant took anywhere from just under one year to seven years. There are numerous factors that take time while trying to conceive including a six-month quarantine period for known donor sperm, time to find a lawyer and draw up contracts with sperm donors and breaks due to failed attempts and built up stress. The time-consuming nature of the process caused distress for many participants and it seemed that the longer the process took, the larger the impact was on mental wellbeing. It is important to note that typically, the process took longer due to unsuccessful assisted reproduction attempts. For participants in this study, the more failed attempts, the longer the process, the more distress was felt. In addition, participants described the lack of control they had over the process and how that impacted their emotional wellbeing, increasing stress, anxiety, anger, and depression. However, one participant discussed the lack of control as a protective factor. Seeing the process as out of her control allowed her to cope with the difficulty of trying to conceive.

The nature of assisted reproductive treatments and procedures and the female reproductive system allows for about one attempt each month. Participants discussed tracking their cycles to identify the highest chance of conception to inform when they would complete their insemination. They then would wait for a missed period or a few weeks (about 10-14 days) to take a pregnancy test. Many participants who did not become pregnant on their first insemination described repeating this cycle for back to back months. The anticipation of the success of an insemination was described as an “emotional rollercoaster.” Some participants

discussed how after a failed attempt or after a chemical pregnancy or pregnancy loss, the emotional experience became even more intense. One participant who experienced pregnancy loss during the process described her ambivalence each time she was about to read her pregnancy test. On one hand, she of course wanted to become pregnant while on the other hand, she was worried about her emotional health if she became pregnant again and experienced another loss.

There is limited research that specifically looks at anticipation, the time-consuming nature, and lack of control during the trying to conceive period for queer families; however, extensive research has been completed about these factors for heterosexual couples using IVF. Factors such as cost, duration, and lack of control over outcomes have been identified as stressful factors in the process according to heterosexual couples (Burns & Covington, 2006; Williams, Marsh, & Rasgon, 2007). In addition, Society for Assisted Reproductive Technology (SART) data reveals that the waiting period between transfer and receiving the pregnancy test results is often described as the most difficult part of the cycle for families going through IVF. Participants reports from this study supported these findings as they identified the duration of the process of becoming pregnant, the lack of control over the outcome, and the anticipation of insemination results to contribute to stress and emotional wellbeing. Understanding that these factors contribute to higher levels of stress is important for mental health professionals to consider when working with queer families trying to conceive.

Discussion of Category 2: Conducting Research

All eight participants discussed having to do research about queer family building to inform their own processes. Conducting research was defined by the participants’ process of systematically investigating and studying different sources of information in order to inform decisions about the process of starting a family and becoming pregnant. Conducting research

took time and also revealed the heteronormativity of becoming pregnant, as participants realized the lack of material available to guide them through their processes. Additionally, all eight participants in this study revealed using social media platforms for conducting research to inform their decisions. An observation from this study was that few participants received helpful, thorough information about their options to conceive from medical providers. This was the case for both participants who intentionally avoided interacting with the medical system and for participants who sought medical care. General providers appeared to lack basic knowledge about the process of conceiving for non cishetero families. As a result, participants turned to the internet, friends, family, and other queer community supports for research and information.

Previous research has suggested that queer women experience barriers to seeking health care, especially care related to reproductive health (Dahl et al., 2013; Fields and Scout, 2001; Hayman et al., 2013; McManus et al., 2006; Ross et al., 2006; McNair et al., 2008; Rondahl et al., 2009). For queer individuals who have difficulty accessing medical information from providers, it is common to seek medical information online (Cline & Haynes, 2001; Eysenbach & Jadad, 2001; Korp, 2006; Bhandari et al., 2014; Mano, 2014; O’Higgins et al., 2014). However, there is a lack of online information for queer family conception produced by medical professions, which often leads to queer women seeking information from peers (Ruppel, Karpman, Delk, & Merryman, 2017). A study conducted by Ruppel, Karpman, Delk, and Merryman (2017), utilized a qualitative content analysis of 400 discussions in lesbian-oriented, conception, pregnancy, and parenting Facebook groups. They found that although the Facebook groups were created for social support, 30% of interactions involved seeking or providing medical advice and over one fourth of those interactions were related to assisted reproductive treatments. They also found that these percentages were significantly higher than similar

Facebook group interactions for heterosexual women. Despite the differences in the processes of conception for queer women compared to heterosexual women, the findings suggest that queer women may need more medical information regarding the conception process than heterosexual women and/or that queer women are less likely to obtain this information from medical providers.

The findings from this dissertation study support the research done by Ruppel and colleagues (2017) and have significant implications for queer families. When queer women turn to peers to conduct research about medical decisions, they may receive misleading or inaccurate advice, which may put them at higher risk for poor fertility outcomes as well as potential implications for the fetus or health of the pregnant person (Ruppel, Karpman, Delk, & Merryman, 2017). For example, Ruppel and colleagues (2017) discovered advice about certain tools to use in at home insemination, discussions about sperm sources (which made up 9.9% of posts), and common myths about conception (i.e. cough syrup aids in conception) to be inaccurate, not informed by research, and potentially harmful. Regardless, this phenomenon reveals the lack of cultural competence in the medical field and the necessity for structural change within the system to eliminate barriers to accessing care for queer individuals and families. For example, there is a need to provide evidence-based online resources about queer family building practices. Providing these resources online to support queer families in their conducting research and decision-making process may help to minimize the health disparities for queer women during conception and pregnancy.

Discussion of Category 3: Decision Making

This category explored the concept of decision making during the process of becoming pregnant. Because there is no one way to become parents for queer families, the journey to

parenthood involves many decisions. How do we want to start our family, who will carry, how do we decide on a sperm donor, where will we receive treatment and what method(s) will we use, were the most common decisions participants discussed having to make in this dissertation study.

Descriptive research has been done on the decision-making process for lesbian couples. Hayman, Wilkes, Halcomb, & Jackson (2015) interviewed 15 lesbian couples to explore the ways lesbian mothers constructed mothering and identified the theme “becoming mothers” with three subthemes regarding the decisions that needed to be made: deciding to be mothers, sperm donor decisions, and methods of conception. Chabot and Ames (2004) also described the decisions lesbian couples made and how they experienced those decisions in their transition to parenthood. The authors proposed a decision-making model that emerged from their data with seven questions: 1) Do we want to become parents? 2) Where do we access information and support? 3) How will we become parents? 4) Who will be the biological mother? 5) How will we decide on a donor? 6) How do we incorporate inclusive language? 7) How do we negotiate parenthood within the larger heterocentric context? (Chabot & Ames, 2004).

The findings of this dissertation study support the research in regard to the most common decisions queer women are faced with during their journey to becoming pregnant. The main decisions identified by participants were how do we want to start our family, who will carry, how do we decide on a sperm donor, where will we receive treatment and what method(s) will we use. Chabot and Ames (2004) discussion of understanding the complexity and importance of the decision-making process for lesbian couples is helpful in contextualizing participants decisions shared in this dissertation study as an interconnected process. We can think about all of the decisions participants had to make as an interconnected process that was intentional, involved

conducting research, was challenging, and involved taking risks. The decision-making process was a large component in the overall process of becoming pregnant.

This research provides insight into thinking about clinical implications for queer families during the transition to parenthood. Their decision-making model could be used as a guide for queer families who are just beginning their journey to parenthood.

Discussion of Category 4: Interactions with Healthcare System

This category explored the experiences of interacting with the healthcare system. It had two subcategories: interactions with providers and procedures and treatment. Regarding interactions with providers, all eight participants mentioned the importance of having queer affirming health care providers and most participants stated that they intentionally searched for queer competent providers for all of their treatment needs. At least three participants discussed a desire to bypass the medical system as much as possible in their journey to conceive. One reason given for bypassing the medical system was fear of discrimination due to the participant’s family’s queer identity. Participants reported experiencing both validating, affirming experiences with providers and interactions that were not queer affirming. In addition, one participant mentioned having to teach or explain the process of becoming pregnant to some of her providers.

There is no direct research on queer women’s’ experiences accessing pregnancy related healthcare; however, researchers have explored the queer communities’ general access to healthcare systems and the barriers that exist. The findings from this dissertation study support the existing literature that identifies and discusses these barriers. Direct and indirect discrimination, lack of provider education about queer specific needs, legal barriers, and increased financial barriers to care have all been identified as barriers to seeking medical care for queer women (Fields and Scout, 2001; McManus et al., 2006; Ross et al., 2006; McNair et al.,

2008; Rondahl et al., 2009; Dahl et al., 2013; Hayman et al., 2013). Haymen et al., identified four types of homophobia queer women may experience when they seek healthcare: lack of recognition for their queer relationship, the assumption of heterosexuality, inappropriate questions, and direct refusal of services (2013, p.122). In addition, many queer identified women may protect themselves by not disclosing their queer identity to their medical providers; however, when seeking reproductive or maternity health care, it becomes more challenging not to disclose their queer identity (McManus et al., 2006; Ross et al., 2006; McNair et al., 2008; Dahl et al., 2013; Hayman et al., 2013). When queer women do seek reproductive health care, providers may be unaware of conception options available to queer families and unable to provide adequate support (McManus et al., 2006). This dissertation study supported the literature as participants identified a desire to bypass the medical system due to fear of being discriminated against based off their queer identity, having to teach or explain their process to providers, and providers making assumptions about their reproductive desires based on their gender expression. Unfortunately, once the participants became pregnant they had to interact with medical providers to receive prenatal care. In addition, participants discussed foreseeable challenges interacting with healthcare providers related to their families queer identity when they will begin well-child visits and other medical visits throughout their child’s lives.

Discussion of Category 5: Financial Burden

This category explored the burden of expenses and financial concerns during the conception process. There are a myriad of barriers and stressors in the process of becoming pregnant for queer women; financial barriers and burdens were identified as one of the most stressful for participants in this dissertation study.

Fertility treatments are expensive for both queer and cisheterosexual families. Holley and Pasch (2015) suggest that queer families may face additional financial barriers while trying to conceive. These include limited insurance coverage for specific procedures and additional processes needed to conceive, as well as needing legal protection during the process (e.g. sperm donor agreements, second parent adoption). The results from this dissertation research support these findings. For example, participants using IUI often needed to pay for donor sperm, the shipping for the sperm, the procedure itself, and legal guidance around sperm donor rights. Per reports of women in this dissertation study, one cycle of IUI can cost families $500-$2,000.

Research on heterosexual couples using Assisted Reproduction Technologies to become pregnant has found that the financial burden of the process is a frequent reason for treatment dropout (Land, Courtar, & Evers, 1997; Smeenk, Verhaak, Stolwijk, Kremer, & Braat, 2004). Many treatment options are afforded to those who have access to financial resources or insurance coverage. With this in mind, queer parenthood through assisted reproductive treatments seems to be a privileged experience that is not available to all. Low socioeconomic status serves as an additional intersectional oppression faced by queer individuals who do not have the financial means to conceive. The inaccessibility of starting a family for queer families sends a message from society about who should be able to have children.

Discussion of Category 6: Life Events

This category explored the impact of life events while trying to conceive. Queer families often have to navigate the time-consuming and physically intensive process of trying to conceive while also dealing with everyday life events such as work, school, and maintaining familial and social relationships and supports. On top of the already difficult experience of trying to conceive, participants from this dissertation study shared experiences which impacted their emotional and

physical wellbeing during their journey such as, the loss of a mother, the hospitalization of a partner, navigating COVID-19, and having medical complications. One of the major medical complications and life events discussed by participants was pregnancy loss. Three out of eight participants experienced pregnancy loss. In sharing their experiences, the researcher became aware that queer pregnancy loss is a unique experience and more research is needed to understand the experience in order to provide support. For the three participants who experienced pregnancy loss, their mental health and wellbeing during the process of becoming pregnant and during their eventual pregnancy was impacted. These participants shared a heightened sense of fear, worry, concern, sadness, loneliness, and depression.

Few studies have examined the experience of pregnancy loss for queer families. However, research suggests that queer pregnancies are likely to have more involved lengthy planning and resources during the preconception period that may contribute to and amplify experiences of loss (Craven and Peel, 2014; Peel, 2010; Luce, 2010). Peel (2010) found that 85% of mothers (gestational and “social”) felt that their pregnancy loss had a “significant” or “very significant” impact on their lives. Participants shared that their experience was amplified due to their emotional investment, financial investment, and the heterosexism they experienced from health professionals (Peel, 2010). Data from this dissertation study support the literature as participants identified the emotional and financial investment as well as a misunderstanding of their experience by society and providers (largely due to heterosexism and comparing the experience to cishetero women) as impacting their experience of pregnancy loss. Although, it is important to note that one participant felt supported by her providers after her pregnancy loss and believed that she received more support due to being monitored so closely because she was receiving fertility treatments. Taken together, these findings suggest that the preconception

period has a role in the experience of pregnancy loss and should be of consideration for mental health providers in treatment.

Luce (2010) shares narratives of conception among lesbian, bisexual, and queer women in British Columbia, and highlights that queer women may experience an increase in feelings of isolation and not belonging when accessing assisted reproduction support groups for pregnancy loss due to homophobia or imbedded heteronormativity. One participant from this present study described her intense feelings of loneliness and isolation after her pregnancy loss due in part to living physically distanced from her typical queer supports. Queer specific social support following pregnancy loss appears to be of significant importance and should be considered in mental health assessment post pregnancy loss. Participants in this study described social media as a means for queer and stressor specific social support when they were unable to access that type of support in person.

Section 2: Mental Health during Pregnancy

Data from this study suggest that the process of becoming pregnant and the mental health challenges experiences by queer women during conception impacts the experiences of pregnancy. The following sections include a discussion of the experiences of pregnancy.

Discussion of Category 7: Physical and Emotional Aspects of Pregnancy

This category explored the physical and emotional aspects of pregnancy. The physical aspects included how participants felt physically as well as any medical complications that occurred during their pregnancy. The emotional aspects included how participants experienced their emotional/mental health during the pregnancy and the factors that impacted their emotional experience.

To date, there is extremely limited research, if any, on the physical and mental health experiences of pregnancy for queer women who have used assisted reproductive treatments to conceive. Research that has been conducted with heterosexual women using IVF to become pregnant found that pregnancy through IVF involves the increased risk of various medical complications including chance of miscarriage, premature birth, and various somatic complications when compared to a pregnancy conceived spontaneously (Yakupova, Zakharova, & Abubakirov, 2015). All three participants in this dissertation study who became pregnant through IVF described somatic complications during their pregnancy. They attributed some of the physical discomfort to the IVF procedures. Researchers in Sweden found that women who became pregnant through IVF reported significantly higher levels of anxiety associated with the risk of losing a child in the first trimester of pregnancy when compared to pregnant women who conceived spontaneously (Hjelmstedt, Widstro, Wramsby, Matthiesen, & Collins, 2003). The researchers also cite evidence that this increased level of anxiety persists throughout the period of pregnancy. Research has also demonstrated that heterosexual women who have used IVF to become pregnant report higher levels of anxiety during pregnancy when they have experienced previous pregnancy loss or have experienced other physical complications (Yakupova, Zakharova, & Abubakirov, 2015). This dissertation study did not specifically find the three participants who used IVF to report higher anxiety related to the risk of losing a child when compared to the other participants; however, participants who experienced pregnancy loss and participants who experienced physical discomfort or medical complications with their pregnancy all reported worry, fear, concern, anxiety or depression during their pregnancy.

Research has also identified the harmful long-term effects of distress during the family building stage including distress continuing into pregnancy and postpartum periods (Eisenberg et

al., 2010; Smeenk, Verhaak, Stolwijk, Kremer, & Braat, 2004), suggesting that the process of trying to conceive through assisted reproductive treatments may have implications for mental health and wellbeing during pregnancy. Participants from this dissertation directly stated this to be the case:

> My experience of being pregnant has certainly been impacted by everything that happened. For sure, having had a miscarriage has been a huge factor in how I have experienced pregnancy since then. But also yeah, I think all those other elements of the process leading up to it are definitely factors in how I feel about it, and in some ways they make it harder and more complicated, and in some ways they do give me that perspective and make it a little bit easier. I think it contributes in a lot of different ways. (P3)

Discussion of Category 8: Queer Identity and Pregnancy

This category explored the concept of the participants’ queer identities and pregnant identities. Participants discussed ways in which their queer identities were validated during their pregnancy, as well as ways in which their queerness had been “invisible,” dismissed, or invalidated during pregnancy. During these discussions, participants described the process of integrating their queer and pregnant identities and how this was both empowering and challenging due to the larger cisheteronormative view of pregnancy and parenthood.

Cao, Mills-Koonce, Wood & Fine (2016) reviewed potential stressors associated with the identity transformation experienced by same-sex couples during their transition to parenthood. They used identity theory framework to understand the way in which same-sex couples develop a sense of self that merges the “conflicting” identities as parents and queer women. However, they also discuss how same-sex couples cope with this distress in order to alleviate these

negative feelings and achieve a “verification state” which they refer to as “the process of bringing one’s perceived self-relevant meanings in a situation into agreement with the actual self-meanings one holds in identity standards by modifying one’s output to the environment” (Cao, Mills-Koonce, Wood & Fine, 2016, p.6). Although the participants in this dissertation study were not yet considered parents as they were still pregnant, the same psychological processes of identity integration appear to have occurred in the process of becoming pregnant and during pregnancy as evidenced by participants discussions. Participants attempted to cope with these feelings in different ways. For example, one participant reclaimed her queer and pregnant identity by writing “Made of Queer Magic” across her pregnant belly at the annual Pride march.

Defining under the umbrella term, queer, leaves room for participants to have identified their sexual orientation, gender identity, and gender expression in many ways. It became clear that there seemed to be certain nuances of pregnancy related to participants’ queer identities that were specific to their queer expression. For example, almost all participants touched on queer invisibility during pregnancy. However, queer invisibility was experienced and described differently by one participant who identified as a bisexual, queer femme with a transmale partner. She discussed navigating her queer identity after her husband transitioned and she became pregnant, as well as how she coped by claiming her queerness,

> I worried a little bit about losing my queer visibility. But ultimately it hasn't felt like a problem. I think that's partly because I got better at claiming my queerness and bi identity as something inherent to me, which doesn't change depending on who I'm in a relationship with, and partly because my husband and I are still queer together, as a family. We're both queer, our marriage is queer, and that's a solid enough foundation for

> me. But I can't expect queerness to be something the whole family is or does together once we have a baby. Odds are the baby will be cis and straight, just by general population statistics (and we'll love and accept them no matter what). Hopefully they'll be a good ally and understand that gender isn't a binary and all that. But somehow being a family with a mom and a dad and a baby feels more straightening than just being husband and wife. (P2)

These findings from this study reveal that although there are similarities within the queer community in regard to their experiences of navigating their queer and pregnant identities there are also nuanced differences depending on how an individual identifies their queerness within themselves and in relation to their partner. Some research has begun to understand these differences and has sought to examine the uniqueness of the perinatal period for bisexual, lesbian, and heterosexual women (Ross et. al, 2012). Ross et. al. (2012) specifically examined the question of whether the experiences of bisexual mothers are comparable to those of lesbian mothers. They focused this examination on self-reported mental health, stress, and social support and also utilized qualitative interviews to explore what factors might contribute to differences between the groups. Their results indicated poorer outcomes among bisexual women in regard to mental health, stress, and social support during the perinatal period when compared to lesbian and heterosexual women. In addition, their qualitative data described the challenges bisexual women face including a sense of invisibility (which increases during pregnancy) and difficulty seeking validating support which contributed to poorer mental health outcomes. They explained that the ability to “pass” as heterosexual may be seen as a privilege to some but more frequently was not seen as a positive attribute and rather a source of discomfort and frustration. Further, this

invisibility often contributes to a lack of support from the larger queer community and a lack of feeling of general community belonging.

The results from this dissertation support the research by Ross et. Al. (2012) which revealed that bisexual women face a sense of invisibility and some difficulty seeking validating support. However, the results from this dissertation study did not suggest that the process was any more distressing for bisexual individuals. Rather, the results highlight that the experience for queer individuals may have nuanced differences depending on how an individual identifies their queerness within themselves and in relation to their partner.

Although queerness and gender are represented in this study as separate categories, it is impossible to completely separate the two as they have many overlapping qualities. When one identifies as queer, it often includes pieces of sexual orientation and gender identity and expression.

Discussion of Category 9: Rejecting the Binary - Gender Related Items

> Pregnancy is a uniquely instructive process for dealing with the concept of doing gender. It allows us to think about how we do gender while managing our bodies, and it highlights dominant culture’s ability to make us feel accountable for experiencing our sex in a gendered fashion. (Ryan, 2013, p. 131)

The topic of gender was discussed by all eight participants. Gender came up in speaking about the fetus/baby, participant’s own gender identity, their partner’s gender identity, or other queer individual’s gender identity. In addition, almost all participants discussed how the experience of becoming pregnant and being pregnant had amplified their awareness of how binarily gendered society is. Participants referenced medical forms, birthing classes, reactions to pregnancy from family, friends, providers, and other members of society, the names mom and

dad, “maternity” clothing, baby clothing and even how they experienced their own bodily transition during pregnancy.

The quote above, suggests that pregnancy is a unique time in regard to experiencing gender. Research has examined the gendered nature of pregnancy and the implications that may have on women who are not outwardly feminine presenting. Ryan (2013) suggests that similar to menstruation, pregnancy is both a biological and a cultural production. Culturally, we have conflated “motherhood” and pregnancy as we have deemed pregnancy as a path to “motherhood” due to the hetero-patriarchal ideals of society (Ryan, 2013). This idea can be a barrier to becoming pregnant, or damaging and harmful to individuals who do not conform to these ideals. Ryan, (2013) interviewed masculine female-bodied individuals about becoming pregnant. Their findings revealed that masculine identifying women resolve the conflict of conflating motherhood and pregnancy by either rejecting or redefining pregnancy. For some of their participants, pregnancy was not desired for different reasons. For others, pregnancy was redefined as something they could do as “masculine” identified people. One reason cited for wanting to become pregnant was because it was described as a unique human experience and one that the individual’s body was physiologically able to do.

It appeared that for all participants, issues around gender related to pregnancy were extremely important. Research suggests that pregnancy may be a time where individuals are closely connected or more aware of expressions of gender within themselves and society (Ryan, 2013). This dissertation study supports the existing literature around gender and pregnancy and suggests that for queer individuals, gender related to pregnancy is a large part of the experience. All eight participants in this study identified as cisgender women, however their gender presentation ranged. For example, some participants described their gender as femme while

others described their gender as masculine. One participant in this study described pregnancy as the “pinnacle of straight womanhood” and discussed how as a queer femme with a trans male partner, her queer identity was often invalidated as she appeared to the world as straight. Another participant who described herself as more masculine presenting, had significant challenges finding pregnancy clothing that aligned with her gender expression. She described the psychological toll this took on her and how it was a larger concern than she had anticipated it to be.

Discussion of Category 10: Connection to Community

This category explored the concept of participants connecting to community. There were two subcategories: social support and resiliency.

Social Support

All eight participants discussed the importance of receiving social support during the process of becoming pregnant and during pregnancy. They expressed the usefulness of connecting with individuals who have gone through the experience as offering the most support. Often, this type of support was found online through social media platforms. Social support appeared to be a protective factor and the lack of social support as a risk factor for mental health concerns for the women in this study. During the process of becoming pregnant, many participants described difficulty seeking social support from close friends and family due to the fact that they had not disclosed that they were trying to conceive. This created challenges for participants, especially those who experienced pregnancy loss or other life events along the journey. They were not able to turn to their typical supports at some of the most stressful times of their lives.

There have been a few studies have addressed the importance of social support for queer families during their transition to parenthood and the mental health implications a lack of support can yield. Yager and colleagues (2010), compared social support scales between lesbian and bisexual women who were trying to conceive with lesbian and bisexual women postpartum. Their findings reveal that women in the trying to conceive group reported lower levels of social support compared with women in the postpartum group. These findings may be explained by the fact that some women in the trying to conceive group had not disclosed their intention to conceive to important members of their usual social support networks. Research has suggested that lower levels of social support are associated with poor mental health in lesbian and bisexual women (Blair & Holmberg, 2008). Results from this dissertation study support these findings and highlight that the lack of social support during the process of becoming pregnant should be of clinical concern due to the potential impact on mental health experiences.

Participants in this study discussed receiving significant support from other queer families who had also utilized donor insemination or assisted reproduction and had similar experiences to their own. In other words, when participants had queer-specific and stressor-specific social support they felt validated, understood, and that they were not alone. These findings align with the research on the matching theory of social support. The matching theory of social support suggests that support will have the most impact when it aligns with and addresses the specific stressor (Doty et al., 2010). Research on social support among LGB youth has found that sexuality-related social support, but not general social support, had a buffering effect on sexuality-related emotional distress (Doty, Willoughby, Lindahl, & Malik, 2010). Participants in this study identified other queer families who have gone through the process or are going

through the process to be the most useful support. Often, participants identified finding this type of support either through LGBTQ community centers or on social media.

Finally, all eight participants in this study mentioned the support from their partners throughout the transition to parenthood as being critical to their mental health. It was clear that the process of becoming pregnant and the experience of pregnancy where deeply shared experiences between the participant and their partner. The required intentionality of the process, the research that needed to be conducted, and the decisions that needed to be made were often completed together. The findings revealed that for the carrying partner, support of the noncarrying partner was of significant importance.

Resiliency

All eight participants were observed by the researcher as demonstrating significant resiliency throughout their process of becoming pregnant and during their pregnancy. Despite the challenges most participants faced, they found ways to cope and overcome through advocating about the process and sharing their own stories to improve the experience for others as well as reclaiming the experience of pregnancy as a queer one.

Generally, pregnancy can be distressing even when it is anticipated and wanted. Stress has been identified as a risk factor for physical and psychological health during pregnancy for heterosexual women (Garcia-Leon et al., 2019). Garcia-Leon et al. (2019) found that women with high resilience had lower levels of perceived stress, pregnancy-specific stress, psychopathological symptoms, psychological wellbeing, and Hair Cortisol Concentrations during the third trimester than women with low resilience. They measured resilience using the Connor-Davidson Resilience Scale (CD-RISC; Connor & Davidson, 2003), which reflects the capacity to tolerate experiences such as change, personal problems, illness, pressure, failure, and feelings of

pain. Their findings suggest that resilience may serve as a protective factor for physical and mental wellbeing during pregnancy. Although this study was limited to heterosexual women, it may extend to the experiences of queer women as well.

Meyer (2015) expands on the model of minority stress and discusses how resilience mitigates the negative impact of stress on health for sexual and gender minority individuals. Resilience is defined as “the quality of being able to survive and thrive in the face of adversity” (Meyer, 2015, p. 2010). Meyer proposes that sexual and gender minority individuals possess resilience at the individual and community level. Community resilience refers to “how communities further the capacities of individuals to develop and sustain well-being” (Hall & Zautra, 2010, p. 350). In the context of minority stress, community level resilience includes tangible resources such as access to LGBT community centers, role models, sharing information and knowledge, and community mobilization/advocacy for affirmative policies.

This dissertation study began by highlighting the need for future research due to the potential risk factors queer families face during their transition to parenthood because of their sexual minority status. Although specific risk factors were identified in this study, the significant impact of resiliency on participants experiences of pregnancy was a critical finding. The participants in this dissertation study demonstrated resiliency at both the individual and community level as a protective factor for physical and mental wellbeing during pregnancy. Embedded in every participant’s motivation to share their story for this study was a desire and motivation to give back to the queer community and contribute to the communal knowledge of the experience. Participants’ motivation to share their experiences was an effort to improve the experience for the next generation of queer families embarking on this journey.

Substantive Theory and Conceptual Model

A constructivist approach theorizes the experiences shared by participants while also acknowledging that the resulting theory is an interpretation that is influenced by the researcher’s views (Charmaz, 2014, p.239). The proposed substantive theory that emerged from this study is described in this section and represented through the conceptual model in Figure 2.

Substantive Theory

This study suggests that the process of becoming pregnant impacts the physical and mental health experiences during pregnancy. The categories discussed in the process of becoming pregnant section (intentionality, conducting research, decision-making, interactions with healthcare providers, financial burden, and life events) all played a role in participants’ mental health while trying to conceive and consequently impacted their mental health during pregnancy. Additionally, the larger cisheteronormative society, including the dominant narratives of pregnancy and parenthood, as well as social, political, and cultural contexts (including factors of minority stress) also negatively impact overall mental health during both conception and pregnancy. Participants shared different emotional experiences during the process of becoming pregnant and taken together they described their emotional experiences as some combination of depressed, anxious, lonely, stressed, fearful, worried, concerned, angry, frustrated, vulnerable, confused, hopeless, devastated, overwhelmed, out of control, optimistic, hopeful, excited, happy, and grateful. Several participants explicitly stated that they felt the process of becoming pregnant impacted their experience of pregnancy, reporting that they were still holding on to fear, concern, and worry during their pregnancy as well as anger about the overall process of trying to conceive. Some participants held simultaneous feelings of frustration/anger and gratitude for their process. It is likely that the stress experienced during the process of trying to become pregnant continues to be held during pregnancy. Pregnancy offered a time for participants to

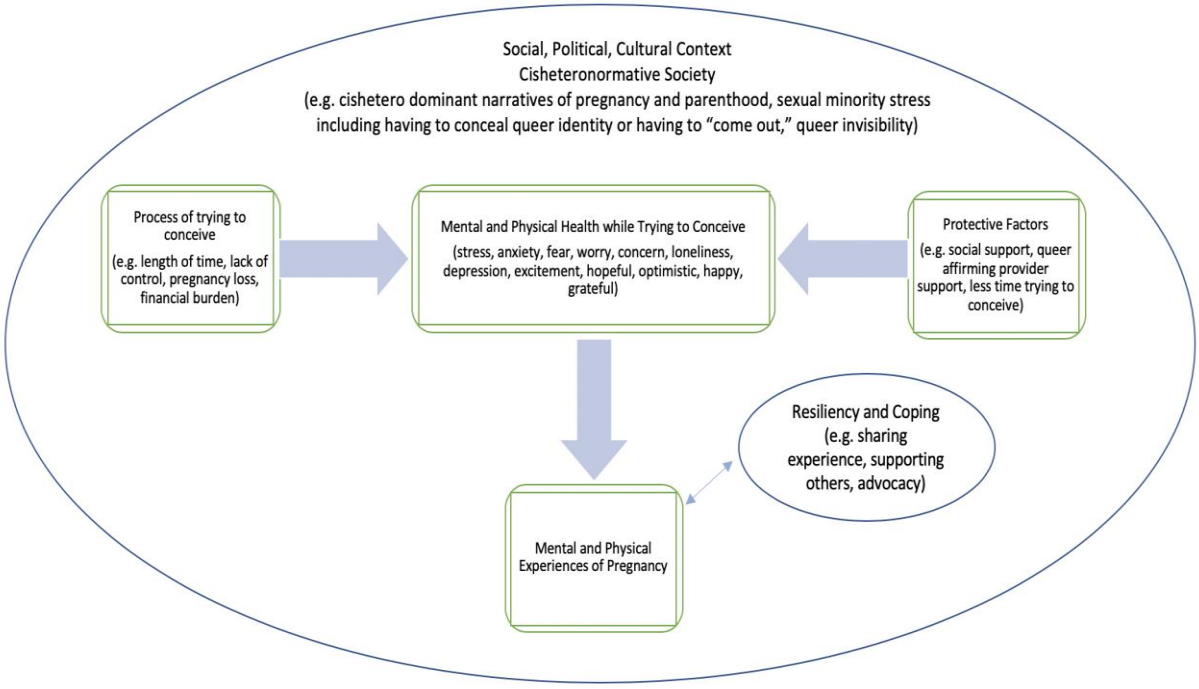
attempt to make sense of their experience and work through their emotions. Perhaps the experience continues to affect participants during pregnancy because they are attempting to reconcile and integrate their experience of becoming pregnant, with their experience of pregnancy, into their narrative as they transition to parenthood.

It is important to highlight the protective factors that influenced mental health experiences during the process of becoming pregnant that served as a buffer for mental health during pregnancy. The participants’ narratives revealed a number of protective factors for mental health during pregnancy such as having partner and family support, experiencing positive interactions and supportive relationships with providers, matching social supports (matching stressor and queer identity), spending less time trying to conceive, and having access to queer affirming care and supports.

Despite the challenges and adversity faced by participants in the process of becoming pregnant and during pregnancy, participants found ways to cope and demonstrate their resiliency. The participants in this study demonstrated coping and resiliency through advocating, sharing their stories, acting as support to others in the process, and reclaiming the experience of pregnancy as a queer one. One example of this is giving back to the community. For example, all eight participants discussed their motivation to participate in this study largely due to the challenges they faced in their experience. They wanted to inform the process for future queer families trying to conceive and starting their families.

Conceptual Model

Figure 2. Conceptual Model of Queer Pregnancy



Limitations

In accordance with grounded theory methodology, this study sought to include a homogenous sample. Originally, the researcher had thought the inclusion criteria of self-identifying as a queer woman would make the sample homogenous while also not excluding members of the community. Opening participation to all queer women meant that there were differences among the women in terms of their gender identity (i.e., femme, masculine) and the gender of their partners. For example, some women in the study had partners who also identified as women and others had partners who identified as transmen. Although there were similarities in experiences there were also differences. This study suggests that the experience of pregnancy for a woman who identifies as femme and the experience of a women who identifies as more masculine may be different based on gender identity/expression. Thus, this study provides an overview of the experience for queer women and future research is needed focused on more

specific identities within the “queer women” umbrella to more deeply understand their unique experiences.

Another limitation of this dissertation study is lack of diversity in regard to race, socioeconomic status, and education. Most of the research on LGBQ parenthood experiences has been done on white, middle-class, and highly educated samples of same-sex couples living in urban areas. This study was no different. As discussed throughout the study, using assisted reproductive treatments to become pregnant is an expensive process which can be seen as a privileged way to become pregnant. In addition, the experience of becoming pregnant for queer identified people of color and members of the queer community who have other marginalized identities may look different than what is presented with this data. Given the oppressive structures within our society, they face additional barriers due to other marginalized identities. Furthermore, the women in this study all lived in urban cities which likely afforded them connections to resources, such as LGBTQ centers, that queer individuals in more rural areas do not have.

Another limitation of this study was that the noncarrying partner’s experience was not included. Future research should explore the experience of the process of becoming pregnant and pregnancy for the noncarrying partner.

Clinical Implications and Recommendations

Fertility counseling with queer families should take into consideration that the process of becoming pregnant is different than it is for cisgender heterosexual couples. There are unique barriers, challenges, and stressors and fertility counselors should be aware of those differences and intervene accordingly. The results of this study demonstrate important implications for mental health clinicians as they point to several variables that should be considered when

working with queer families in the process of becoming pregnant and during pregnancy. For example, this study revealed that the process of becoming pregnant impacted the physical and mental health experiences during pregnancy. Knowing this information, it is critical to provide supports and interventions earlier during the process of becoming pregnant that target the specific areas that are most distressing. Participants in this study identified a need for a more comprehensive resource to support them in conducting research and making decisions about their process of becoming pregnant. Currently, queer families utilize many different resources and are often pulling many different perspectives from various online sources to inform their decisions. Some participants in this study described this as overwhelming and mentioned that they wondered if they were “doing it the right way.” Knowing this, it would be helpful for providers to create a more streamlined database, online resource, or textbook which includes thorough explanations of the process and options for queer families. As discussed in the decision-making discussion section, Chabot and Ames (2004) proposed a decision-making model for queer families with seven questions: 1) Do we want to become parents? 2) Where do we access information and support? 3) How will we become parents? 4) Who will be the biological mother? 5) How will we decide on a donor? 6) How do we incorporate inclusive language? 7) How do we negotiate parenthood within the larger heterocentric context? (Chabot & Ames, 2004). Providers working with queer families should be aware of these decisions and could utilize Chabot and Ames (2004) model to support queer families as they get started with their process.

In addition, other variables such as the time consuming nature of the process, the lack of control felt, pregnancy loss/medical complications and the side effects of treatments and medications have all been found to cause distress during the process for queer families. Providers

should be aware of these common stressors in an effort to normalize, support, and validate queer families’ experiences.

It is critical that mental health providers who work with queer families do their own personal reflective work around cultural humility related to working with queer families. Based on the results of this study and previous research, a major stressor and barrier to accessing care are the cisgender heterosexual assumptions of the family system and of pregnancy. Clinicians should seek trainings and explore their assumptions and ideas around gender, sexual orientation, the family system, and pregnancy to identify ways in which their biases may impact treatment with queer families.

Another major finding from this study is the importance of the types of social support queer pregnant individuals have throughout the process. Based on the matching theory of social support, support that matches one’s queer identity and specific stressor (i.e. trying to conceive, pregnancy loss, invalidating experiences with providers) may serve as a larger buffer or protective factor for distress. Knowing that trying to conceive is a unique experience for queer families, providers should conduct a thorough assessment of support networks and be able to provide referrals to on-line or in-person support groups or other resources that may provide the specific support needed. This research provides insight that queer specific support groups may be an effective intervention for this community. One idea for a stressor specific support group is a group for queer families trying to conceive who have experienced a pregnancy loss. Another idea would be to have an ongoing support group specifically for queer families with different weekly topics related to the trying to conceive process. For example, one week’s topic could be on donor sperm discussions and decisions while another week could be managing stress while trying to conceive.

Another idea to encourage social support and connection is to create a peer-to-peer support program. This program could pair a family with another family who has gone through the process. This idea could be effective for families who would like an intimate connection while not having to join a support group.

Research Implications and Recommendations

Despite its limitations, this study highlights that the experience of pregnancy for queer families is a unique experience that can have an impact on one’s mental and physical health. Future research of a larger scope may be able to add data that further illuminates the results from this study. A mixed methods study that utilizes measures of stress, anxiety, and depression that have been normed with the queer community, could provide insight into the presence of clinical levels of these mental health concerns.

An area that arose in this study that appears to have significantly impacted participants mental health experiences during the process of becoming pregnant and during pregnancy was experiencing pregnancy loss. It appeared that the challenges of achieving pregnancy amplified the effects of pregnancy loss. There is extremely limited research on the experience of pregnancy loss for queer individuals and this study begins to highlight that it may be a unique experience, when comparing to a cisgender heterosexual experience, that should be considered by mental health providers.

During follow-up interviews, three participants spoke about experiencing postpartum anxiety or depression. Research has suggested that distress during the family building stage may be carried over to pregnancy and postpartum (Eisenberg et al., 2010; Smeenk, Verhaak, Stolwijk, Kremer, & Braat, 2004). One study found that lesbian and bisexual women reported significantly higher depression scores than a sample of heterosexual postpartum women (Ross et al., 2007).

Future research should examine the mental health experiences of queer families postpartum who use assisted reproductive treatments to become pregnant.

Another area that arose for future research was the experience of the non-carrying partner. Participants frequently brought up their partners during interviews and reflected on how they had experienced both the conception period and the pregnancy period. There are additional and unique stressors that come up for the non-carrying partner that should be explored in future research. For example, participants from this dissertation study revealed instances where their partners have been excluded or left out from attending appointments or procedures. Research by Cravel and Peel (2014) on pregnancy loss in queer women, suggests that the non-gestational mother experiences the loss of the pregnancy as significantly or more significantly than the gestational parent and that additional factors play a role in their experiences of distress such as assumptions that they do not have as much as a connection to the pregnancy because they are not carrying. There is a need to further explore and understand the experience of trying to conceive and of the pregnancy period for the non-carrying partner.

Finally, another area that all eight participants addressed was thinking about the experience of pregnancy for transgender, gender non-conforming (GNC), or non-binary individuals. The results from this study regarding gender and pregnancy reveal that even for cisgender women, issues related to gender expression during pregnancy were prevalent and caused distress. Participants discussed how the transition to parenthood revealed how binarily gendered the idea of pregnancy is in today’s society. The larger message from society is that pregnancy is an experience for feminine presenting females. Participants were curious about the implications those messages from society may have for an individual who identifies outside of societal standards of gender. Future research should explicitly explore the concept of gender during

pregnancy and the implications gender expression and gender identity may have on mental health during pregnancy.

Conclusion

This study is one of few to examine the experience of pregnancy for pregnant, queer, cisgender women who use medically assisted reproductive treatments to become pregnant. The findings suggest that the process of becoming pregnant impacted the physical and mental health experiences during pregnancy. In addition, the results reveal that there are unique experiences that queer families face such as their intentionality, decision making process, interactions with the healthcare system, and navigating the transition to parenthood within a cisheteronormative society. Queer and stressor specific social support was identified as a protective factor and most participants found this type of support via social media groups rather than in person. Future research should examine clinical levels of mental health disorders during pregnancy for pregnant, queer, cisgender women as well as seek to further understand the mechanisms by which the process of becoming pregnant impact pregnancy. Understanding the mental health experiences during pregnant is crucial for mental health providers and may have implications on postpartum mental health, attachment to the infant, and the infant’s development.

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Appendices

Appendix A
Recruitment Flyer Content

UNIVERSITY OF SAN FRANCISCO | School of Nursing and Health Professions

RESEARCH STUDY LOOKING FOR PREGNANT, QUEER WOMEN.

Contribute your voice to the understanding of this experience!

Hello! My name is Lindsey and I am a graduate student in the Clinical Psychology Doctoral Program at the University of San Francisco. I am conducting a study to better understand the unique social and emotional experiences of pregnancy for queer women and am recruiting participants to be a part of the study.

Your participation will include a 45-90-minute interview on your experience. *Participants will be compensated in the amount of a $15 Amazon gift card for their participation.*

You are invited to participate if:

- You identify as a queer woman;
- You are pregnant with your first child*;
- You are currently in the 2nd or 3rd trimester of pregnancy (14-40+ weeks)**;
- The pregnancy is a result of assisted reproductive treatments (this includes DIY conception methods, donor insemination, IUI, IVF, Reciprocal IVF, etc.)
- You are 18 years or older
- Interested in sharing your experience

*Participants are still eligible if they have experienced prior pregnancy loss
**Individuals may be considered for future participation if they are still in their first trimester and meet other criteria

Please contact me by phone or email. I am happy to further discuss the study and answer any other questions.

Lindsey Rogers
Lrrogers2@usfca.edu
978-290-0781

Appendix B
Informed Consent

Participant Consent Form

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

Below is a description of the research procedures and an explanation of your rights as a research participant. You should read this information carefully. If you agree to participate, you will sign in the space provided to indicate that you have read and understand the information on this consent form. You are entitled to and will receive a copy of this form.
You have been asked to participate in a research study entitled Queer Ladies Having Babies conducted by Lindsey Rogers a graduate student in the Clinical Psychology doctoral program at the University of San Francisco. The faculty supervisor for this study is Michelle Montagno, Psy.D. a professor in the Clinical Psychology program at the University of San Francisco.

WHAT THE STUDY IS ABOUT:

The purpose of this research study is to understand the experiences of pregnancy for individuals who identify as queer, female, and cisgender and who have decided to build a family through assisted reproductive treatments.

WHAT WE WILL ASK YOU TO DO:

During this study, you will be asked to participate in one in-person interview in which you will be asked to share about your pregnancy experience, as well as about your mental health during this time.

DURATION AND LOCATION OF THE STUDY:

Your participation in this study will involve one session that will last about 45-90 minutes and another optional session that will last about 20 minutes. Sessions will take place at the University of San Francisco or over Zoom video conferencing.

POTENTIAL RISKS AND DISCOMFORTS:

Potential risks of this study are minimal but can include discomfort from discussing sensitive topics such as sexual identity and parenthood. If you wish, you may choose to withdraw your consent and discontinue your participation at any time during the study without penalty.
BENEFITS:

Participants will have the option of receiving a summary of the research findings upon conclusion of the study. Participants may or may not benefit personally from this study through the experience of being able to contribute to the body of knowledge about same-sex female couples utilizing medically assisted reproductive technologies to build their family.

PRIVACY/CONFIDENTIALITY:

Any data you provide in this study will be kept confidential unless disclosure is required by law. In any report we publish, we will not include information that will make it possible to identify you or any individual participant. Specifically, we will store data in computer files that will be password protected and encrypted. Hard copies of this or any other form will be kept in a locked file cabinet. The researcher will use a master list that includes each participant's name and a code linking the name to the data. This master list will be kept secure and separately from the collected data.

VIDEO AND AUDIORECORDINGS: Interview sessions will be audio recorded for the

purpose of being transcribed for data analysis. These data files will be stored in computer files that will be password protected and encrypted. Upon completion of the research the data will be archived after transcription, for potential future use.

COMPENSATION/PAYMENT FOR PARTICIPATION:

You will receive $15 Amazon gift card per interview for your participation in this study. If you choose to withdraw before completing the study, you will receive only gift cards for interviews that you have completed.

VOLUNTARY NATURE OF THE STUDY:

Your participation is voluntary and you may refuse to participate without penalty or loss of benefits. Furthermore, you may skip any questions or tasks that make you uncomfortable and may discontinue your participation at any time without penalty or loss of benefits. In addition, the researcher has the right to withdraw you from participation in the study at any time.

OFFER TO ANSWER QUESTIONS:

If you have questions at any time, you may contact the principal investigator Lindsey Rogers at 978-290-0781 or lrrogers2@usfca.edu, or the faculty advisor Michelle Montagno at (415) 422-4074 or mjmontagno@usfca.edu. If you have questions or concerns about your rights as a participant in this study, you may contact the University of San Francisco Institutional Review Board at IRBPHS@usfca.edu.

I HAVE READ THE ABOVE INFORMATION. ANY QUESTIONS I HAVE ASKED

HAVE BEEN ANSWERED. I AGREE TO PARTICIPATE IN THIS RESEARCH PROJECT AND I WILL RECEIVE A COPY OF THIS CONSENT FORM.

Name:_____

Signature: _____

Date: _____

Appendix C
Demographic Questionnaire

Demographics

1. When is your birthday?
2. Are you the carrying or non-carrying partner?
3. What is your baby’s due date?
4. How do you currently describe your gender?
5. How do you currently describe your sexual orientation?
6. What are your preferred gender pronouns?
7. How do you identify racially?
8. How do you identify ethnically?
9. Do you have a religious affiliation/preference?
10. Are you currently in a romantic relationship with a partner or partners?
    - No
    - Yes, one partner
    - Yes, multiple partners
11. What is your relationship status?
    - Married
    - Civil union
    - Domestic partnership
    - Dating
    - Open relationship
    - Polyamorous relationship
    - Other, please specify:
12. Do you and your partner (primary) live together?
    - Yes
    - No
13. When did your current relationship begin?
14. What is the highest level of education you have completed?
    - Some high school
    - High school graduate or GED or equivalent
    - Vocational training
    - Some college (at least one year)
    - Associate’s degree
    - Bachelor’s degree
    - Some post-graduate work
    - Master’s degree
    - Specialist degree
    - Applied professional doctorate degree
    - Doctorate degree
    - Other:_____
15. Current employment:
    - Employed full-time
    - Employed part-time
    - Not working for pay, homemaker
    - Unemployed, looking for work
    - Student
    - Retired
    - Other, please specify:
16. What is your current (or most recent) job or occupation?

17. What is your annual income?
    - Less than $25,000
    - $25,000 - $50,000
    - $50,001 - $75,000
    - $75,001 - $100,000
    - $100,001 - $150,000
    - $150,001 - $200,000
    - More than $200,000

Medically Assisted Reproductive Treatments

18. How man MAR treatment cycles have you attempted so far?
    - IUI:
    - IVF:
    - Reciprocal IVF:
    - Home insemination:
    - Other:
19. Please indicate the total amount you have spent on all services related to family building efforts (whether covered by insure or not):
    - $0 - $10,000
    - $10,001 - $20,000
    - $20,001 - $30,000
    - $30,001 - $40,000
    - $40,001 - $50,000
    - $50,001 - $60,000
    - $60,001 - $70,000
    - $70,001 - $80,000
    - $80,001 - $90,000
    - $90,001 - $100,000
    - More than $100,000
20. Has insurance covered any of the costs of this process?
21. Please estimate the total amount you have spent out of pocket for all services related to family building:
    - $0 - $10,000
    - $10,001 - $20,000
    - $20,001 - $30,000
    - $30,001 - $40,000
    - $40,001 - $50,000
    - $50,001 - $60,000
    - $60,001 - $70,000
    - $70,001 - $80,000
    - $80,001 - $90,000
    - $90,001 - $100,000
    - More than $100,000

Appendix D
Initial Interview Guide

Objective: The purpose of this semi-structured interview guide is to understand the experiences of pregnancy for same-sex female couples who have chosen to use medically assisted reproductive technologies to build their families.

Process: The following potential questions serve as a template for interviews for the purpose of prompting discussion with participants. These questions are aimed to address specific content areas relevant to the study and may be altered based upon participants’ responses in effort for the interviewer to further explore the way in which each participant experiences these topics.

Semi-structured interview questions:

1. Can you tell me about your journey of becoming pregnant?
2. Can you tell me about the day you found out you and your partner were pregnant?
3. How has your pregnancy been?
    1. This can include, physically, emotionally, socially or anything you want to touch on.
4. Have you experienced stress during your pregnancy? If so, how, why?
5. Do you feel any parts of your pregnancy experience have been particularly stressful because you are a member of same-sex couple?
    1. If so, could you share what you found to be the most stressful because you are a member of a same-sex couple? Why do you think this is so?
6. Have you ever felt like you had to conceal your sexual orientation identity when talking about your pregnancy and fertility treatment processes in any contexts such as medical settings, work, with friends/family?
7. Before you and your partner became pregnant, have you ever had any mental health challenges in the past?
    1. If yes, can you talk a little more about this?

8. In general, have you experienced any challenges or difficulties with your mental health since becoming pregnant?
    1. If yes, can you talk more about this?
9. Have you sought any support?
    1. Counselor, friends, parents?
10. Thinking about all we have talked about today, is there anything that you would like to mention that we haven’t yet talked about? Anything you feel would be important for me to know about your experiences?
11. Questions? Feedback for future interviews?

Appendix E
Follow-Up Interview Guide

Participant:_____

Date:_____

Start Time:_____

End Time:_____

Ask for permission before recording and remind about confidentiality.

Start recording.

SCRIPT: “Thank you, again, for continuing your participation with this study. I have sent you a document that includes some of the themes that have been identified thus far in the research study. Today, I would like for us to take a look at this document together. I have a few questions that I will ask about your reaction to these themes and I would also like to get your feedback about the study and anything else you may want to share related.

1. As you look at these themes and their related constructs, was there anything that **did not** seem to resonate with your beliefs and/or experiences? If so, could you tell me which ones and briefly why they did not resonate with you?
2. In looking at the themes, in general, are there any that really stuck out for you?
3. Any themes that you believe are missing?

“Thank you again for your participation. I appreciate you taking the time to meet with me. As a reminder, you will be receiving an Amazon gift card through email within 24 hours.”

Appendix F
IRB Approval

UNIVERSITY OF SAN FRANCISCO

Annual Report Approval Notification

To: Lindsey Rogers
From: Richard Greggory Johnson III, IRB Chair
Subject: Protocol #1141
Date: 01/13/2020

The annual report for your research (IRB Protocol **#1141**) with the project title **Queer Ladies Having Babies** was approved on **01/13/2020**.

This approval is good through **12/15/2020**.

If you have any questions, please contact the IRBPHS via email at IRBPHS@usfca.edu. Please include the protocol number assigned to your application in your correspondence.

On behalf of the IRBPHS committee, I wish you much success in your research.

Sincerely,

Dr. Richard Greggory Johnson III
Professor & Chair, Institutional Review Board for the Protection of Human Subjects
University of San Francisco
irbphs@usfca.edu
IRBPHS Website