

Accepted Manuscript - Dec 2025

**“Doctors Asked if we Are Sisters or Friends”: Experiences of 2S/LGBTQIA+ Couples in
the Context of Medically Assisted Reproduction**

Benoit, Z., **Rosen, N. O.**, Renaud, M., Bergeron, S., Brassard, A., & Péloquin, K. (2024).
“Doctors asked if we are sisters or friends”: Experiences of 2S/LGBTQIA+ couples in the
context of Medically Assisted Reproduction. *Canadian Journal of Human Sexuality*, 33,
429-42. <https://doi.org/10.3138/cjhs-2024-0028>

Published by University of Toronto Press. This manuscript version is made available under their
self-archiving policy.

doi: 10.3138/cjhs-2024-002

Abstract

Although 20% of couples who seek medically assisted reproduction (MAR) identify as 2S/LGBTQIA+, MAR services are primarily based on a medical/cisgender definition of infertility, failing to account for 2S/LGBTQIA+ individuals' experience of social infertility—that is, their inability to conceive due to their relationship status. Whereas the consequences of the MAR process on various aspects of mixed-gender/sex couples has been demonstrated (e.g., emotional, relationship, sexuality, social life), the generalization of this knowledge to the 2S/LGBTQIA+ community remains unexplored. This qualitative study aimed to explore the specific impacts of MAR on different aspects of 58 Canadian 2S/LGBTQIA+ couples' lives. While participants were asked about the impact of their MAR journey on the various spheres of their lives, the thematic analysis revealed that what proved most central to their experience were the barriers they encountered to access sensitive and inclusive care, echoing themes from existing literature such as heteronormativity and cisnormativity, lack of tailored services, psychological distress triggered by the MAR process, and experiences of stigma and discrimination (Kirubarajan et al., 2021). Other themes outside the healthcare context were also identified; financial burden, lack of social models and support systems, the emotional toll of repeatedly coming out and microaggressions from family members. These findings underscore the urgent need for targeted research and reforms in reproductive healthcare to better serve 2S/LGBTQIA+ couples and address the systemic barriers they face.

“Doctors Asked if we Are Sisters or Friends”: Experiences of 2S/LGBTQIA+ Couples in the Context of Medically Assisted Reproduction

As of 2024, approximately 4% of the North American population identifies as part of the 2S/LGBTQIA+¹ community, a term used to "encompass many different sexualities, sexes and genders, including lesbian, gay, bisexual, trans, queer, intersex, asexual and Two-Spirit identities" (Downie, 2019, p. 7; Gates, 2011; Statistics Canada, 2021). Moreover, it is estimated that between 30% and 50% of lesbian women have a desire to become a parent and that 28% of adults identifying as 2S/LGBTQIA+ wish to have a biological child (Amato & Jacob, 2004; Pew Research Center, 2013). The desire to be a parent is as prevalent among trans and gender-diverse people as it is among cisgender people (Moravek, 2019). The main obstacle to the creation of a biological family among 2S/LGBTQIA+ couples lies in their social infertility—that is, the impossibility to conceive biologically because of their relationship status (Murphy, 1999). Consequently, the use of medically assisted reproduction (MAR) is increasingly common within the 2S/LGBTQIA+ community. Indeed, the use of MAR is marked by the highest growth among lesbian, gay, bisexual, transgender, and queer populations (Kirubarajan et al., 2021), which now represents nearly 20% of Canadian fertility clinics' clientele (Amato & Jacob, 2004; Green et al., 2012; Leung & al., 2019; Rausch & Wikoff, 2017). With nearly a third of the Canadian population identifying as part of the 2S/LGBTQIA+ community being under the age of 25 (Statistics Canada, 2021), this trend is expected to become even more prominent in the coming years.

¹ While we recognize the many possible variations of the acronym, the placement of the 2S (i.e., (i.e., "Two-Spirit") at the beginning of the acronym is intended to recognize **Indigenous** nations as the first sexual and gender minorities in North America. The plus sign (+) is intended to recognize the various identities not identified in the generic acronym. The use of "/" serves as a linguistic marker to emphasize the distinctiveness and cultural significance of the Two-Spirit identity within the broader 2S/LGBTQIA+ community.

The psychological and relational consequences of infertility and the MAR process have been demonstrated by numerous studies carried out with mixed-gender/sex couples consulting for medical infertility (Bright et al., 2020; Greil et al., 2010; Johansson et al., 2010; Pélouin & Lafontaine, 2010), which is defined as a condition in either the male or female reproductive system leading to the inability to conceive after 12 months or more of regular, unprotected sexual intercourse (WHO, 2020). However, the generalization of this knowledge to the 2S/LGBTQIA+ community, who faces social infertility, remains largely unexplored. Current literature suggests that infertility and MAR is intimately linked to the socio-cultural context in which it takes place (Greil et al., 2010). Thus, the political context, the cultural construction of motherhood and fatherhood, gender and reproduction (e.g., Logan et al., 2019; Widge, 2001), religious beliefs (e.g., Okantey et al., 2021) or wealth inequalities (WHO, 2020) are all examples of factors to consider in the experience of infertility (Leke et al., 1993). In that sense, it is possible that 2S/LGBTQIA+ couples undergoing MAR do not encounter the same difficulties as mixed-sex/gender couples (Green et al., 2012). This qualitative study thus aimed to explore the lived experiences of 2S/LGBTQIA+ couples to provide a more comprehensive understanding of the impact of their MAR journey on different aspects of their life.

The Sociocultural Context of Healthcare for 2S/LGBTQIA+ Patients

The discrimination towards individuals identifying as 2S/LGBTQIA+ is rooted in a history of medicalization, homosexuality having been considered a mental health disorder in the Diagnostic and Statistical Manual of Mental Disorders from 1952 to 1974 (De Block & Adriaens, 2013; Giami, 2015). Historically, these individuals have faced legal barriers to healthcare, institutional discrimination, and maltreatment within the healthcare system (Connors et al., 2020; Klein and Nakhai, 2016; Shapiro and Powell, 2017). An illustrative instance of this discrimination is the response to the AIDS epidemic. Initially identified in the early 1980s, AIDS

disproportionately affected homosexual men in the United States and other Western countries (CDC, 2021). The resultant fear led to a surge in discrimination and violence against the 2S/LGBTQIA+ community (Herek et al., 2005). Misconceptions about the transmission of HIV fueled widespread social ostracization; individuals faced denial of healthcare, loss of employment, and eviction upon a positive HIV diagnosis (Blendon & Donelan, 1988). Although there has been improvements and social change regarding the quality of healthcare services for 2S/LGBTQIA+ individuals, recent reports, including a 2019 study presented to the Canadian House of Commons (Casey, 2019), underscore persistent healthcare inequalities faced by 2S/LGBTQIA+ individuals, reflecting the enduring impact of such historical prejudices.

MAR is no exception. Since the emergence of successful reproductive technologies in the 1980s, individuals from diverse sexual and gender orientations, diverging from this established societal prototype of parenthood and pregnancy, encountered discrimination, particularly experiencing restricted access to MAR and facing doubts about their competence as prospective parents (Wiesenthal et al., 2022). To this day, persistent disparity in access to MAR services for the 2S/LGBTQIA+ community endures (Maxwell et al., 2018). Despite advances in research, field studies tend to highlight the lack of cultural competence training for healthcare providers with 2S/LGBTQIA+ patients (Bonvincini, 2017; Caceres et al. 2020). Yet culturally competent care can, through a stronger provider-patient relationship, lead to better health outcomes and greater satisfaction (Shwarz et al., 2015).

The Experience of 2S/LGBTQIA+ Couples Undergoing MAR

In 2021, Kirubarajan et al. undertook a systematic review of the literature focused on characterizing patients' and providers' perspectives regarding cultural competence in fertility care for 2S/LGBTQ+ individuals by identifying barriers and facilitators to inclusive care, synthesizing empirical data and research findings in a broad range of contexts, including some

within the Canadian landscape. The review, including 25 studies, suggested that 2S/LGBTQIA+ individuals face unique barriers in fertility care, including heteronormativity/cisnormativity, lack of tailored services, psychological distress/triggering situations, as well as stigmatization and discrimination, underscoring the need for research to explore how their peculiar context can impact various spheres of their life.

Heteronormativity and Cisnormativity. The medical and physiological definition of infertility forms the basis for services rendered by fertility clinics, establishing a treatment framework entrenched in heteronormativity, thereby excluding individuals from the 2S/LGBTQIA+ community (Bell, 2016; Darwin & Greenfield, 2019; Gregg, 2018; Kirubarajan et al., 2021; Lo & Campo-Engelstein, 2018; Machado & Brandão, 2013; Maxwell et al., 2018). Evidence of this framework manifests through various facets such as the design of medical forms solely catering to mixed-gender/sex couples (Ross et al., 2006; Ross et al., 2014; Rozental & Malmquist, 2015), the use of heteronormative cisgender language by clinic staff, and the failure to discern between social and medical reasons for seeking MAR (Carvalho et al., 2019; Epstein, 2009). Qualitative reports from same-sex couples underscore a sense of exclusion within the heterocentric structure of fertility clinics (Appelgren Engström et al., 2018; Cherguit et al., 2013; Malmquist & Nelson, 2014), which can have emotional ramifications for clients (i.e., high level of stress and psychological distress), as illuminated in a study involving lesbian and bisexual women undergoing MAR (Yager et al., 2010). Moreover, 2S/LGBTQIA+ couples may perceive their relationship as being devalued or regarded as inferior, a perception that has been linked to reduced relational satisfaction (Tremblay et al., 2008; Giammattei, 2015).

Lack of Tailored Services. The assimilation and navigation of information and education for 2S/LGBTQIA+ parents pose considerable challenges (Kreines et al., 2018; Renaud et al.,

2024). Several qualitative investigations have noted the lack of comprehensive training of fertility clinic personnel on issues pertinent to the 2S/LGBTQIA+ community (Fantus, 2017; Greenfield & Seli, 2011; James-Abra, 2015; Klittmark et al., 2019). Yet, 2S/LGBTQIA+ couples undergoing MAR may require specialized services, such as assistance in deciding who will be the gestational partner, navigating their parental identity outside of traditional norms, and managing the potential lack of support from family and friends (Goldberg, 2010). Conversely, Epstein (2009) and Green et al. (2012) delineated how fertility clinic services predominantly cater to medical infertility, exhibiting limited flexibility for patients seeking support for social infertility. Consequently, 2S/LGBTQIA+ couples may encounter requests for investigative examinations, usually required for medical infertility treatment, incurring additional costs and sometimes invasive procedures. Moreover, Ross et al. (2006) emphasized the importance of involving both partners in medical consultations, deviating from the prevalent practice of engaging solely with the biologically involved individual in conception. The acute necessity for tailored psychosocial support and decision coaching for 2S/LGBTQIA+ patients remain largely unaddressed (Johnson et al., 2016; Ross et al., 2006; Ross et al., 2014).

Triggers/Psychological Distress. For gender-diverse individuals, such as trans and non-binary individuals, the MAR process poses unique challenges due to its potential to exacerbate gender dysphoria rooted in biological reproductive elements (Walks, 2013). Specific triggers within the MAR journey, such as the interruption of hormone therapy necessitated by treatment protocols or invasive procedures like genital examinations and transvaginal ultrasounds, can induce significant psychological distress by compelling patients to confront dysphoric aspects of their anatomy (Armund et al., 2017; Charter et al., 2018; Chen et al., 2019). Qualitative studies also indicate healthcare staff encountering challenges in navigating the complex intersections between body parts, gametes, gender, sex, sexual orientation, and reproductive practices (Epstein,

2009). A qualitative study by James-Abra et al. (2015) highlighted the emotional distress experienced by individuals with gender non-conforming identities when misgendered or faced with gendered documentation requirements within clinical settings.

Stigmatisation and Discrimination. While most fertility clinics in North America extend care to women identifying as lesbian, a minority feature non-discriminatory statements on their websites (Corbett et al., 2013; Johnson, 2012; Wu et al., 2017). Additionally, Kirubarajan et al.'s (2021) review sheds light on the prevalent yet often concealed discrimination within fertility clinics, surfacing through adverse interactions with care providers. Microaggressions experienced by individuals of sexual and gender diversity, often subtle, unconscious, or unintended, are linked to distress and an escalation in depressive symptoms and suicidal tendencies due to the stress they generate (Hong et al., 2016; Swann et al., 2016; Woodford et al., 2018). This subtle form of discrimination has been shown to be particularly detrimental to couple relationships, manifesting in issues such as decreased sexual desire, frequent conflicts, and emotional withdrawal, largely due to its chronic nature and the challenges in managing it (Goldie, 2017; Lev & Sennott, 2021; Mitchell, 2017).

The Current Study

While the unique barriers faced by 2S/LGBTQIA+ couples in MAR are well documented in the literature (Kirubarajan et al., 2021), less is known about the impact of the MAR process on different spheres of their lives. Moreover, Greenfield and Seli's (2011) study is the sole study focusing only on 2S/LGBTQIA+ patients actively engaged in MAR services (i.e., 15 cisgender gay male couples presenting for oocyte donors and gestational carrier assisted reproduction), and uniquely examining experiences from both partners in the couple. All other studies used retrospective designs. Moreover, existing research either focused on individual members of couples or segregated the 2S/LGBTQIA+ community into distinct identities with studies focusing

on single identities (e.g., lesbian women), potentially missing the nuances of shared challenges and intersectional experiences within the community and between partners. In this sense, little is known about the impact of an active MAR process on the lives of 2S/LGBTQIA+ couples. However, recent research indicates that these barriers significantly affect psychological adjustment (Mioagi et al., 2021), access to care (Alencar Albuquerque et al., 2016), and demonstrate a notable association between social stigma and deteriorating relationship functioning (de Doyle & Molix, 2015), thereby potentially impacting both partners and their relationship dynamics.

Addressing these limitations, the objective of this qualitative study was to explore the multifaceted impacts of MAR on the lives of 2S/LGBTQIA+ couples, considering the perspective of both partners. Using an exploratory approach and by conducting a thematic analysis, we aimed to identify and describe the most central impacts of their MAR journey on different spheres of their life. Relying on a large sample of couples representing diverse identities within the 2S/LGBTQIA+ community, our goal was to provide a deeper understanding of the unique challenges faced by the 2S/LGBTQIA+ community in this context, thereby contributing to the literature and informing more targeted research and interventions.

Method

Participants and Procedures

This research was part of the broader mixed-method JOURNEY Study, which investigated the psychological adaptation of couples undergoing MAR. To be eligible for inclusion in the broader study, individuals had to be at least 18 years old, be within six months of their first visit in a fertility clinic and possess proficiency in either French or English. Both partners were mandated to partake in the study. Collaboration with multiple fertility clinics in

Canada facilitated the recruitment process, employing promotional materials such as posters in clinic waiting areas. We also used Facebook advertisements and postings on infertility-related association websites. Prospective participants who expressed interest reached out to the research team for additional details and were screened for eligibility by telephone. Eligible participants received an information and consent form, along with online questionnaires via Qualtrics Research Suite. Partners were instructed to complete an online survey independently, without consulting each other, and each participant received CAN\$15 for their involvement. The research protocol was approved by the institutional research ethics boards overseeing the investigators.

Of all the participants who took part in the broader JOURNEY study ($N = 305$ couples), 116 identified as 2S/LGBTQIA+ (58 couples). To account for different experiences in mixed-gender/sex couples with medical infertility and couples from the 2S/LGBTQIA+ community, we included an open-ended question at the end of the quantitative survey inquiring about the specific experience of 2S/LGBTQ+ individuals in MAR. A total of 78 2S/LGBTQIA+ individuals provided a response to this question. The present study presents a phenomenological thematic analysis of these responses.

The couples included in the present qualitative study included either (1) two partners with the same gender identity and/or (2) one and/or both partners with a gender identity different from the sex assigned at birth. We here present the characteristics of the 78 individuals who provided a response to the open-ended question and for which the response was analysed using the qualitative analysis. The mean age was 31.73 ($SD = 4.78$). The sexual orientation and gender identity of the participants are displayed in Table 1. Other demographic data are displayed in Table 2. A majority of participants identified as women (87.1%), lesbians (55.2%), and White (87.9%). All participants were from Canada, and most individuals were employed full-time (77.6%) and made an income ranging between CAN\$50,000 and 60,000 (27.6%).

Qualitative Question and Conceptual Framework

In the current study, a single open-ended item was used to give participants the freedom to share their fertility clinic experiences in their own words. Compared to quantitative measures, open-ended questions allow for a more flexible and exploratory data collection approach, as they do not constrain responses to predefined options (Tasker and Cisneroz, 2019). Participants were invited to answer the following open-ended question: “We are interested in the experiences of 2S/LGBTQIA+ people who consult fertility clinics, but the current research does not tell us much about what 2S/LGBTQIA+ people actually go through during this process. If you or your partner identify as 2S/LGBTQIA+, what should we know to help us better understand the impact of medically assisted reproduction on different aspects of your life (emotional, relationship, sexuality, professional life, social life, etc.)?”. Participants could provide responses of any length, which were then analyzed using qualitative thematic analysis within a phenomenological framework. This phenomenological approach, as described by Charlebois and Bouchard (2007), suggests that knowledge is directly derived from the lived experiences of participants. The aim is to understand and describe the meaning participants attribute to their subjective experiences, without distortion, based on their consciousness and narratives.

Data Analysis

A thematic analysis was conducted on participants' detailed responses to the open-ended question about their experience in MAR, through inductive coding (Blais & Martineau, 2006). This methodological approach was chosen to accurately account for the subjective and idiographic experiences of the participants (Giorgi, 1997). The experience reported by each participant was considered equally valid as those of others, and the study aimed to depict a diversity of viewpoints. This method facilitated the extraction of rich qualitative data, allowing for the identification of connections and the development of new thematic categories (Blais & Martineau, 2006). As a result, significant themes were identified, providing a comprehensive portrayal of what 2S/LGBTQIA+ couples considered central to their MAR journey.

Two coders conducted several independent readings to enhance immersion and explore content thoroughly. They independently categorized all qualitative responses according to emergent themes. The perspectives of all 78 participants who answered the open-ended question were examined individually, with attention to how experiences might differ between partners (e.g., the partner undergoing MAR procedures versus their supportive partner). In cases where responses spanned multiple themes, content was categorized under each relevant theme. The coders then compared their categorizations to ensure consistency and reliability, resolving any disagreements through discussion. Researcher triangulation was employed to enhance the quality and robustness of the findings through cross-validation and a comprehensive analysis approach. Unclear quotes during classification were excluded from the final analysis. Following classification, the coders regrouped quotations within themes and named these themes for the purpose of writing the results. Given that the study included both English and French-speaking participants, French quotes were translated into English using the reverse translation process (Vallerand, 1989).

Results

Questionnaires and Terminology

Participant responses revealed that the questionnaires used by fertility clinics frequently demonstrated a disconnect with the lived experiences of 2S/LGBTQIA+ couples. One participant noted, "The forms required at the initial consultation were directed towards heterosexual couples, and, as a result, very little of the form actually applied to my situation" (P267.1 White, lesbian and cisgender woman). Another participant suggested the need for separate forms tailored to 2S/LGBTQIA+ couples, highlighting the existing confusion and lack of inclusivity. The prevailing issue reported by the participant was that the same form is distributed universally, irrespective of the unique circumstances of same-gender/sex couples and limiting response options concerning relationship structures. In that sense, a participant stated that "respondents were only allowed to select one answer... but a person undergoing fertility treatments can be married and be polyamorous and be divorced, etc." (P972.1 Asian, bisexual and cisgender woman). Often, the same questionnaire is sent "to all couples to get information from both the man and the woman without any acknowledgement that the situation is very different [as a same-sex couple]" (P267.2 Indigenous, pansexual and cisgender woman). Participants emphasized the necessity for standardized and more inclusive terminology, pointing out that the assumption of respondents being exclusively men and women reflects heteronormative and cisnormative biases.

Social Versus Medical Infertility

Common knowledge says that infertility is linked to the inability to conceive a child biologically. This medical definition of infertility does not resonate with the experience of 2S/LGBTQIA+ couples facing social infertility and whose relational status prevents them from having children without assistance (i.e., medical assistance, use of a donor). Therefore, participants mentioned that "we are being treated as an infertile patient when it is not necessarily the case" (P970.2 White, lesbian, and cisgender woman). Another respondent said, "we do not

have a fertility problem, we only need sperm” (P969.2 White, lesbian, and cisgender woman). “The approach and procedures are, by default, for heterosexual couples” (P269.2 White, lesbian and cisgender woman) and sometimes, “medical tests or appointments are required even if no medical infertility is diagnosed” (P988.2 White, lesbian and cisgender woman). As a result, despite “the request for services focusing on social infertility, couples are welcomed and treated as one dealing with medical infertility” (P953.1 White, queer and cisgender woman).

Social Norms and Assumptions

Participant responses suggested that the heteronormative climate in society creates a feeling of exclusion for the 2S/LGBTQIA+ couples seeking MAR. The MAR process is considered to be “a heterosexual model that accepts lesbian couples” (P681.2 Latina, lesbian and cisgender woman) and the complexity of this process is frequently “not understood by people that do not identify as LGBTQ+” (P201.1 White, lesbian and cisgender woman). The participants mentioned that the attitude and questions from strangers were intrusive. People were very curious about “the sperm donor, that people call the father” (P938.1 White, heterosexual (in love with a woman) and cisgender woman) and the artificial insemination process is hard to navigate when questions are too frequently asked about the “father”. A participant said that even if she was comfortable with her sexual orientation, for once in her life, she thought “it would have been much easier to be heterosexual” (P685.1 White, lesbian and cisgender woman). Respondents also expressed that administrative staff and health care providers in the institutional medical environment often assumed information about couples. For example, a respondent said that “instances at hospitals assumed we were in a heterosexual relationship and nurses or doctors asked if we are sisters or friends”; this experience was considered “unprofessional” and “disheartening” (P979.1 White, lesbian and cisgender woman). Overall, the intricacies of the MAR journey for 2S/LGBTQIA+ couples contribute to a sense of difficulty, complication, and a

struggle to feel validated throughout the experience.

Treatment Personalization and Resources

The analysis suggested that the MAR process inadequately addresses the unique needs of 2S/LGBTQIA+ couples, prompting a participant to suggest “The fertility clinics should adjust their branding and their services for the LGBTQ+ clientele” (P681.2 Latina, lesbian, and cisgender woman). Concretely, when going on certain fertility clinics’ websites, “there is only a brief mention of LGBTQ+ couples in the *Who uses our services* section” (P267.2 Indigenous, lesbian, cisgender woman), creating an atmosphere where this clientele is not openly welcomed or normalized. This lack of visibility appeared to contribute to a palpable sense of isolation for the participants: “it’s frustrating because I feel like we are alone, and we can’t really talk to anyone that truly understands” (P125.2 White, bisexual, and cisgender woman). “Socially, there are more questions to deal with as a same-sex couple such as deciding who is genetically related to the child, who carries [the baby], how to choose a sperm donor, etc.” (P979.2 White, lesbian and cisgender woman). Participants also reported a scarcity of quality resources addressing the specific needs of 2S/LGBTQIA+ couples undergoing MAR. A participant mentioned “my wife and I have struggled with finding quality resources that talk about healthy lesbian couples undergoing fertility treatments with a sperm donor” (P614.2 White non-binary lesbian). Another participant said, “I found that there was no adequate information or a roadmap of the steps of what needed to happen and when” (P201.1 White, lesbian and cisgender woman). Several participants agreed on the fact that it was demanding and yet difficult to have answers to their questions. As a potential solution, one of the participants going through the fertility process suggested creating “a separate stream for LGBTQ+ couples without any known fertility problems” (P31.1 White, bisexual and cisgender woman). Overall, participants’ responses pointed out that the MAR journey is often characterized by uncertainty, stress, and a profound

sense of loneliness.

Inadequate Treatments and Procedures

The participants also mentioned the lack of distinction in fertility treatments for different types of couples (social infertility versus medical infertility). In many cases, it was reported that both partners in a lesbian couple underwent tests, with the partner not carrying the child assuming the roles of "man" or "father". This was made explicit in the testimony of a participant when she stated, "According to the questionnaire, her partner expressed discomfort regarding the necessity of undergoing paternal examinations" (P682.1 White/Moyen Oriental, queer, intersex, and transgender person). When this couple requested information on the reasons for these procedures, the respondent reported that the medical staff responded that it was protocol, without providing a specific justification for their situation. In general, "unnecessary tests were requested," (P972.1 Asian, lesbian and cisgender woman) and "some of these tests were invasive, not to mention that some of them posed a significant health risk" (P972.1 Asian, lesbian and cisgender woman). The participants expressed dissatisfaction with the tests, questionnaires, and appointments that appeared inappropriate or unnecessary, and the lack of satisfying explanation from medical staff compounded participant exasperation, often leaving them feeling unsupported and uninformed.

Involvement of Both Partners

Many respondents addressed the lack of attention given to both partners in the MAR process. One participant explained: for a same-sex couple, the MAR process can "feel the same as being a single woman in the way how things work" (P972.1 Asian, lesbian and cisgender woman). In other words, "no importance is given to the person who will not carry the child. [The medical staff] do not know the spouse's name, do not look at her, and do not speak to her" (P548.2 White, lesbian, and cisgender woman). The lack of acknowledgment and involvement of the non-carrying partner, particularly during insemination procedures, contributes to a sense of

powerlessness and exclusion: “not being able to be in the room while my wife is inseminated hurts tremendously. It’s hard enough not being able to make her pregnant, but to also not be allowed in when it could potentially be the moment we make our baby, makes me feel less involved” (P260.2 White, lesbian, and cisgender woman). There is a “feeling of powerlessness for the person not undergoing the treatments, a sense of lacking involvement in the process despite being present for every step” (P970.1 White, lesbian and cisgender woman). Some participants alluded to a culture of loneliness in fertility clinics, which affects the couples, who reported it is “emotionally tough to be excluded when the baby is being made” (P681.1 White, queer, trans, fluid, and nonbinary person). A participant who was not carrying the baby stated that “the magic of procreation is absent” (P935.1 White, bisexual and cisgender woman).

Medical Staff Training

Participants’ responses suggested that the medical staff may lack training to provide sensitive and adapted care to 2S/LGBTQIA+ couples, which at times led to awkward, insensitive, or hurtful interactions. Indeed, participants felt that “there is a significant lack of inclusion and knowledge in the healthcare system regarding our [2S/LGBTQ+] everyday reality.” (P423.2 White, lesbian and cisgender woman). One participant mentioned that “the reception from the medical staff was uncomfortable” (P550.1 White, pansexual and cisgender woman) and another said she understands that “people can be awkward or clumsy in certain situations, but a minimum of consideration is necessary” (P548.2 White, lesbian, and cisgender woman). A participant stated: “it was stressful because the clinic was so cold in the way my wife and I were treated. Medical staff showed no empathy, it was purely technical. Some procedures were surprisingly painful for my wife, and there was no empathy or warning beforehand” (P681.1 White, queer, transgender, fluid, and nonbinary person). In fact, “the healthcare environment needs to adapt” (P548.2 White, lesbian and cisgender woman) through specialized training so that patients feel

understood by healthcare professionals.

Nomenclature, Gender Dysphoria and Coming-out

The impact of gender identity and gender expression on the MAR process is profound, presenting both tangible and apprehended challenges. Non-binary and trans individuals face unique difficulties during fertility treatments. As one respondent stated, participants concerned by this issue “have to be out or deal with the emotional repercussions of misgendering or using legal names instead of their preferred name or the assumption of either or both” (P69.2 White, queer, transgender/nonbinary person). Similarly, wanting to have children, as a couple identifying as 2S/LGBTQ+, means to constantly come out of the closet: “Being able to assume the sexual orientation difference is similar to coming-out throughout life and it is [emotionally] heavy” (P550.1 White, lesbian and cisgender woman). Clearly illustrating this challenge, one participant shared: “We are currently not openly “out” to very many people so there is the anxiety of feeling like I'm living a double life with my work colleagues and my extended family” (P33.1 White, bisexual and cisgender woman).

Furthermore, for individuals receiving gender affirming care, MAR brings about additional challenges and sources of distress because hormonal therapy intersects with fertility treatments, hence introducing complexities. A respondent mentioned that “feminizing hormone therapy causes a loss of fertility, and I need to consult to preserve my sperm before starting hormone treatment” (P886.2 Latina, pansexual and transgender woman). Also, “the waiting times are causing me a lot of distress because in the meantime, I have no choice but to endure my gender dysphoria without being able to do anything about it. (P886.1 White, queer, nonbinary, and transgender man). Thus, for many, the gender transition process is inseparable from the process of fertility. For participants apprehending the MAR process, they know that they will “need to temporarily stop the hormonal therapy (the testosterone)” (P886.1 White, queer,

nonbinary, and transgender man) and they “negatively anticipate this moment because it will delay the transition and increase their dysphoria” (P886.2 Latina, pansexual and transgender woman).

Lastly, partners’ gender expression and the decision of who will carry the baby are often intertwined. For example, “people assume only the more feminine one in female same-sex relationships will be the one to carry. At times, people can experience confusion over both partners wanting to conceive” (P265.2 White, bisexual, and cisgender woman). The participants underlined that the way a person looks does not always relate with their desire or ability to carry a child. Yet, respondents referenced to the challenge of facing this presumption.

Negative Emotions

Participants’ responses suggested that the MAR process unfolds as a complex and emotionally draining journey. A participant said: “it’s difficult for others to understand our pain after a failure and in our relationship, I feel powerless because the burden is on my partner’s shoulders because she’s still not pregnant” (P709.1 White, lesbian and cisgender woman). The responses revealed a significant array of negative emotions experienced by participants. For 2S/LGBTQIA+ couples, the fertility process causes “disappointment each month” (P196.1 White, lesbian and cisgender woman), “frustration and injustice of being unable to conceive at home” (P710.1 White, lesbian and cisgender woman), “performance anxiety” (P546.1 Egyptian, lesbian and cisgender woman) when, in fact, nothing is controllable, and a “huge amount of stress” (P260.1 White, bisexual and cisgender woman). The MAR process “puts a strain on the relationship, it is “an emotional toll for both partners” (P614.1 White, lesbian and cisgender woman) and “there is a lot of riding on hope” (P34.1 White, bisexual and cisgender woman). Many individuals mentioned “the grief of not being able to naturally conceive a family” (P966.2 White, bisexual, and cisgender woman).

Behaviors, Judgement and Microaggressions from their own Family

The journey of 2S/LGBTQIA+ couples through MAR is not always accompanied by the support of close and extended family members. As one participant said, there is an “emotional and a mental strain when family members are not supportive of your choice to have children and be in a 2S/LGBTQ relationship” (P196.1 White, lesbian and cisgender woman). Based on participants’ responses, judgment, and a lack of comprehension from their inner circles are common challenges. Some families struggle to be open-minded about fertility procedures, with one respondent sharing: “my parents have suggested we just have sex with anonymous men in order to get pregnant rather than going through this expensive, medically intensive process” (P972.1 White, bisexual and cisgender woman). The responses suggested that limited understanding of non-traditional methods of conception can lead to concerns about acceptance within the family. As a result, couples are “worried that the family [of the partner not carrying the baby] will not embrace with the same level of love as they would for their biological grandchild” (P151.1 White, lesbian and cisgender woman). The future family of a same-sex couple, for example, is frequently considered to “lack a real family affiliation” (P550.1 White, lesbian and cisgender woman). When the genetics of one partner is not included in the process, many families said, “it is not really their child” (P977.1 White, lesbian and cisgender woman). Also, “it’s hard to make people understand that there is no father. It’s hurtful for the mother who isn’t carrying the baby” (P736.2 White, lesbian and cisgender woman). The judgment extends to societal norms, as evidenced by hurtful comments and microaggressions, such as a friend questioning the participant’s contribution to the pregnancy: “when my wife was pregnant, a friend of hers, when we told him, said to me: ‘usually we say congratulations to the HUSBAND, but in this case (addressing me as female), haha, you did NOTHING!’ This was very painful for me” (P681.1 White, queer, transgender, fluid and nonbinary person). A participant mentioned that “families as

well as outsiders don't seem to think we can have children despite our [sexual] orientation” (P977.1 White, lesbian and cisgender woman). Therefore “there is a feeling of guilt using science to give lesbians children because ‘they shouldn’t have children’. Using MAR makes me feel selfish and ‘less than’. There is a social stigma against MAR, especially against gay couples” (P83.2 Middle Eastern, lesbian and cisgender woman). These responses indicate that the pervasive societal biases create an unsettling environment during the fertility procedures.

Financial Burden

Embarking on fertility treatments entails a significant financial commitment, with government coverage often falling short of covering the entire procedure. Disparities also exist across Canadian provinces and “some of them simply provide no grants and the costs are astronomical” (P260.1 White, bisexual and cisgender woman). In some contexts, “the LGBTQ+ group is completely left out of [the financing]” (P260.1 White, bisexual and cisgender woman). The financial burden intensifies for couples wanting to choose donors outside the provided options, as out-of-pocket expenses become necessary. This financial strain adds pressure to couples' budgets, “which contributes to the stress related to the MAR process” (P685.2 White, lesbian and cisgender woman). In some cases, “the entire [fertility] treatment is only possible for people with a good income” (P681.1 White, queer, transgender, fluid and nonbinary person).

Role Models and Support System

2S/LGBTQIA+ couples reported often finding a lack of role models and support in their fertility journey. The scarcity of representation and documentation appeared to add pressure on couples as they navigate the process without clear guidance: “Not many models are present, the norms are still in the process of becoming plural” (P550.1 White, lesbian and cisgender woman). Participants understood their relationships are directly involved in the process of normalizing atypical family configurations, but this situation can put a lot of pressure on them. “This reality is

poorly documented, and choices are made blindly” (P938.2 White, pansexual and cisgender woman). Within our sample, respondents “would like to see more experiences that they can relate to, included in fertility [clinics] resources”. Respondents expressed that it is challenging to learn from other couples who have gone through the same process because their support system, meaning the “people that truly understand every aspect of the process” (P125.2 White, bisexual and cisgender woman) is limited. Some participants had friends who identify as 2S/LGBTQ+, which represented a great source of relief, but “without those friends we would have been lost” (P201.1 White, lesbian and cisgender woman).

Positive Feedback

While the MAR process is widely acknowledged as challenging, positive aspects were also highlighted within the sample. A participant felt “extremely grateful that these [fertility] clinics even exist and are welcoming of LGBT people”. (P151.1 White, lesbian and cisgender woman) Many respondents brought up the positive impact of the LGBTQ+ community which contributed to the psychological well-being of the couples who felt lost, at first, during the process. The support that each couple receives is highly variable, but for those with a “welcoming environment, it has been possible to navigate fertility treatments more easily” (P151.1 White, lesbian and cisgender woman).

Discussion

This qualitative study delved into the firsthand experiences and perspectives of 2S/LGBTQIA+ Canadian couples undergoing MAR, aiming to explore the impact of MAR on various aspects of their lives. By adopting an open-ended and exploratory approach, we sought to uncover unique and nuanced insights into the specific challenges faced by these couples. To our knowledge, this study represents the first investigation into the experiences of a wide range of 2S/LGBTQIA+ couples, encompassing a diverse array of sexual orientations and gender

identities, who are currently undergoing MAR treatment.

While participants were asked to reflect on how their MAR journey influenced different spheres of their lives, the thematic analysis revealed that the most central aspect of their experience was the barriers they encountered. Notably, these findings align closely with the barriers identified by Kirubarajan et al. (2021), highlighting their significance within the fertility care context and patients' experience: (1) Heteronormativity and Cisnormativity, encompassing issues such as inadequate terminology and questionnaires used by fertility clinics, misunderstanding of social infertility, and societal assumptions about gender and relationships; (2) Lack of Tailored Services, including lack of personalized treatments for 2S/LGBTQIA+ individuals, inadequate medical procedures, and neglect of non-carrying partners; (3) Triggers and Psychological Distress, involving experiences of gender dysphoria, the emotional toll of repeatedly coming out, and negative emotions such as disappointment and stress; and (4) Stigmatization and Discrimination, covering microaggressions from family members, societal judgments, financial burdens, and a lack of role models and support systems.

In addition to these well-documented barriers, our study also uncovered new themes. One significant finding was the considerable financial burden associated with MAR, which couples identified as central to their experience. While financial disadvantages for 2S/LGBTQIA+ Canadian couples undergoing MAR have been noted in previous papers (e.g., Jordan, 2022; Ranaldi, 2022), this study is the first to emphasize this burden as a core aspect of their journey. Financial strain has been shown to increase stress levels in mixed-sex/gender couples undergoing MAR (Allsop et al., 2023; Sharma & Shrivastava, 2022), and our findings suggest that this might also be a critical issue for 2S/LGBTQIA+ couples.

Moreover, participants reported experiencing stigma both within and outside the healthcare context, including the emotional toll of repeatedly coming out. The process of coming

out is associated with significant psychological stress, anxiety, and fear of discrimination (Meyer, 2003), and the continuous nature of this process can lead to chronic stress and identity concealment, further exacerbating mental health issues (Pachankis & Jackson, 2023). Additionally, microaggressions from family members were frequently mentioned, echoing findings in the broader literature on homo/trans-parenthood (e.g., Haines et al., 2018; Todd et al., 2016). Despite these challenges, some participants shared positive experiences with supportive healthcare providers and inclusive practices in certain clinics, underscoring the importance of culturally competent care (Bonvicini, 2017).

While our findings are consistent with existing literature, particularly the barriers outlined by Kirubarajan et al. (2021), they also shed light on additional issues through several key aspects. The thematic analysis revealed nuanced subcategories within these barriers, offering a deeper understanding of challenges related to heteronormativity and cisnormativity, lack of tailored services, triggers and psychological distress, and stigmatization and discrimination. By adopting an exploratory approach, we provided participants with the space to highlight the most significant aspects of their MAR experience, bringing to light specific nuances and personal accounts that enrich our understanding of these barriers. The complexity of these experiences, as evidenced by the interconnected themes that emerged from participants' responses, points to a multifaceted and deeply rooted institutional and social problem. The explicit articulation of these challenges by participants, even in the absence of direct prompts, underscores their prominence within the fertility care context and highlights the need for systemic reforms in fertility clinics to create a more inclusive and supportive environment for 2S/LGBTQIA+ couples.

Social and Clinical Implications

The findings of this study suggest that addressing the barriers encountered by members of the 2S/LGBTQIA+ community within the context of MAR requires a multi-faceted approach

involving healthcare providers, fertility clinics, policymakers, and support networks. The current research provides additional insights into the promotion of services that are sensitive to the realities of 2S/LGBTQIA+ couples undergoing assisted reproduction.

(1) Inclusive fertility care: Our investigation validates the urgent need to expand the definition of infertility to recognize social motivations for assisted reproduction, advocating for a fundamental reform of the fertility care system to accommodate 2S/LGBTQIA+ needs (Lo & Campo-Elgestein, 2018). The essential adoption of inclusive practices, including 2S/LGBTQ+-affirmative language and tailored services, aligns with prior qualitative research that emphasized the need for gender-neutral spaces and inclusivity indicators (Ross et al., 2006; Ross et al., 2014). Furthermore, our nuanced investigation into the use of inappropriate terminology and the entrenched societal views on gender and relationships reveals the extensive societal and institutional biases ingrained within the fertility care sector. This observation aligns with the work of Mamo and Fishman (2013), who critiqued the language practices in fertility clinics for perpetuating traditional gender roles and heteronormativity, advocating for a shift towards more inclusive linguistic practices. By dovetailing these insights with existing literature, our study corroborates the findings of other qualitative inquiries into the healthcare experiences of 2S/LGBTQIA+ communities (e.g., Aylagas-Crespillo et al. 2018; Stewart & O'Reilly, 2017). In doing so, it emphasizes the significance of our findings within the broader context of healthcare reform, highlighting the imperative for systemic changes that are both innovative and reflective of the challenges identified in prior research.

(2) Target educational programs: Our findings suggest a critical need for targeted educational programs aimed at fostering 2S/LGBTQIA+ inclusivity and sensitivity among fertility staff. This recommendation aligns with Gameiro et al. (2013), who highlighted the profound impact of healthcare experiences on the psychological well-being of individuals

undergoing MAR. Our study extends this understanding to the 2S/LGBTQIA+ community, suggesting that improved healthcare provider's awareness could significantly enhance patients' experiences, particularly in mitigating experiences of gender dysphoria through respectful inquiries about pronouns, gender identity, and body nomenclature (Broughton & Omurtag, 2017; Epstein, 2018; Wiesenthal et al., 2022). This approach embodies the principles of patient-centered care, as described by Corrigan et al. (2001), and its demonstrated benefits, such as improved quality of life and reduced anxiety and depressive symptoms in women undergoing MAR (Aarts et al., 2012).

(3) Resource development: The insights garnered from our study underscore the critical need for the development of resources specifically designed to cater to the distinctive needs of 2S/LGBTQIA+ couples undergoing MAR. This entails not only the dissemination of informative materials that address their concerns, but also the creation of supportive networks and the provision of specialized educational programs. Such initiatives should aim to ease the navigation through the intricacies of the MAR process for those within the 2S/LGBTQIA+ community, as highlighted by previous research (e.g., Klittmark et al., 2019).

(4) Family and social support: Our findings suggest that efforts should be directed towards educating families and communities about the diverse paths to parenthood for 2S/LGBTQIA+ couples. Initiatives that challenge societal norms and reduce discrimination can contribute to a more supportive environment and ultimately ease these couples' journey as they go through an already physically and psychologically demanding process. Given that 2S/LGBTQIA+ individuals often view social support and acceptance, particularly from friends and family, as crucial factors in their ability to cope with adverse experiences, fostering an inclusive environment becomes paramount (Peel et al., 2023). Providing resources, information, and open discussions within families and communities can not only promote empathy but also

reduce stigma, ultimately facilitating the journey of 2S/LGBTQIA+ couples towards parenthood. In addition, Xie et al.'s (2023) literature review highlighted the association between stigma towards infertility and mental health consequences in infertile women, underscoring the importance of addressing societal attitudes towards infertility within the context of 2S/LGBTQIA+ parenthood.

(5) Financial accessibility: According to our findings, addressing financial accessibility is crucial in ensuring equitable access to fertility treatments, regardless of individuals' sexual orientation or gender identity. A study by Woods et al. (2021) have highlighted financial strain as a key dimension of infertility-related stress, that would be negatively associated to individual's psychological adjustment. This is consistent with the findings of Allsop et al. (2023), who found that perceived financial strain was negatively and indirectly associated with sexual well-being in couples undergoing MAR. Additionally, Mackay et al. (2023), in their scoping review, demonstrated that having little or no coverage from insurance companies can act as a barrier, discouraging individuals from starting or continuing assisted reproduction procedures. Therefore, policymakers should work to mitigate financial disparities associated with medical assistance in reproduction (MAR), ensuring that all individuals have equal opportunity to pursue fertility treatments without undue financial burden and its related consequences.

Strength and Limitations

The qualitative approach employed in this study allowed participants to describe their experiences with MAR in depth, providing a richer understanding of the issues faced by 2S/LGBTQIA+ couples in the context of MAR. A key strength of the study is its large and diverse sample, which enhances the breadth of perspectives and complements the existing body of qualitative research on this topic. The inclusion of a bilingual sample, with participants proficient in either French or English, also contributes to the diversity and transferability of the

findings. This linguistic diversity reflects the multicultural nature of the Canadian population.

However, the study's reliance on a single open-ended survey question, without the ability to probe further into participants' responses, limits our capacity to fully explore and analyze the consequences of the barriers identified. This limitation restricts our ability to uncover additional insights that might have emerged through more detailed follow-up, as would be possible in an interview setting.

Moreover, while the present research delves into the sociocultural context of 2S/LGBTQIA+ couples, it is crucial to acknowledge that the exploration is not exhaustive in considering the diverse identities that may intersect within this population. For instance, Black women face unique challenges in the realm of assisted reproduction, being twice as likely to experience infertility as white women, a significant propensity that persists even when accounting for socio-economic status and known risk factors (Wellons et al., 2008). Surprisingly, they also are half as likely to seek MAR (Chandra et al., 2014). Importantly, existing studies do not conclusively demonstrate lower infertility-related distress among BIPOC individuals (including black people, indigenous people and other people of color), raising questions about the potential impact of social barriers and inequalities. This highlights the necessity for future research to adopt an intersectional lens, encompassing various dimensions of identity and recognizing the distinct challenges faced by different subgroups within the broader context of reproductive healthcare (Tam, 2021).

Conclusion

In conclusion, this qualitative study sought to provide a comprehensive exploration of the most significant impacts reported by 2S/LGBTQIA+ Canadian couples during their MAR journey. The findings reveal that the primary concern for these couples was the barriers they faced in accessing sensitive and inclusive care. Recognizing the urgency of addressing these

challenges, the study underscores the critical need for targeted research and meaningful adjustments to reproductive healthcare services. By contributing to the ongoing discourse on 2S/LGBTQIA+ reproductive health, this study advocates for sustained efforts to deepen our understanding and enhance support for individuals navigating assisted reproduction within this diverse and resilient community.

References

- Amato, P. et Jacob, M. C. (2004). Providing fertility services to lesbian couples: The lesbian baby boom. *Sexuality, Reproduction and Menopause*, 2(2), 83-88.
<https://doi.org/10.1016/j.sram.2004.04.005>
- Appelgren Engström, H., Häggström-Nordin, E., Borneskog, C. et Almqvist, A.-L. (2018).

- Mothers in same-sex relationships describe the process of forming a family as a stressful journey in a heteronormative world: a Swedish grounded theory study. *Maternal and child health journal*, 22(10), 1444-1450. <https://doi.org/10.1007/s10995-018-2525-y>
- Armuañd, G., Dhejne, C., Olofsson, J. I. et Rodriguez-Wallberg, K. A. (2017). Transgender men's experiences of fertility preservation: a qualitative study. *Human Reproduction*, 32(2), 383-390. <https://doi.org/10.1093/humrep/dew323>
- Aylagas-Crespillo, M., García-Barbero, Ó. et Rodríguez-Martín, B. (2018). Barriers in the social and healthcare assistance for transgender persons: A systematic review of qualitative studies. *Enfermería Clínica (English Edition)*, 28(4), 247-259. <https://doi.org/10.1016/j.enfcle.2017.09.005>
- Bell, A. V. (2016). The margins of medicalization: Diversity and context through the case of infertility. *Social Science & Medicine*, 156, 39-46. <https://doi.org/10.1016/j.socscimed.2016.03.005>
- Blais, M., & Martineau, S. (2006). L'analyse inductive générale: description d'une démarche visant à donner un sens à des données brutes. *Recherches qualitatives*, 26(2), 1-18. <https://doi.org/10.7202/1085369ar>
- Broughton, D., & Omurtag, K. (2017). Care of the transgender or gender-nonconforming patient undergoing in vitro fertilization. *International Journal of Transgenderism*, 18(4), 372-375.
- Carvalho, P. G. C. de, Cabral, C. da S., Ferguson, L., Gruskin, S. et Diniz, C. S. G. (2019). 'We are not infertile': challenges and limitations faced by women in same-sex relationships when seeking conception services in São Paulo, Brazil. *Culture, Health & Sexuality*, 21(11), 1257-1272. <https://doi.org/10.1080/13691058.2018.1556343>

- Chandra, A., Copen, C. E. et Stephen, E. H. (2014). *Infertility service use in the United States: data from the National Survey of Family Growth, 1982-2010* (No. 73). US Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics.
- Charter, R., Ussher, J. M., Perz, J. et Robinson, K. (2018). The transgender parent: Experiences and constructions of pregnancy and parenthood for transgender men in Australia. *International Journal of Transgenderism*, 19(1), 64-77.
<https://doi.org/10.1080/15532739.2017.1399496>
- Chen, D., Kyweluk, M. A., Sajwani, A., Gordon, E. J., Johnson, E. K., Finlayson, C. A. et Woodruff, T. K. (2019). Factors affecting fertility decision-making among transgender adolescents and young adults. *LGBT health*, 6(3), 107-115.
<https://doi.org/10.1089/lgbt.2018.0250>
- Cherguit, J., Burns, J., Pettle, S. et Tasker, F. (2013). Lesbian co-mothers' experiences of maternity healthcare services. *Journal of Advanced Nursing*, 69(6), 1269-1278.
<https://doi.org/10.1111/j.1365-2648.2012.06115.x>
- Corbett, S. L., Frecker, H. M., Shapiro, H. M. et Yudin, M. H. (2013). Access to fertility services for lesbian women in Canada. *Fertility and sterility*, 100(4), 1077-1080.
<https://doi.org/10.1016/j.fertnstert.2013.05.048>
- Corrigan, J., Donaldson, M. et Kohn, L. (2001). *A new health system for the 21st century. crossing the quality chasm*. Washington, DC: Institute of Medicine.
- Cousineau, T. M. et Domar, A. D. (2007). Psychological impact of infertility. *Best Practice & Research Clinical Obstetrics & Gynaecology*, 21(2), 293-308.
<https://doi.org/10.1016/j.bpobgyn.2006.12.003>
- Darwin, Z. et Greenfield, M. (2019). Mothers and others: The invisibility of LGBTQ people in

- reproductive and infant psychology. *Journal of Reproductive and Infant Psychology*, 37(4), 341-343. <https://doi.org/10.1080/02646838.2019.1649919>
- De Block, A. et Adriaens, P. R. (2013). Pathologizing sexual deviance: A history. *Journal of Sex Research*, 50(3-4), 276-298. <https://doi.org/10.1080/00224499.2012.738259>
- Epstein, R. (2009). *Who's your daddy?: And Other Writings on Queer Parenting*. Sumach Press.
- Epstein, R. (2018). Space invaders: Queer and trans bodies in fertility clinics. *Sexualities*, 21(7), 1039-1058. <https://doi.org/10.1177/1363460717720365>
- Fantus, S. (2017). The Path to Parenthood isn't Always Straight: A Qualitative Exploration of the Experiences of Gestational Surrogacy for Gay Men in Canada—Perspectives of Gay Fathers and Surrogates.
- Fertility Matters Canada. (2020). *Funding by provinces*. <https://fertilitymatters.ca/funding-by-province/>
- Gameiro, S., Canavarro, M. C. et Boivin, J. (2013). Patient centred care in infertility health care: direct and indirect associations with wellbeing during treatment. *Patient education and counseling*, 93(3), 646-654. <https://doi.org/10.1016/j.pec.2013.08.015>
- Gates, G. J. (2011). How many people are lesbian, gay, bisexual and transgender?
- Giorgi, A. (1997). The theory, practice, and evaluation of the phenomenological method as a qualitative research procedure. *Journal of phenomenological psychology*, 28(2), 235-260.
- Giami, A. (2015). Between DSM and ICD: Paraphilias and the transformation of sexual norms. *Archives of Sexual Behavior*, 44(5), 1127-1138. <https://doi.org/10.1007/s10508-015-0549-6>
- Giammattei, S. V. (2015). Beyond the binary: Trans-negotiations in couple and family therapy. *Family Process*, 54(3), 418-434. <https://doi.org/10.1111/famp.12167>
- Goldberg, A. E. (2010). *Lesbian and gay parents and their children: Research on the family life*

cycle. American Psychological Association.

- Goldie, P. (2017). Overt and covert discrimination against the LGBT community. *Applied Psychology Opus*, 8. https://wp.nyu.edu/steinhardt-appsych_opus/overt-and-covert-discrimination-against-the-lgbt-community/
- Greil, A. L., Slauson-Blevins, K. et McQuillan, J. (2010). The experience of infertility: a review of recent literature. *Sociology of health & illness*, 32(1), 140-162.
<https://doi.org/10.1111/j.1467-9566.2009.01213.x>
- Green, D., Tarasoff, L. A. et Epstein, R. (2012). Meeting the assisted human reproduction (AHR) needs of lesbian, gay, bisexual, trans and queer (LGBTQ) people in Canada: a fact sheet for AHR service providers. *Toronto, ON: LGBTQ Parenting Network*.
- Greenfeld, D. A. et Seli, E. (2011). Gay men choosing parenthood through assisted reproduction: Medical and psychosocial considerations. *Fertility and sterility*, 95(1), 225-229.
<https://doi.org/10.1016/j.fertnstert.2010.05.053>
- Gregg, I. (2018). The health care experiences of lesbian women becoming mothers. *Nursing for women's health*, 22(1), 40-50. <https://doi.org/10.1016/j.nwh.2017.12.003>
- Haider, A. H., Schneider, E. B., Kodadek, L. M., Adler, R. R., Ranjit, A., Torain, M., Shields, R. Y., Snyder, C., Schuur, J. D. et Vail, L. (2017). Emergency department query for patient-centered approaches to sexual orientation and gender identity: the EQUALITY study. *JAMA internal medicine*, 177(6), 819-828.
<https://doi.org/10.1001/jamainternmed.2017.0906>
- Hong, J. S., Woodford, M. R., Long, L. D. et Renn, K. A. (2016). Ecological covariates of subtle and blatant heterosexist discrimination among LGBQ college students. *Journal of Youth and Adolescence*, 45(1), 117-131. <https://doi.org/10.1007/s10964-015-0362-5>
- James-Abra, S., Tarasoff, L. A., Green, D., Epstein, R., Anderson, S., Marvel, S., Steele, L. S. et

- Ross, L. E. (2015). Trans people's experiences with assisted reproduction services: a qualitative study. *Human Reproduction*, 30(6), 1365-1374.
<https://doi.org/10.1093/humrep/dev087>
- Johansson, M., Adolfsson, A., Berg, M., Francis, J., Hogström, L., Janson, P. O., Sogn, J. et HELLSTRÖM, A. (2010). Gender perspective on quality of life, comparisons between groups 4–5.5 years after unsuccessful or successful IVF treatment. *Acta obstetricia et gynecologica Scandinavica*, 89(5), 683-691. <https://doi.org/10.3109/00016341003657892>
- Johnson, K. M. (2012). Excluding lesbian and single women? An analysis of US fertility clinic websites. *Women's Studies International Forum*, 35(5), 394-402.
<https://doi.org/10.1016/j.wsif.2012.05.002>
- Johnson, E. K., Chen, D., Gordon, E. J., Rosoklija, I., Holl, J. L. et Finlayson, C. (2016). Fertility-Related care for gender and sex diverse individuals: a provider needs-assessment survey. *Transgender health*, 1(1), 197-201. <https://doi.org/10.1089/trgh.2016.0030>
- Jordan, K. D. (2022, 30 avril). *Reproductive rights for trans people*. Kelly D. Jordan Family Law Firm. <https://kellyjordanfamilylaw.com/2022/04/family-law-in-canada-reproductive-rights-for-trans-people/>
- Kirubarajan, A., Patel, P., Leung, S., Park, B. et Sierra, S. (2021). Cultural competence in fertility care for lesbian, gay, bisexual, transgender, and queer people: a systematic review of patient and provider perspectives. *Fertility and Sterility*, 115(5), 1294-1301.
<https://doi.org/10.1016/j.fertnstert.2020.12.002>
- Klittmark, S., Garzón, M., Andersson, E. et Wells, M. B. (2019). LGBTQ competence wanted: LGBTQ parents' experiences of reproductive health care in Sweden. *Scandinavian journal of caring sciences*, 33(2), 417-426. <https://doi.org/10.1111/scs.12639>
- Kreines, F. M., Farr, A., Chervenak, F. A. et Grünebaum, A. (2018). Quality of web-based

family-building information for LGBTQ individuals. *The European Journal of Contraception & Reproductive Health Care*, 23(1), 18-23.

<https://doi.org/10.1080/13625187.2018.1432036>

Leadem, S. (2022, 16 mai). Access to Fertility-Insurance Coverage for LGBTQ Employees Post-Bostock. *On Labor*. <https://onlabor.org/access-to-fertility-insurance-coverage-for-lgbtq-employees-post-bostock/>

Lev, A. I. et. Sennott, S. L. (2021). Sexuality and desire landscapes in transgender, nonbinary, and genderqueer relationships. In R. Harvey M. J. Murphy, J. J. Bigner et J. L. Wetchler (ed.), *Handbook of LGBTQ-Affirmative Couple and Family Therapy* (p. 149-174). Routledge.

Lo W. et Campo-Engelstein L. (2018). Expanding the Clinical Definition of Infertility to Include Socially Infertile Individuals and Couples. Dans L. Campo-Engelstein et P. Burcher (dir.), *Reproductive Ethics II* (p. 71-93). Springer, Cham. https://doi.org/10.1007/978-3-319-89429-4_6

Machado, T. C. et Brandão, A. M. (2013). Regulating lesbian motherhood: gender, sexuality and medically assisted reproduction in Portugal. *Laws*, 2(4), 469-482.
<https://doi.org/10.3390/laws2040469>

Malmquist, A. et Nelson, K. Z. (2014). Efforts to maintain a 'just great' story: Lesbian parents' talk about encounters with professionals in fertility clinics and maternal and child healthcare services. *Feminism & Psychology*, 24(1), 56-73.
<https://doi.org/10.1177/0959353513487532>

Mamo, L. (2007). *Queering Reproduction - Achieving Pregnancy in the Age of Technoscience*. Duke University Press.

Maxwell, E., Mathews, M. et Mulay, S. (2018). More than a biological condition: the

heteronormative framing of infertility. *Canadian Journal of Bioethics/Revue canadienne de bioéthique*, 1(2), 63-66. <https://doi.org/10.7202/1058269ar>

Mamo, L., & Fishman, J. R. (2013). Why justice? Introduction to the special issue on entanglements of science, ethics, and justice. *Science, Technology, & Human Values*, 38(2), 159-175. <https://doi.org/10.1177/0162243912473162>

Mitchell, V. (2017). Couple therapy with same-sex and gender-variant (LGBT) couples: Sociocultural problems and intrapsychic and relational consequences. In J. J. Snyder & M. A. Simpson (Eds.), *The Oxford handbook of relationship science and couple interventions* (pp. 241-255). Oxford University Press.

Murphy, T. F. (2010). The ethics of helping transgender men and women have children. *Perspectives in biology and medicine*, 53(1), 46-60. <https://doi.org/10.1353/pbm.0.0138>

Péloquin, K. et Lafontaine, M.-F. (2010). What are the correlates of infertility-related clinical anxiety? A literature review and the presentation of a conceptual model. *Marriage & Family Review*, 46, 580-620. <https://doi.org/10.1080/01494929.2010.543042>

Peixoto, M. M. (2022). Problematic sexual desire discrepancy in heterosexuals, gay men and lesbian women: differences in sexual satisfaction and dyadic adjustment. *Psychology & Sexuality*, 13(5), 1231-1241. <https://doi.org/10.1080/19419899.2021.1999313>

Peixoto, M. M. et Nobre, P. (2015). Distressing sexual problems and dyadic adjustment in heterosexuals, gay men, and lesbian women. *Journal of Sex & Marital Therapy*, 42(4), 369-381. <https://doi.org/10.1080/0092623X.2015.1053020>

Peterson, B. D., Gold, L. et Feingold, T. (2007). The experience and influence of infertility: Considerations for couple counselors. *The family journal*, 15(3), 251-257. <https://doi.org/10.1177/1066480707301365>

- Peterson, B. D., Pirritano, M., Christensen, U., Boivin, J., Block, J. et Schmidt, L. (2009). The longitudinal impact of partner coping in couples following 5 years of unsuccessful fertility treatments. *Human reproduction*, 24(7), 1656-1664.
<https://doi.org/10.1093/humrep/dep061>
- Pook, M. et Krause, W. (2005). The impact of treatment experiences on the course of infertility distress in male patients. *Human Reproduction*, 20(3), 825-828.
<https://doi.org/10.1093/humrep/deh646>
- Ranaldi, C. (2022, 26 mars). *Same-sex couple's fertility treatments stalled as private clinic holds out for more government funding*. CBC News.
<https://www.cbc.ca/news/canada/montreal/same-sex-couple-fertility-treatment-on-hold-due-to-fee-dispute-1.6398389>
- Randall, A. K., Tao, C., Totenhagen, C. J., Walsh, K. J. et Cooper, A. N. (2016). Associations between sexual orientation discrimination and depression among same-sex couples: Moderating effects of dyadic coping. *Journal of Couple & Relationship Therapy*, 16(4), 325-345. <https://doi.org/10.1080/15332691.2016.1253520>
- Rausch, M. A. et Wikoff, H. D. (2017). Addressing concerns with lesbian couples experiencing fertility treatment: Using relational cultural theory. *Journal of LGBT Issues in Counseling*, 11(3), 142- 155. <https://doi.org/10.1080/15538605.2017.1346494>
- Renaud, M., Brassard, A., et Péroquin, K. (submitted). Creating a homoparental family in a heteronormative society: Quebec lesbian couples' apprehension of parenthood. *Canadian Journal of Behavioural Science*.
- Ross, L. E., Steele, L. S. et Epstein, R. (2006). Lesbian and bisexual women's recommendations

for improving the provision of assisted reproductive technology services. *Fertility and sterility*, 86(3), 735-738.

Ross, L. E., Tarasoff, L. A., Anderson, S., Epstein, R., Marvel, S. et Steele, L. S. (2014). Sexual and gender minority peoples' recommendations for assisted human reproduction services. *Journal of Obstetrics and Gynaecology Canada*, 36(2), 146-153.

[https://doi.org/10.1016/S1701-2163\(15\)30661-7](https://doi.org/10.1016/S1701-2163(15)30661-7)

Rowe, D., Ng, Y. C., O'Keefe, L. et Crawford, D. (2017). Providers' attitudes and knowledge of lesbian, gay, bisexual, and transgender health. *Federal Practitioner*, 34(11), 28-34.

Rozental, A. et Malmquist, A. (2015). Vulnerability and acceptance: lesbian women's family-making through assisted reproduction in Swedish public health care. *Journal of GLBT Family studies*, 11(2), 127-150. <https://doi.org/10.1080/1550428X.2014.891088>

Steelman, R. E. (2018). Person-centered care for LGBT older adults. *Journal of Gerontological Nursing*, 44(2), 3-5. <https://doi.org/10.3928/00989134-20180110-01>

Stewart, K., & O'Reilly, P. (2017). Exploring the attitudes, knowledge and beliefs of nurses and midwives of the healthcare needs of the LGBTQ population: An integrative review. *Nurse Education Today*, 53, 67-77. <https://doi.org/10.1016/j.nedt.2017.04.008>

Swann, G., Minshew, R., Newcomb, M. E. et Mustanski, B. (2016). Validation of the Sexual Orientation Microaggression Inventory in two diverse samples of LGBTQ youth. *Archives of sexual behavior*, 45(6), 1289-1298. [https://doi.org/10.1007/s10508-016-0718-](https://doi.org/10.1007/s10508-016-0718-2)

2

Tam, M. W. (2021). Queering reproductive access: reproductive justice in assisted reproductive technologies. *Reproductive Health*, 18, 1-6. <https://doi.org/10.1186/s12978-021-01214-8>

- Tasker, T. J., et Cisneroz, A. (2019). Open-ended questions in qualitative research. *Curriculum & Teaching Dialogue*, 21(1/2), 119-122.
- E. Todd, M., Oravec, L. et Vejar, C. (2016). Biphobia in the family context: Experiences and perceptions of bisexual individuals. *Journal of Bisexuality*, 16(2), 144-162.
<https://doi.org/10.1080/15299716.2016.1165781>
- Tremblay N., Fortier, C., Leblond de Brumath, A. et Julien, D. (2008). L'intervention auprès des couples de même sexe. Dans Y. Lussier, S. Sabourin et J. Wright (Eds.), *Manuel clinique des psychothérapies de couple* (p. 397-437). Presses de l'Université du Québec.
- Verhaak, C. M., Smeenk, J. M. J., Evers, A. W. M., Kremer, J. A. M., Kraaimaat, F. W. et Braat, D. D. M. (2007). Women's emotional adjustment to IVF: A systematic review of 25 years of research. *Human Reproduction Update*, 13, 27-36.
<https://doi.org/10.1093/humupd/dml040>
- Walks, M. (2013). Gender identity and in/fertility.
- Wellons, M. F., Lewis, C. E., Schwartz, S. M., Gunderson, E. P., Schreiner, P. J., Sternfeld, B., ... & Siscovick, D. S. (2008). Racial differences in self-reported infertility and risk factors for infertility in a cohort of black and white women: the CARDIA Women's Study. *Fertility and sterility*, 90(5), 1640-1648.
<https://doi.org/10.1016/j.fertnstert.2007.09.056>
- Wiesenthal, E., Cho, K., Roberts, J. et Dunne, C. (2022.). Fertility options for transgender and gender-diverse people. *BC Medical Journal*, 64(2), 75-80.
<https://bcmj.org/articles/fertility-options-transgender-and-gender-diverse-people>
- Woodford, M. R., Weber, G., Nicolazzo, Z., Hunt, R., Kulick, A., Coleman, T., Coulombe, S. et Renn, K. A. (2018). Depression and attempted suicide among LGBTQ college students:

- Fostering resilience to the effects of heterosexism and cisgenderism on campus. *Journal of College Student Development*, 59(4), 421-438. <https://doi.org/10.1353/csd.2018.0040>.
- Woods, B. M., Patrician, P. A., Fazeli, P. L., & Ladores, S. (2022, May). Infertility-related stress: A concept analysis. In *Nursing forum* (Vol. 57, No. 3, pp. 437-445). <https://doi.org/10.1111/nuf.12683>
- Wu, H. Y., Yin, O., Monseur, B., Selter, J., Collins, L. J., Lau, B. D. et Christianson, M. S. (2017). Lesbian, gay, bisexual, transgender content on reproductive endocrinology and infertility clinic websites. *Fertility and sterility*, 108(1), 183-191. <https://doi.org/10.1016/j.fertnstert.2017.05.011>
- Yager, C., Brennan, D., Steele, L. S., Epstein, R. et Ross, L. E. (2010). Challenges and mental health experiences of lesbian and bisexual women who are trying to conceive. *Health & Social Work*, 35(3), 191-200. <https://doi.org/10.1093/hsw/35.3.191>
- Zegers-Hochschild, F., Adamson, G. D., de Mouzon, J., Ishihara, O., Mansour, R., Nygren, K., Sullivan, E. et van der Poel, S. (2009). The international committee for monitoring assisted reproductive technology (ICMART) and the world health organization (WHO) revised glossary on ART terminology, 2009. *Human reproduction*, 24(11), 2683-2687. <https://doi.org/10.1093/humrep/dep343>

Figures

Table 1

Demographic Data (N = 78)

Sexual orientation (%)	Lesbian	56.4
	Bisexual	19.2
	Pansexual	11.5
	Queer	7.7
	Heterosexual	3.8
	Other	1.3
Gender identity (%)	Woman	89.7
	Man	2.6
	Another gender identity (e.g., gender fluid, non-binary)	7.7
	Identify as trans	5.1
Ethnicity (%)	Caucasian	89.7
	Latino/Hispanic	3.8
	Asian	2.6
	Middle Eastern	1.3
	Indigenous/First nations/Métis	1.3
	Other	1.3
Highest level of education (%)	High-school diploma or general educational development certificate	6.4
	Community college diploma	26.9
	University degree	33.3
	Masters/Ph. D.	26.9
	Second university degree	6.4
Annual personal income (%)	Less than 29,999\$	14.1
	30,000\$ to 69,999\$	44.9
	70,000\$ to 109,999\$	34.6
	More than 110,000\$	6.4
Location of the fertility clinic (%)	Quebec	59.0
	Nova Scotia	35.9
	Ontario	2.6
	British Columbia	2.6