"We enter the clinic nine times out of ten just imagining that we need some help with insemination – we are immediately treated as though we have fertility issues… For some of us this becomes a reality, but still our needs are different.”

- Dahlia Riback, Still Trying facilitator

This month’s column addresses the particular experiences and concerns of lesbian, bisexual and queer (LBQ – or queer for short) cisgender (non-trans) women in the course of their fertility, and infertility, journeys. The column is specifically about those who choose pregnancy as their route to parenthood.

A complex route to parenthood

While some LBQ women might get pregnant through heterosexual intercourse, the majority of those planning pregnancies do not choose this route. And while some may have more direct access to sperm, for example those partnered or co-parenting with trans women, most do not have easy access to sperm. The planning of a pregnancy can involve considerable time, energy, thought, and often, expense. As a participant from the Creating Our Families (see box right) study puts it:

“When we were looking for options for having a family, there’s a lot of logistics that come into it. We were like, Wow! I knew this would be work but I didn’t know it would be this much work. We actually called it Project Pregnancy. It was like a part-time job. We both called in sick one day and spent the day doing research, making phone calls and figuring out our options.”

Probably the most complex decision for queer women planning a pregnancy relates to

The quotes in this column are all taken from participants in the Creating Our Families (COF) research project. The COF project was a CIHR-funded partnership between researchers at the Centre for Addiction and Mental Health, the Sherbourne Health Centre, St. Michael’s Hospital and York University in Toronto. The pilot study interviewed 66 LGBTQ people across Ontario about their experiences with fertility clinics. For more information and to download the bilingual resources developed from the project, go to: www.lgbtparentingnetwork.ca/resources.cfm.

The project also created an interactive theatre piece (see LGBTQ Column, Creating Families, Winter 2012/2013) which is now being made into a video for presentations to fertility clinics and other AHR services. For more info, or to support the project, email: parentingnetwork@sherbourne.on.ca.
Before most LBQ women get to the point of actually trying to get pregnant, they have spent a lot of time hunting down information, exploring options and making complicated decisions.

choosing a sperm donor. The first order of decision-making involves choosing a donor from a sperm bank or one known to the intended parent(s). If one is going the sperm bank route there are choices to be made about complete anonymity or what is known as I.D. Release – i.e. donor information can be made available to the child when he or she turns 18. The route of the known donor involves another set of choices and negotiations. Each of these options involves a different, and complex, set of issues, the details of which are beyond the scope of this column (but perhaps the subject of a future one!)

What is significant for a discussion of “infertility” is the fact that before most LBQ women get to the point of actually trying to get pregnant, they have spent a lot of time hunting down information, exploring options and making complicated decisions.

A fuzzy line between ‘fertility’ and ‘infertility’

Depending on the decisions we make about sperm donors, we may choose to simply inseminate at home (most likely with a syringe - not the iconic turkey baster), or we may choose referral to a fertility clinic. Many would prefer to stay at home, but find themselves in clinics because of the choices they make regarding the source of sperm or because they want to access some of the services and technologies available in the clinic, such as cycle monitoring or various forms of tests. For those of us who choose to access fertility clinics as the first stop in our journey to conception there are several implications. Because we are entering a system set up to serve heterosexual, cisgender couples dealing with infertility, there is often a fuzzy line in our own treatment between ‘fertility’ and ‘infertility.’

“Not having access to sperm is a really different thing than trying to get pregnant with sperm and having trouble… I think the idea that ‘queerness,’ like being a lesbian, in and of itself is a fertility problem, is ridiculous. I just think [AHR services] need a whole re-think in order to make sense to everybody who is accessing them.”

– Single queer woman in a small city who had a child but avoided AHR.

When we enter clinics we encounter intake and consent forms and language that do not work for us, as well as incorrect assumptions about our sexual/gender identities and family configurations. The result is an experience that is often alienating, and sometimes hurtful and frustrating. And because we have often spent months, sometimes years, researching and planning, by the time we arrive at the clinic or begin home insemination we may already feel depleted and impatient with the process. Some people find the clinic environment itself a source of stress:

“I’m quite certain it took me so long to get pregnant because my stress level spiked… Having someone you don’t know inseminate you is not exactly the most conducive to relaxing. The metal thing they put in you… the whole procedure isn’t comfortable, right?”

While many queer women do get pregnant in a home or clinical setting without the need for any kind of ‘fertility treatment,’ some queer women do experience fertility problems. The question is, how does their experience differ from that of straight women or couples? The first answer is: it doesn’t. Infertility and pregnancy/infant loss are painful, no matter who you are:

“In some ways your sexual orientation feels almost irrelevant when you’re struggling with fertility issues … because that becomes the central thing.”

On the other hand, our identities, family configurations and routes to parenthood mean there are some particularities to our experience.

Early detection of problems

The upside of our early entry into fertility clinics is that sometimes we can detect fertility problems early on. For example, the couple below discovered that each of them had a significant barrier to fertility that needed to be addressed:

“She originally thought, ‘we don’t need a fertility specialist, it’s not like we’re infertile, we just need somebody to get us pregnant…’ Then it turned out that my partner had endometriosis… And then [after the first baby
I went for the dye test and it was like agonizingly painful and he said, ‘You’ve got blocked tubes, the dye is just not going to go through.’"

In this case, both women were able to be treated quickly, and each of them got pregnant.

**Informed consent versus informed choice**

Another implication of our early entry into clinics is that often women who have no known fertility problems are subjected to tests and medical interventions designed for those who do. Clinics have a range of practices in relation to testing and interventions; and queer women clients have a range of feelings about this issue. Some clients welcome the tests that might provide valuable information about potential problems early on:

“… then I had to have an ink test to see if my tubes were open, so they went through all the fertility procedures as if I had a fertility problem. There was no assumption that the fertility problem was just that we had no sperm… I never imagined that it would take six months to get to the actual point of insemination. It was a lot more technical than I expected and a lot more expensive than I expected.”

What these varied experiences point to is the value of, “informed choice,” a way of thinking and a paradigm that differ from that of, “informed consent.” Informed consent involves a patient agreeing to a procedure or medication recommended by another, usually someone in authority, an expert of some sort. As Spaeth (2010) puts it, “Consent implies a relationship based on power… and does not engender trust or make the patient feel cared for.”

Informed choice, on the other hand, involves patients making autonomous decisions for themselves, based on the provision of full information. Queer women who enter fertility clinics, like all healthcare patients, want the opportunity to make informed choices about the tests and medical interventions they undergo.

Financial issues

The fact that the fertility clinic is often our entry point also means that we can’t “try quietly at home” for a while before incurring the time and expense of fertility ‘treatments.’ While costs are a barrier, and sometimes prohibitive, to all those who use the services of fertility clinics, queer people often incur these costs from the get go. This means that, much as we might like to, we do not always have the financial capacity to try every month. It is important to consider that some of us are living on a single income, and that as queer women we are systemically disadvantaged in the labour force in relation to men (i.e. no male income).

**Support (or lack of support) from family and work**

Often those dealing with fertility issues count on ongoing support from family, friends and work mates. This, of course, is true for LGBTQ people as well, but sometimes our families are not supportive of our sexual orientations, gender identities, family configurations or choice to have children. This lack of support can become painfully heightened with the stress of infertility. One woman describes her partner’s mother’s initial reaction to their relationship and then to receiving the news that her daughter is pregnant:

“Her mother was very upset when she found out about us, you know, she didn’t talk to me for a period of time and just was really not very nice… It took [her partner] a while to get pregnant [due to infertility issues] and we didn’t tell them about the process along the way, and then when we did they just couldn’t handle it… We phoned and there was like silence on the phone and then there was yelling and screaming and it was just horrible, I mean it was absolutely terrible. It was very unfortunate.”

Similarly, because many of us are not able to be “out” at work, we must often remain silent with work mates and colleagues about
struggles with fertility, the birth or adoption of a child and other life-impacting events.

Have uterus ≠ Wants to get pregnant

Sometimes, when one partner in a lesbian couple is experiencing fertility challenges, clinic medical staff assume that (lucky for them!) there is another uterus available, i.e. the other woman can attempt to get pregnant. In some cases, this is true, but often it is not. Some queer women have no desire to become pregnant; and for some the idea runs counter to their gender identity and/or bodily experience.

An interracial couple, who ended up going to the United States to access a sperm donor of the racial background they desired, describes the assumption by clinic staff that they could just switch who was getting pregnant:

“They said, ‘Why doesn’t [your partner] try and get pregnant instead, and then you can use a white donor and it won’t be a problem. But we already told her in the beginning that I don’t want to be pregnant, that wasn’t an option for us… It was interesting, it was like, just because you have the capacity to, you should.’”

Another woman talks about the ways her partner’s gender is misrecognized in the clinic and, again, how it is assumed that they are interchangeable when it comes to conception:

“My partner’s gender appearance is not very traditionally female and she kept kind of getting ‘sir’… She would never go to the washrooms there and the technicians called her ‘Poppa’ a couple of times, which bothered her. I would correct them sometimes but then sometimes she doesn’t want me to correct people because she gets embarrassed… The doctor did try and convince my partner to get pregnant, and she was like, No, I’m never doing that.”

As the above quotes illustrate, it is incumbent on those working with queer women to refrain from making assumptions about people’s desires and preferences when it comes to their bodies and, in particular, to not assume that simply having the parts means you want to use them.

Negotiations with donors

Those inseminating at home with known sperm donors have usually had to engage in what are sometimes (though not always) awkward discussions with their donors about
With the psych interview, they have a script and they have a protocol that is based on the assumption that it’s a man and a woman and one or both of them can’t have children for some reason.”

Like other fertility clinic staff, counsellors need to take into account the specific needs and concerns of LGBTQ clients, and how these might differ from those of heterosexual clients.

A place to talk

LGBTQ people have historically been denied the right to have children and have had children taken away from them. One impact of this history is that much of the focus in recent years has been on creating LGBTQ-positive spaces where people can find the information, the support and the community they require in order to bring children into their lives. An unfortunate, though unintentional, effect of this focus has been a lack of discussion of difficult issues like infertility and pregnancy/infant loss. As Shira Spector puts it:

“We are in the midst of an LGBT baby boom, and where there is a baby boom there is infertility and pregnancy loss… One of the problems around infertility/pregnancy loss is this great quietness for all women. No one really wants to talk about it - it’s all so painfully icky and somehow viewed as self-indulgent to mourn one’s fertility or failed pregnancies. So it’s really quiet when it happens to you, except suddenly everyone has a story to tell you about someone suffering a miscarriage or hopeless fertility pursuit. It’s so common, why is it so quiet?”

Shira goes on to articulate what would help:

“Here’s what I want for those of us who are struggling: support and love. I know that’s vague, but support and love anyway. The sound of our voices and our stories counted in, as common and
Queer women want to be included in the wider circle of those with whom they share a common experience; and, at the same time, our particular circumstances, family configurations and identities need to be recognized, acknowledged and respectfully held.

About the author

Rachel Epstein has been an LGBTQ parenting activist, educator and researcher for over 20 years. She coordinates the LGBTQ Parenting Network at the Sherbourne Health Centre in Toronto and is currently completing her doctoral dissertation at York University. She is editor of the anthology *Who’s Your Daddy? And Other Writings on Queer Parenting* (Sumach Press, 2009).

References:


Still Trying is an informal support group for LGBTQ people who are in the process of trying to conceive. The group started as a community initiative, and is now run by the LGBTQ Parenting Network, Sherbourne Health Centre, Toronto. Our interest in supporting this initiative came from observing the overwhelming emphasis on the experience of cisgender heterosexual couples in most fertility-focused resources and support. Facilitator Dahlia Riback came to the group because she felt strongly that LGBTQ people have specific experiences of fertility and infertility. Together, we noted a lack of LGBTQ-specific fertility support that is inclusive of single people, couples and other family configurations.

Participants in the group may or may not fit medical definitions of infertility, and, in fact, many do not. Our intent is to support all LGBTQ people in their fertility journeys, no matter how long or short or complex.

Still Trying meets once a month, at Sherbourne Health Centre, 333 Sherbourne St, Toronto. Visit www.lgbtqparentingnetwork.ca/stilltrying for more information, current dates and times, or e-mail parentingresources@sherbourne.on.ca.