

TWO FEMALES, ONE FAMILY: EXPLORING COUNSELORS' ROLE DURING THIRD-
PARTY FAMILY FORMATION

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ABSTRACT

“Same-sex women” households are the third largest household in the United States (Rausch & Wikoff, 2017). Female partners are increasingly deciding to have children in the context of their queer relationships (Dionisius, 2015) and are aiding to redefine traditional conceptions of family (Ben-Ari & Livni, 2006; Wall, 2011). However, female partner family formation is unique due to limited resources, a multitude of decisions, and layers of heteronormativity and discrimination. There is scant research available outside nursing literature, yet often to receive third-party fertility services fertility counseling is required. This qualitative study utilized Interpretative Phenomenological Analysis (IPA) to explore the experiences of female partners receiving third-party fertility treatments during family formation and to investigate counseling’s potential role in the family formation process. Three female partner couples were interviewed, individually. There were two emerging themes: love and disconnection. Counselors are encouraged to address love and disconnection when working with female partners engaging in family formation. More specifically, to enhance love counselors can address relational images and integrity and to heal disconnection counselors can address autonomy and belonging. Recommendations and directions for future research are discussed.

Keywords: lesbian mother, family formation, LGBT family, LGBT counseling, infertility services, LGBT parents

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DEDICATION

To all the powerful and courageous women who are conquering each day.

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1. INTRODUCTION

1.1. Introduction

There are nearly 400,000 reported queer female couples in the United States, according to a 2013 survey conducted by the U.S. Census Bureau. In addition, 20.71% of the reported queer female couples indicated that they are raising biological children in their household (U.S. Census Bureau, 2013). This supports that female partners are increasingly creating families (Rausch & Wikoff, 2017). However, accurate estimates of the number of female partner couples who have or are engaging in family formation is difficult to obtain due to barriers such as limited research.

Western societies have been in the process of redefining family over the past four decades (Dionisius, 2015; Pelka, 2009; Wojnar & Katzenmeyer, 2013). Redefining the traditional definition of family, a man and a woman with their biological children, began in the 1970s with the Gay and Lesbian Rights Movement (Ben-Ari & Livni, 2006; Bos, van balen, & van den boom, 2005; Wojnar & Katzenmeyer, 2013). In 1973 the American Psychiatric Association removed homosexuality as a diagnosable mental health disorder (Ben-Ari & Livni, 2006; Kranz & Daniluk, 2008). After this, individuals began “coming out” and divorcing their heterosexual partners (Bos et al., 2005) which ignited the “gayby boom” in the 1980s when individuals were seeking custody of their children conceived in their heterosexual relationship (Bos et al., 2005; Kranz & Daniluk, 2008) and continues today (Ehrensaft, 2008). Female partner families were prominently created in the context of heterosexual relationships at this time (Bos et al., 2005; Kranz & Daniluk, 2008) and single females did not have access to fertility services until 1983, when states began to remove “married” from their fertility laws (Rausch & Wikoff, 2017).

In 2000, Vermont was the first state in the United States to provide queer couples with civil unions (Holley, 2016). Massachusetts was the first state in the United States to legally recognize the marriage between queer couples (Holley, 2016). In 2015, *Obergefell v. Hodges* went to the Supreme Court which ruled queer marriage a constitutional right requiring all 50 states in the United States to recognize non-heterosexual marriage (Holley, 2016; Rausch & Wikoff, 2017). Queer couples now have access to privileges that historically only heterosexual married couples were entitled to including spousal benefits (social security and health insurance coverage), the ability to make medical decisions and visit during hospitalizations, and an exemption from inheritances taxes (Holley, 2016). In addition, *Obergefell v. Hodges* increased legal recognition for female partners' parenthood (Bos, van Balen, van den Boom, 2004). Female partners are now one of the fastest growing populations to seek fertility services with 47% of female partners seeking fertility services (Ehrensaft, 2008).

Researchers became interested in female partners beginning in the late 1970s and focused on raising children conceived in the context of a previously assumed heterosexual relationship (Johnson, 2012). Researchers specifically targeted disclosure of affectional orientation to children and the potential conflicts of custody between the mother and father (Johnson, 2012). In the 1980s and 1990s the focus of research shifted to female partners having children in the context of their non-heterosexual relationship (Johnson, 2012; Wojnar & Katzenmeyer, 2013). Researchers began to emphasize gaining knowledge on outcomes for the child being raised by two female partners (Abelsohn, Epstein, & Ross, 2013; Hayman & Wilkes, 2016; Johnson, 2012). It was during this period that research comparing female partner relationships to heterosexual relationships began to peak (Hayman & Wilkes, 2016; Johnson, 2012). Overwhelmingly, researchers discovered that there are no differences in child outcomes when

raised by female partners versus heterosexual partners (Hayman & Wilkes, 2016; Johnson, 2012; Wojnar & Katzenmeyer, 2013;). After decades of research on queer couples' children it was concluded that female partners appear to be as effective or more effective than heterosexual counterparts in developing household structure, sustaining parental relationships, and raising well-adjusted and highly functioning children (Johnson, 2012). These decades of research were essential to address the child and family functioning of female partners within the context of “normal” in order to gain momentum in family formation rights (Johnson, 2012).

Starting in the new millennium, research continued to evolve and has started to focus on the unique experience of female partners including their relationship satisfaction, parental goals, decision-making process during family formation, family roles between partners, and the challenges experienced during family formation (Doinisius 2015; Hayman & Wilkes, 2016 Johnson 2012; Wojnar & Katzenmeyer, 2013). This new millennium of research is trending away from heterosexual comparison and towards emphasizing more specific and informative studies of female partners and their family formation process. More recent research is working to challenge oppressive heteronormative and homophobic structures that create significant barriers for female partners during family formation (Hayman & Wilkes, 2016).

1.2. Definitions of Terms

This section outlines definitions of terms utilized in this study. It is important to note the researcher's intention in selecting terms such as female partners and queer, when focusing this study. The researcher intended to be inclusive with terminology and acknowledged potential risks with using female partners and queer. The term female partners was utilized, rather than women, to enhance inclusivity for gender identities beyond cis-gendered identities. Also, the researcher believed emphasizing gender, versus sex, was more important in order to address

heteronormative culture during family formation (i.e., gender roles, gender constructs). Also, the researcher intentionally utilized the term queer, rather than lesbian, to avoid further marginalization of other affectional orientations (i.e., bisexual, pansexual, demisexual).

However, the researcher understood that the terms, female partners and queer, are not necessarily widely accepted terms by lesbian, bisexual, gay, queer, questioning, and asexual/ally (LGBQQA) populations or researchers. More specifically, it is essential to clarify queer has been historically a derogatory term, which has more recently been reclaimed by emerging generations. Language is a barrier to addressing the topic of female partner family formation, including for this study, and will be addressed in future sections.

Affectional orientation refers to the direction an individual is predisposed emotionally, physically, spiritually, and/or mentality to bond and share affection with (ALGBTIC, 2009).

Counselor for the purposes of this study refers to professionals who are licensed to provide mental health services in their community including mental health counselors, social workers, psychologists, marriage and family therapist, etc.

Donor Insemination refers to the procedure of placing semen into a vagina or uterus in order to achieve pregnancy (American Pregnancy Association, 2017).

Family formation refers to the discussion and negotiation of the processes of conception, pregnancy, birth, and parenting (Wojnar, & Katzenmeyer, 2013).

Heteronormative refers to the cultural bias that indicates individuals should follow traditional norms of heterosexuality (ALGBTIC, 2009).

Heterosexism refers to the assumption or idea that all individuals are heterosexual or should be heterosexual. Heterosexism represents a systematic ideology that ignores and

marginalizes individuals identifying as members of the LGBQQA community by making them invisible or silencing their lived experiences (ALGBTIC, 2009).

Homophobia refers to an aversion, fear, hatred, or intolerance of individuals identifying as queer or aspects of queer culture (ALGBTIC, 2009).

Intracervical insemination or ICI occurs when semen is placed inside the cervical opening and covers the cervix (American Pregnancy Association, 2017). This is also referred to as vaginal insemination, which can be conducted at-home or at a fertility clinic.

Intrauterine Insemination or IUI occurs when semen is inserted through the cervix and placed directly into the uterine cavity (American Pregnancy Association, 2017).

In Vitro Fertilization or IVF occurs when fertilization occurs outside the body, between the egg and the sperm, and is then inserted directly into the uterus (American Pregnancy Association, 2017). In Vitro Fertilization can occur using any combination of personal eggs, personal sperm, donated eggs, or donated sperm.

Marginalization occurs when an individual is included in two cultures and does not feel included in either one which generates feelings of isolation, exclusion, and invisibility (Hayman et al., 2013.2). In addition, marginalization includes identities that are outside of societal norms and are therefore silenced or made invisible in society (Hayman & Wilkes, 2016).

Queer generally refers to individuals who identify their affectional orientation outside of heterosexuality and is an umbrella term referring to lesbian, gay, bisexual, queer, questioning, and asexual/ally (LGBQQA) community. (ALGBTIC, 2009). This study utilizes queer instead of LGBQQA in order to be more inclusive of persons that do not identify within the confines of those affectional orientations (i.e. demisexual, pansexual, etc.)

Social mother refers to the female partner that did not birth the child(ren) and is still acting in the role of a mother through social connection (Brown & Perlesz, 2008). Additional terminology to refer to the social mother include nonbiological mother, nonbirth mother, co-mother, and other mother.

Third-party conception refers to the process of conceiving a child through donor insemination, egg donation, embryo donation, or surrogacy (Peterson, Boivin, Norre, Smith, Thorn, & Wischmann, 2012). Due to the parameters of this study surrogacy is not included in the study.

1.3. Statement of the Problem

As social and institutional shifts toward lesbian, gay, bisexual, queer, questioning, and asexual/ally (LGBQQA) human rights continue in the United States, females identifying as members of the LGBQQA community are increasingly more visible (Bos et al., 2005; Lavner, 2016; Wojnar & Katzenmeyer, 2013). This increased visibility challenges the heteronormative nature of mainstream culture surrounding relationships, marriage, and families and encourages the examination of existing heterosexism and homophobia experienced in these contexts. Specifically, more females are deciding to have children in the context of their queer relationships (Dionisius, 2015) and redefining the traditional concept of family (Ben-Ari & Livni, 2006; Wall, 2011). In the United States, “same-sex women” households are the third largest household (Rausch & Wikoff, 2017).

There is significant research available regarding counseling queer clients and queer partners raising children (e.g., Moringstar, 1999; Clarke, 2002; Patterson, 2002). However, there is limited research available that emphasizes queer couples and family formation and scarcer research focusing on the role of counseling couples during family formation (Rausch & Wikoff,

2017). With significant advances in reproductive technologies (Hayman, Wilkes, Halcomb, & Jackson, 2014) and policies requiring counseling services to receive third-party fertility services, it is important that counselors are providing affirmative and culturally sensitive services.

Counselors can provide affirmative and culturally sensitive services to female partners by understanding unique challenges and barriers to family formation (Rausch & Wikoff, 2017; Wojnar & Katzenmeyer, 2013).

Though counseling research is scarce in this area, research conducted in the field of nursing suggests sufficient evidence that the healthcare system provides heteronormative services and that female partners experience multiple forms of homophobia when seeking fertility services (Hayman, Wilkes, Halcomb, & Jackson, 2013). Specifically, this homophobia presents in the form of heterosexism which is present at macro, meso, and micro-levels. There is a significant gap in literature between the healthcare services and mental health services related to female partners' fertility services. Due to this significant gap in research it is difficult to identify the role counseling has in female partners' family formation including their specific needs and experiences.

1.4. Research Questions

The overarching question of this study is "How do female partners experience counseling during family formation?" More specifically, this study will explore counseling's role in female partner family formation by understanding their experiences throughout their family formation process and during counseling, if applicable. This study explores the lived experiences of female partners during family formation including potential homophobia and heterosexism experienced, their level of satisfaction and how they perceived the services received, topics addressed, and potential counselor areas of weakness. The secondary research questions are:

1. What perception did female partners have of their providers?
2. What expectations did the female partners have of counseling during family formation?
3. How do female partners perceive their providers' ability to provide culturally sensitive and affirmative services when working with female partners during family formation?

1.5. Purpose of the Study

The purpose of the study is trifold: (a) to explore the experience of female partners receiving third-party fertility treatments, (b) to identify the perceived implications of counseling services during the family formation process, and (c) to develop implications for counseling practices specific to female partners during family formation.

1.6. Need for the Study

Providing culturally sensitive and affirmative counseling services to queer individuals had been identified as an ethical obligation and is present in research (Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling, 2009). Counselors often are aware that they can make an effort to have a welcoming environment for queer individuals, including LGBQQA resources and magazines, rainbow flag stickers, and clarifying inclusivity in mission statements. However, cultivating a welcoming environment includes more than the physical environment and does not translate to affirmative and culturally sensitive counseling practices. Culturally sensitive counseling in this study is defined as an understanding and appreciation for unique barriers, challenges, and strengths marginalized populations experience (Yager, Brennan, Steele, Epstein, & Ross, 2010). Therefore, in order to be culturally sensitive when working with LGBQQA individuals counselors need to have an understanding of their unique experience in society.

There is a plethora of research available to increase counselors' cultural sensitivity when working with LGBQQA individuals. Topics include addressing LGBQQA children and youth in schools, the coming out process, suicide and self-harm, parenting concerns, and more. However, research appears to decrease when moving past queer individuals and towards queer couples and families. There is significantly less research available regarding queer couples and families. More specifically, there is scant research available for counseling queer couples during the family formation process. In order to be culturally sensitive when working with queer couples during family formation, counselors must have access to research and information about queer couples' experiences. This study focuses on female partners, rather than queer couples as a whole, because there are unique barriers and challenges only specific to female partners during family formation and because female partners are increasingly seeking third-party fertility services to create families (Rausch & Wikoff, 2017). According to a study conducted by Carpinello, Jacob, Nulsen, and Benadiva (2016), female partners accounted for 41% of the third-party fertility services between 2004 and 2015, which outnumber services provided to single mothers and heterosexual couples. As female partners continue to seek fertility services, there will be an increased need for counselors to be culturally sensitive to their unique family formation processes.

There is meager research regarding female partners engaging in family formation. The bulk of available research emphasizes parenting. The remainder of available research has been conducted in nursing-related fields focusing on the heteronormative structures of healthcare services. There are only a few studies focusing on counseling during family formation (e.g., Carpinello, Jacob, Nulsen, & Benadiva, 2016; Hayman, Wilkes, Halcomb, & Jackson, 2014), although counseling is a requirement prior to donor insemination. Therefore, little is known

about the services counselors are providing to female partners during family formation. Examining the experiences of female partners receiving counseling for family formation could offer numerous implications for research, advocacy, and counselor competency. Currently, the best knowledge we have is that female partners are unique and that they are as successful at parenting as their heterosexual counterparts (Johnson, 2012). We also understand that healthcare systems are heterosexist and homophobic which can negatively impact female partners physical and emotional well-being (Fields & Scout, 2015). These insights are valuable for cultivating advocacy for female partners' family formation and for beginning to understand their unique experiences. However, these insights fail to connect healthcare to mental health and to provide a more holistic understanding of the experiences of female partners during family formation.

Answering this question could guide counselors working with female partners engaging in family formation. For example, if counselors can understand the experiences of female partners during family formation they can create more culturally sensitive treatment and improve the overall well-being of female partners. Furthermore, the results of this exploratory study could inform future research and advocate for female partners. Researchers could advocate at macro, meso, and micro-levels for female partners through identifying heteronormative and homophobic institutions, policies, and procedures. For example, if female partners are attending infertility counseling and are not experiencing concerns with infertility counselors might have a different approach when working with them. Counselors might advocate to be more inclusive in infertility counseling by updating service titles to fertility counseling, updating paperwork to be more inclusive, and addressing heterosexism and homophobia in sessions and with additional providers.

1.7. Brief Overview

The following research study is divided into five chapters. Chapter One provided a broad overview of the history of barriers and challenges to female partner family formation, established the importance of counseling during female partner family formation, illuminated current gaps in female partner family formation research, set the stage for the study, and suggested ways that the study may positively impact society and the counseling field. In Chapter Two, unique barriers and challenges for female partners engaging in family formation are analyzed, synthesized, and contextualized using a feminist framework. The proposed study is outlined in Chapter Three including specific methodological steps and considerations. In Chapter Four, the results of the study are reported and described, while limitations, implications, and directions for future research are discussed in Chapter Five.

2. LITERATURE REVIEW

2.1. Introduction

The following chapter includes critical information for understanding the unique experiences of female partners during family formation and will present the historical context surrounding the evolution towards female partners having the right to create families. The researcher reviews and discusses language, psychosocial factors, relationships and counseling, parenthood and family formation, and the conception process of female partners. Each of these broad sections illuminate the unique barriers and challenges female partners encounter when engaging in family formation, with a focus on counseling implications. Finally, this discussion will conclude with a synthesis of information that depicts the current state of evidence for counseling female partners during family formation with the intention to depict areas of best practice that are unclear. The power of language must be explored in order to understand the unique barriers female partners experience during family formation.

2.2. Language

Historically researchers (Diamond, 2016) described a romantic relationship between two females as a “lesbian relationship.” This trend is still present in research and is problematic because of the expanded understanding of sexual identity and gender identity. Specifically, females that are romantically or sexually attracted to other females may not identify as lesbian. Increasingly, more females are defining their sexuality as something between the heterosexual and homosexual dichotomy or choosing to not label their affectional orientation at all. Gender identity is also becoming more fluid and nonbinary which impacts how researchers utilize language. The use of limiting language, such as “lesbian relationship,” further perpetuates and restricts the populations that are being researched (Diamond, 2016).

Female partners are not only confined by language surrounding their relationship and sexual identities, language is also a significant challenge for female partners in the family formation process (Abelsohn, Epstein, & Rosee, 2013; Brown & Perlesz, 2008; Miller, 2012; Wall, 2011). Specifically, the absence of consistent language is challenging (Miller, 2012). When reviewing literature there were no consistent terms to describe female partners, their families, or their roles; terms used included same-sex women couples, lesbian mothers, De Novo family, lesbian-parented family, co-mothers, biological and nonbiological mothers, same-sex co-parents, lesbian-headed family, and lesbian women with children. There is also specific concern surrounding the language used for female partner parents and the donor; this will be discussed further when addressing motherhood. This absence and inconsistency of language magnifies issues centered around identification, such as identity development and a sense of legitimacy in various life roles (McManus, Hunter, & Renn, 2006; Miller, 2012). Language has an impact on how individuals define and create their meaning in the world (Julian, Duys, & Wood, 2014), which emphasizes the importance of discussing language surrounding female partners forming families. In addition to language, there are various psychosocial factors that affect female partners' relationships and family formation process.

2.3. Psychosocial Factors

Queer experience sexual minority stress, which is the stress resulting from heterosexist societal stigmatization and marginalization (Cherguit, Pettle, & Tasker; 2012; Holley, 2016; Lewis, Kholodkov, & Derlega, 2012). Female partners considering parenthood are moving against heterosexism and marginalization by continuing to challenge societal norms on the definitions of relationships and family. With this empowerment comes additional barriers and challenges that are unique to female partners' experiences of family formation. In this section,

psychosocial factors are identified for sexual minority females. Before discussing specific psychosocial factors impacting female partners, it is important to consider the intersectionality of the minority identity of female partners (Abelsohn, Epstein, & Rosee, 2013; Lewis et al., 2012). Female partners have two minority identities, their sexual identity and their gender identity. Female partners experience minority stress related to both identities due to the stigmatization and marginalization of each identity. The stress associated with sexism and heterosexism is unique (Hayman et al., 2013.2; Hayman & Wilkes, 2016; Lewis et al., 2012).

Sexual minority females have a higher risk of experiencing a variety of emotional, behavioral, and health problems (Abelsohn, Epstein, & Rosee, 2013; Alang & Fomotar, 2015; Borneskog, Sydsjo, Lampic, Bladh, & Svanberg, 2013; Fields & Scout, 2015; Lewis et al., 2012; Rausch & Wikoff, 2017; Yager et al., 2010). For example, sexual minority females have increased risk of anxiety, depression, substance use, suicidality, obesity, cardiovascular concerns, and certain cancers (Fields & Scout, 2015; Hayman et al., 2013.2; Lewis, Kholodkv, & Derlega, 2012). Female partners report higher minority stress related to family concerns such as their family's reactions to decisions (Lewis, Kholodkv, & Derlega, 2012). In addition, social support is directly related to female partners' overall well-being (Borneskog et al., 2013; Borneskog, Lampic, Sydsjo, Bladh, & Svanverg, 2014; Maccio & Pangburn, 2012). Overall, female partners experience compromised social support which negatively impacts their emotional and behavioral well-being (Connolly, 2008; Maccio & Pangburn, 2012; Yager et al., 2010). Specifically, social support from family is compromised and female partners tend to seek social support from friends and peers (Borneskog, Lampic, Sydsjo, Bladh, & Svanverg, 2014; Maccio & Pangburn, 2012; Yager et al., 2010). Because female partners often experience a lack of social support from

family members, it becomes increasingly important that counselors provide support to female partners during family formation.

As mentioned, sexual minority stress results from heterosexist stigmatization and marginalization (Cherguit, Pettle, & Tasker, 2012; Holley 2016; Lewis, Kholodkov et al., 2012). Raising children in a heterosexist society is one of the most prominent fears of female partners considering parenthood (Hayman & Wilkes, 2016; McManus et al., 2006; Wall, 2011). Common examples of heterosexism include confined legal protection from discrimination based on affectional orientation in employment, housing, and services (Wall, 2011); legal and social recognition of relationship and family; discrimination from family, friends, and strangers; invisibility in society; and rejection and social exclusion (Abelsohn et al., 2013; Alang & Fomotar, 2015; Connolly, 2008; Hayman et al., 2013.2; Holley, 2016; Wall, 2011). An additional stress for female partners choosing parenthood is the absence of role models in society (Ben-Ari & Livni, 2006; Cherguit, Pettle, & Tasker, 2012; Degges-White & Marszalek, 2008; Hayman & Wilkes, 2016). Female partners do not openly have role models to help construct the definitions of relationships and family, specifically the expectations of roles and how to cope with various unique situations related to relationships and family.

There are also factors of sexual minority stress specific to female partners engaging in family formation. For example, female partners seeking fertility services, regardless of their physical ability, receive services at clinics specifically addressing heterosexual couples' infertility concerns (Ehrensaft, 2008). This is problematic for female partners because policies at fertility clinics are often developed with heterosexual couples' needs as the focus (Ehrensaft, 2008; Hayman, Wilkes, Halcomb, Jackson, 2013). An additional example is the scarce resources and information available regarding the family formation between queer couples, including

healthcare information (Abelsohn et al., 2013; Cherguit, Pettle, & Tasker, 2012; Fields & Scout, 2015; Hayman, Wilkes, Jackson, & Halcomb, 2013; Yager et al., 2010). Heteronormative institutional policy is also present in healthcare insurance, specifically access to affirmative healthcare providers can be limited due to coverage (Fields & Scout, 2015).

Sexual minority stress is not about affectional orientation, it is about the environment society is creating. Constant exposure to heteronormativity has a significant negative impact on female partners' wellbeing (Abelsohn, Epstein, & Rosee, 2013; Alang & Fomotar, 2015; Borneskog et al., 2013; Lewis, et al., 2012; Yager et al., 2010), and female partners engaging in family formation face additional aspects of heteronormativity. When working with female partners, it is important that counselors are aware and knowledgeable about the factors that impact the emotional and physical well-being of female partners (Abelsohn, Epstein, & Rosee, 2013). In addition to being aware and knowledgeable about psychosocial factors, it is important that counselors understand dynamics of counseling female partners as a couple.

2.4. Relationships and Couples Counseling

Research conducted on queer couples' relationships has the potential to be integrated with heteronormative assumptions, especially when comparing queer couples' relationships to heterosexual relationships as the normed standard (Grove, Peel, & Owen-Pugh, 2013; Holley, 2016; Kimberly & Williams, 2017). Female partner relationships are largely similar to heterosexual relationships, in some regards, yet still unique (Biaggio, Coan, & Adams, 2008; Smetana & Bigner, 2008; Holley, 2016). Furthermore, research has suggested that the unique aspects of female partners' relationships generally are positive in comparison to heterosexual relationships (Holley, 2016). One of the most unique aspects of a female partner relationship is their egalitarian nature, specifically female partners strive to have equality in their relationships

including equal distribution of household chores and parenting roles (Biaggio, Coan, & Adams, 2008; Borneskog, Lampic, Sydsjo, Bladh, & Svanberg, 2014; Diamond, 2016; Holley, 2016; Johnson, 2012; Kimberly & Williams, 2017; Lavner, 2016; Maccio & Pangburn, 2012; Pelka, 2009;). In particular, female partners tend to report higher levels of compatibility, intimacy, and relationship quality (Johnson, 2012; Kimberly & Williams, 2017). Female partners subsequently tend to report lower levels of conflict (Kimberly & Williams, 2017) and higher levels of conflict resolution (Borneskog et al., 2014; Holley, 2016; Kimberly & Williams, 2017).

In addition, female partners' similarity regarding personal values is an important factor in longevity and level of satisfaction in the relationship (Connolly, 2008; Kimberly & Williams, 2017; Lavner, 2016). Long-term female partner relationships also tend to focus more on maintaining a connected relationship (Kimberly & Williams, 2017). Queer couples have a history of lower institutional support and privilege in defining the legitimacy and significance of their relationships, for example the right to marriage ceremonies (Degges-White & Marszalek, 2008; Diamond, 2016). Therefore, queer couples often do not celebrate or acknowledge the same heterosexual relationship benchmarks (Degges-White & Marszalek, 2008). Overall, female partners demonstrate an increased level of ability to be resilient, especially regarding the amount of oppression they experience (Connolly, 2008).

Heteronormativity is one of the most difficult challenges of navigating queer relationships (Biaggio, Coan, & Adams, 2008; Connolly, 2008; Degges-White & Marszalek, 2008; Hayman et al., 2014) because it can cultivate additional stress on the relationship, or sexual minority stress (Connolly, 2008; Holley, 2016; Lewis et al., 2012). Sexual minority stress is mentionable due to the potential implications in the counseling relationship. There are many forms of sexual minority stress (Holley, 2016), examples specific to the counseling relationship

include affectional orientation being centralized as the root of relational concerns (Connolly, 2008; Grove et al., 2013) and female partners living in a culture that preferences opposite-gender partners and genetically connected families while trying to create their own relational meaning and significance (Connolly, 2008; Degges-White & Marszalek, 2008; Pelka, 2009). In the context of a heteronormative society, female partners are constantly forced to justify their relationship and family to the majority population (Hayman et al., 2013).

Addressing heteronormativity in counseling is especially important because counselors can hold heteronormative assumptions when working with queer couples (Connolly, 2008; Green, Murphy, Blumer, & Palanteer, 2009; Kimberly & Williams, 2017). For example, Skinner and Goodfriend (2009) conducted a qualitative study to investigate counselors' perceptions of queer couples' relationships. It was discovered that counselors perceived queer couples as more committed, satisfied, and invested in their relationship compared to heterosexual couples. In addition, it was suggested that in order to avoid the appearance of bias, counselors may withhold negative feedback from queer couples. Understanding and acknowledging heteronormativity and the additional unique experiences of female partners is vital for the counseling relationship (Connolly, 2008; Degges-White & Marszalek, 2008; Lavner, 2016). This is especially of high importance when discussing female partner family formation, as there is a requirement to receive counseling prior to receiving third-party fertility services (Carpinello et al., 2016). Counseling services are being increasingly utilized by queer couples (Green et al., 2009; Rutter, Leech, Anderson, & Saunder, 2010); yet, limited research has been conducted on the therapeutic experience of queer couples, and more specifically female partners, during their counseling experiences (Baetens, Camus, & Devroey, 2002; Grove & Blasby, 2009; Grove et al., 2013;

Smetana & Bigner, 2008). A study conducted by Bernstein (2000) reported that approximately 80 percent of Marriage and Family Therapists endorsed providing services to queer clients.

Counseling disciplines, overall, recognize the need for cultural competency standards (i.e., American Counseling Association, American Association for Marriage and Family Therapy, and National Association for Social Workers). However, there appears to be a gap in cultural competencies specific to serving queer populations. The Association of Lesbian, Gay, Bisexual, and Transgender Issues in Counseling (ALGBTIC), a branch of the American Counseling Association, is seemingly the only professional organization in the counseling field that specifically outlines competencies for working with queer clients. Unfortunately, the emphasis of the ALGBTIC competencies are providing services to individuals versus the inclusion of couples and families. The lack of competency standards in the counseling field addressing services provided to queer couples and families could negatively impact the level of satisfaction couples and families report when receiving counseling services (Rutter et al., 2010).

One contributing factor to the level of dissatisfaction of queer couples in counseling is their perception of counselors' heterosexism, homophobia, or the counselor's limited understanding of queer identity (Grove & Blasby, 2009; Rutter et al., 2010). Queer couples may enter counseling with the assumption that their relationship will be misunderstood and invalidated by their counselor, until presented with contrary evidence (Grove & Blasby, 2009). Counselor disclosure of affectional orientation was identified as important to female partners, as well as a preference for female counselors (Biaggio, Coan, & Adams, 2008; Grove et al., 2013; McManus et al., 2006; Smetana & Bigner, 2008). Queer couples do not have the privilege of omitting their affectional orientation to counselors, rather they are "outed" immediately upon receiving couples counseling services (Grove et al., 2013). In addition, counselors endorse

limited confidence to address sexual intimacy and physical components of relationships in couples counseling (Rutter et al., 2010) and counselors' inability or unwillingness to address topics is often interpreted by queer couples as a lack of acceptance or perceived heterosexism (Grove & Blasby, 2009).

As mentioned, there is limited research on the experiences of queer couples receiving counseling services; however, there is a vast amount of research available that provides suggestions for counselors working with queer clients. Generally, counselors can utilize and implement therapeutic techniques that are used with heterosexual couples when working with queer couples if remaining culturally sensitive (Biagglo, Coan, & Adams, 2008). Rather, it is suggested that counselors focus on cultivating enhanced awareness and understanding of the unique relationship challenges and addressing heteronormative biases and assumptions personally, societally, and in session that limit counseling's effectiveness when working with queer couples (Alang & Fomotar, 2015; Biagglo et al., 2008; Connolly, 2008; Grove & Blasby, 2009; Grove et al., 2013; McManus et al., 2006; Rausch & Wikoff, 2017). Specifically, exploring the similarities and differences of the queer couple throughout the therapeutic relationship including cultural dynamics (Grove et al., 2013) and moving towards validation and affirmation of the relationship (Biagglo et al., 2008; Connolly, 2008; Grove & Blasby, 2009). Connolly (2008) identified areas for counselors to monitor when working with queer couples to recognize homophobia and heterosexist bias including (a) feeling reluctant to address topics that one would address when working with a heterosexual couple, (b) ignoring the couples' presenting problem and emphasizing affectional orientation, and (c) idealizing the queer experience by focusing only on positives. Furthermore, when providing couples counseling to female partners it is important to be prepared to discuss parenthood and family formation.

2.5. Parenthood and Family Formation

With the lack of societal recognition and the limited availability of role models, female partners are in a unique position that requires them to create their own definition of family and, more specifically parenthood, (Ben-Ari & Livni, 2006; Hayman & Wilkes, 2016). Deciding to engage in the process of family formation has unique challenges and barriers for female partners (Hayman & Wiles, 2016; Johnson, 2012; Miller, 2012; Nelson, 2008). In this section, the unique challenges and barriers to female partners engaging in family formation will be explored including defining parenthood, negotiating parental roles and expectations, transitioning into parenthood, and navigating the multitude of decisions female partners make when engaging in the process of family formation.

As previously mentioned, language confines the understanding, explanation, and communication of female partner family formation. There is currently no formal and consistent language to address female partners' family roles or family structure (Abelsohn, Epstein, & Rosee, 2013; Brown & Perlesz, 2008; Cherguit, Burns, Pettie, & Tasker, 2012; Miller, 2012; Wall, 2011). In addition to the availability of language, female partners are redefining parenthood and the traditional meaning of motherhood (Hayman & Wilkes, 2016; Nelson, 2008; Nordqvist, 2012). Female partner families are composed of two mothers with different roles, functions, and expectations in the family. Redefining motherhood is complicated by social constructs of motherhood and fatherhood (Nelson, 2008; Patterson & Riskind, 2010; Pelka, 2009; Rausch & Wikoff, 2017). In the United States, females are socialized to be caretakers of others – nurturing and warm. Females are also socialized to believe that motherhood is their biological destiny (Hayman, & Wilkes, 2016; Nelson, 2008; Patterson & Riskind, 2010), whereas, males are socialized to be hyper masculine, provide for their family, and be emotionally

strong. These social constructs of motherhood and fatherhood complicate female partners' family formation process due to the absence of a male and the presence of an additional female (Patterson & Riskind, 2010; Pelka, 2009; Rausch & Wikoff, 2017). Social constructs also can create further role confusion and conflict in female partners' relationships during family formation (Pelka, 2009).

Historically, queer females were not perceived to have the privilege of motherhood; rather, they were excluded from motherhood (Hayman et al., 2014; Hayman & Wilkes, 2016; Johnson, 2012; Patterson & Riskind, 2010; Rausch & Wikoff, 2017). In recent decades, female partners have integrated their identities as queer and as mothers (Ben-Ari & Livni, 2006; Hayman & Wilkes, 2016; Nelson, 2008; Wojnar & Katzenmeyer, 2013). Female partners are challenging the societal norms, values, and expectations due to the inapplicable traditional parenting roles of heterosexual society (Ben-Ari & Livni, 2006; Dionisius, 2015; Hayman & Wilkes, 2016; Nelson, 2008; Nordqvist, 2012; Patterson & Riskind, 2010). When engaging in the process of family formation, first, female partners must integrate their queer identity and their developing identity as a parent to create an identity as a queer parent (Ben-Ari & Livni, 2006; Miller, 2012; Nelson, 2008). Female partners describe their journey towards motherhood as a "rollercoaster ride" due to the multitude of decisions, limited social support, financial stress, and additional barriers experienced in the process of family formation (Patterson & Riskind, 2010; Rausch & Wikoff, 2017; Somers, Parys, Provoost, Buysse, Pennings, & De Sutter, 2017; Wojnar & Katzenmeyer, 2013).

Female partners engage in lengthy discussions, often over a duration of years, before deciding to pursue the process of family formation (Hayman et al., 2013; Hayman et al., 2014; Hayman & Wilkes, 2016; Nordqvist, 2012; Wojnar & Katzenmeyer, 2013). Prior to parenthood,

female partners negotiate the way they would each like to be identified, the choice of surname, the names that will appear on the birth certificate, their roles within the context of their family, choosing who will birth and how to conceive, the involvement of each partner in the process of family formation, and the amount of donor involvement (Ben-Ari & Livni, 2006; Hayman et al., 2013; Hayman & Wilkes, 2016; Nordqvist, 2012; Somers et al., 2017). Female partners engage in these discussions between themselves, involve friends and family, and conduct research via the Internet (Hayman et al., 2013). Decisions are also negotiated based on the partner's individual age, health, and current role in the family (Ben-Ari & Livni, 2006; Hayman et al., 2013; Hayman et al., 2014; Wojnar & Katzenmeyer, 2013).

In addition, legal considerations for female partners during family formation exist. Legal considerations include the legal status of the female partners' relationship, the legal status between the social mother and the child(ren), and the legal status and rights of the donor (Ben-Ari & Livni, 2006; McManus et al., 2006; Miller, 2012; Patterson & Riskind, 2010; Wojnar & Katzenmeyer, 2013). The legal status between the social mother and the child(ren) and the legal status and rights of the donor depend largely on individual state laws and healthcare system policy (McManus et al., 2006; Patterson & Riskind, 2010; Rausch & Wikoff, 2017). Social mothers may have to arrange second-parent adoptions or guardianship contracts (McManus et al., 2006).

Social mothers are often more at risk of marginalization due their other position (Ben-Ari & Livni, 2006; Hayman et al., 2013; Hayman & Wilkes, 2016; McManus et al., 2006; Nelson, 2008; Pelka, 2009). Social mothers are outside of the normal heterosexual family construct excluding them from a legitimate position in the family due to not conceiving a child (Ben-Ari & Livni, 2006; Hayman et al., 2013). In addition to social invisibility, social mothers are often

legally disenfranchised; this exclusion increases feelings of powerlessness and vulnerability within the family structure (Cherguit et al., 2012; Hayman et al., 2013; Hayman & Wilkes, 2016; McManus et al., 2006). To cultivate legitimacy for the social mother, the family female partners establish ceremonies, names, and methods of formal recognition which may be integrating heterosexual norms (Hayman et al., 2013; Kimberly & Williams, 2017; Miller, 2012). For example, choosing a surname that connects the social mother to their child(ren) (Hayman et al., 2013). An additional example, female partners may decide to not celebrate the social mother on Mother's Day, rather reserve this day to celebrate the mother that conceived the child(ren) (Somers et al., 2017).

Female partners also have to negotiate how their child(ren) will refer to them. Research suggests that the biological mother is often referred to as mother or mommy, whereas the social mother is referred to as mama, ma, daddy, first names, or non-English words for mother or father (Hayman, Wilkes, Jackson, Halcomb, 2013; Miller, 2012). The decision to refer to the social mother as daddy or an alternative in a non-English represents the assimilation to heterosexual norms (Hayman et al., 2013; Pelka, 2009).

As female partners engage in the family formation process, their roles and responsibilities begin to shift, especially after the birth of their first child (Ben-Ari & Livni, 2006; Pelka, 2009; Rausch & Wikoff, 2017; Somers et al., 2017; Wojnar & Katzenmeyer, 2013). At this time, female partners are confronted with difference and move towards a hierarchy compared to previous equality due to the differences between the biological mother and social mother status (Ben-Ari & Livni, 2006; Pelka, 2009; Rausch & Wikoff, 2017; Somers et al., 2017; Wojnar & Katzenmeyer, 2013). Female partners do not necessarily anticipate the differences in parental roles and initially expect equality in maternal roles (Pelka, 2009). Specifically, parental roles

can trigger feelings of jealousy between female partners (Nordqvist, 2012; Pelka, 2009; Wojnar & Katzenmeyer, 2013).

Female partners are continually required to justify their family structure and the legitimacy of their family (Hayman & Wilkes, 2016; Miller, 2012; Nordqvist, 2012; Pelka, 2009). When female partners decide not to pursue or continue to pursue family formation, it is often due to limited access to health insurance coverage, financial concerns, and the discovery of medical concerns potentially impacting the fertility process (Carpinello et al., 2016; Fields & Scout, 2015). Female partners engaging in family formation experience unique barriers and must consider a multitude of questions before, during, and after engaging in family formation. Female partners must discuss and decide who will conceive, how they will conceive, how they will finance conception, determine the type of donor, explore their roles in the conception process, and define their roles as parents, their family dynamics and structure, and how they will cultivate legal and societal legitimacy for their family. As female partners parent, questions continue to evolve including how to navigate their child(ren)'s school system, what to do when their child(ren) witness or experience homophobia based on their parents' relationship, and how to continue navigating limited support and recognition from family, friends, and/or society while being parents.

In this section, the researcher provided an overview of female partners' decision making. Specifically, the researcher explored the barriers of deciding who will conceive, considering legal implications, and defining their roles as parents and their family dynamics and structure, and cultivating legitimacy for their family. The following section focuses on the conception process which will include conception options, donor types and involvement, and the barriers of

healthcare systems. Heterosexism and homophobia are addressed more in the following section as it relates to the process of family formation.

2.6. Conception Process

Female partners are increasingly creating families through third-party fertility services (Carpinello et al., 2016; Cherguit et al., 2012; Dionisius, 2015; Ehrensaft, 2008; Hayman et al., 2013.2; Hayman et al., 2014; McManus et al., 2006; Rausch & Wikoff, 2017). Female partners, in general, have a desire to equally and actively participate in the process of family formation, especially the conception process and the actual moment of conception (Hayman et al., 2014; Nordqvist, 2012; Somers et al., 2017; Wojnar & Katzenmeyer, 2013). However, there has been limited research on the conception process of female partners (Carpinello et al., 2016; Cherguit et al., 2012). Third-party conception includes donor insemination, egg donation, embryo donation, and surrogacy (Peterson et al., 2012). However, challenges and barriers to surrogacy are not included because it is beyond the scope of this study.

Donor insemination is the most common form of conception utilized by female partners (McManus et al., 2006; Rausch & Wikoff, 2017). Female partners must decide if they would like to complete the insemination themselves or with the assistance of healthcare providers (Hayman et al., 2014; McManus et al., 2006). There are multiple methods of conception female partners can choose including vaginal insemination and artificial reproductive technologies (Hayman et al., 2014). Vaginal insemination is completed between female partners or with the assistance of healthcare providers (Hayman, Wikes, Halcomb, & Jackson, 2014). Artificial reproductive technologies include intrauterine insemination and in vitro fertilization (Hayman et al., 2014; Peterson et al., 2012). When deciding on a method of conception, female partners must consider affordability, access, and preferences (Nordqvist, 2012; Wojnar & Katzenmeyer,

2013). Female partners tend to prefer vaginal insemination as their first option for conception, specifically to complete insemination at home (Hayman et al., 2014). The preference to conceive at home means that female partners do not involve healthcare providers and avoid expected homophobia (Hayman et al., 2014).

In addition to deciding on the method of conception, female partners decide the type of donor, known or unknown, they will use during third-party fertility services. Utilizing a known donor is less expensive and allows female partners to have access to medical and biological information (Hayman et al., 2014; McManus et al., 2006; Nordqvist, 2012). However, a known donor may create complications related to physical health due to sexually transmitted diseases and donor involvement expectations (McManus et al., 2006; Nordqvist, 2012). The advantages of utilizing an unknown donor include increased confidentiality, screening for sexually transmitted diseases, and decreased potential for complications such as legal custody (Hayman et al., 2014; McManus et al., 2006; Nordqvist, 2012; Wyverkens, Provoost, Ravelingien, De sutter, Pennings, & Buysee, 2014). However, female partners do not necessarily have access to complete medical and biological histories to determine potential risks when the donor is unknown (McManus et al., 2006). Most female partners decide to pursue fertility services with an unknown donor, due to the increased legal protection (Wyverkens et al., 2014). In addition, if female partners choose an unknown donor they must decide if the donor remains anonymous or if the child(ren) will be able to know the donor upon becoming an adult. When choosing a donor, female partners often strive to match the social mother's and donor's physical characteristics (Hayman et al., 2014).

When considering the method of conception and the type of donor, female partners must also consider potential legal ramifications of their decisions. There is a varying degree of legal

protection for female partners starting families. For example, egg donors are asked to revoke their parental rights even if the egg donor is intending to be a parent with the womb parent (Ehrensaft, 2008). Another example is the potential threat a sperm donor creates. Sperm donors may attempt to gain legal custody of the child(ren), especially if state regulations do not allow both female partners to be on the birth certificate (Ehrensaft, 2008; McManus et al., 2006). Judicial systems often believe that every child needs a mother and a father, which is at the discretion of individual judges to rule. Legal protections vary between federal, state, and individual institutions (Ehrensaft, 2008; McManus et al., 2006; Wojnar & Katzenmeyer, 2013).

Unlike heterosexual partners, both female partners have the potential to conceive, which is what makes the family formation process for female partners unique (Ben-Ari & Livni, 2006; Hayman et al., 2014; Johnson, 2012). Also, female partners are the only couples that have the option to create a family with children that are biologically related to both same-gendered parents (Ehrensaft, 2008; Nordqvist, 2012). There are several decisions that female partners make that are unique to their family formation process, specific to the conception process. Decisions include method of conception, type of donor, and how to navigate the heteronormative and homophobic healthcare systems (McManus et al., 2006; Rausch & Wikoff, 2017; Yager et al., 2010). In addition to decisions, female partners experience additional stress during conception including utilizing assisted reproductive technology, navigating discrimination in healthcare, and struggling for social and legal recognition as a family (Alang & Fomotar, 2015; Cherguit et al., 2012; Rausch & Wikoff, 2017; Somers et al., 2017).

There are additional barriers for female partners seeking healthcare services which include financial, structural, and cultural barriers (Carpinello et al., 2016; Fields & Scout, 2015; Nordqvist, 2012; Rausch & Wikoff, 2017). These barriers create unique challenges for female

partners seeking fertility services including limited donor selection, potential conception difficulty, legal concerns, limited support during conception, and medicalization of conception (McManus et al., 2006; Visser, Gerrits, Kop, van der Veen, & Mochtar, 2016; Yager et al., 2010;). Homophobia, specifically in the form of heterosexism, is a specific challenge for female partners financially, structurally, and culturally.

Despite the continued increase in visibility and acceptance of female partner parenthood, healthcare systems remain heteronormative and homophobic (Hayman et al., 2013.2; McManus et al., 2006; Somers et al., 2017; Yager et al., 2010). The healthcare system as an entity and individual healthcare providers can be engaging in practices that uphold heterosexism and homophobia. There are four types of homophobia, which include exclusion, heterosexual assumption, inappropriate questioning, and refusal of services (Hayman et al., 2013.2). An example of exclusion is the lack of recognition of female partners as family, which can exclude partners from medical decisions or restrict access to partners and their child(ren) during treatment (Fields & Scout, 2015; Hayman et al., 2013.2). Female partners identified that they felt excluded from healthcare services and that their decision to start a family was not in their control, rather in the control of the healthcare system (Cherguit et al., 2012). Further, healthcare providers assuming female partners are related or friends rather than partners is an example of exclusion and heterosexual assumption (Cherguit et al., 2012; Hayman et al., 2013.2; Heyes, Dean, & Goldberg, 2015). An additional example of heterosexual assumption is asking about the father (Hayman et al., 2013.2; Wojnar & Katzenmeyer, 2013). Examples of inappropriate questioning include asking about gender roles, the method of conception, joking about the possible ways conception could have occurred, and forms that exclude female partners (Hayman et al., 2013.2; Wojnar & Katzenmeyer, 2013). Lastly, examples of refusal of service are health

insurance providers that do not cover affirmative providers (Fields & Scout, 2015; McManus et al., 2006; Rausch & Wikoff, 2017), fertility clinics with policies inhibiting female partners' access to services, and individual providers declining to provide services to female partners (Hayman et al., 2013.2). An example of policy that inhibits female partners from accessing fertility services is requiring a medical diagnosis to receive in vitro fertilization (Hayman et al., 2014). Requiring a medical diagnosis refers to the process of diagnosing the individual receiving fertility treatment with a medical condition that deters natural conception.

Homophobia, specifically heterosexism, is expected by female partners during family formation, specifically during the conception process (Cherguit et al., 2012; Hayman et al., 2014; Yager et al., 2010). Female partners identify an association between negative experiences and conception due to anticipated heterosexism and homophobia (Cherguit et al., 2012). More specifically, social mothers report feelings of being unwelcome and misunderstood by healthcare providers, which impacted their ability to support their partners and participate in the conception process (Wojnar & Katzenmeyer, 2013). Examples of this exclusion are referring to the sperm donor as the father, restricting the social mother's medical decisions, and feeling excluded when healthcare providers' have difficulty naming and defining their co-parenting identity of female partners (Cherguit et al., 2012; McManus et al., 2006; Wojnar & Katzenmeyer, 2013). Female partners often manage homophobia and heterosexism in healthcare by tending to the relationship with the provider and attempting to avoid punishment such as being shamed, excluded, or receiving negative backlash (Cherguit et al., 2012; Heyes et al., 2015).

Homophobia and heterosexism can mask mental health concerns due to the exacerbation of feelings of exclusion, isolation, and otherness (Alang & Fomotar, 2015; Rausch & Wikoff, 2017; Wojnar & Katzenmeyer, 2013). Also, females report higher levels of depression and

anxiety related symptoms when engaging in fertility services (Peterson et al., 2012; Rausch & Wikoff, 2017). Historically, the role of counseling in fertility clinics was to provide crisis intervention for infertility and conduct assessments of eligibility prior to treatment (Peterson et al., 2012; Rausch & Wikoff, 2017; Visser et al., 2016). Conducting assessments to evaluate the psychosocial wellbeing of individuals and couples seeking fertility services continues to be a prerequisite requirement (Hayman et al., 2014; Peterson et al., 2012); however, services are continuing to evolve with the needs of those seeking services including teaching specific interventions to manage conception challenges, developing coping skills, providing education on alternative options, disclosing conception, offering medical and legal information, and facilitating grief counseling (Peterson et al., 2012; Visser et al., 2016).

Fertility counseling, prior to engaging in conception processes, typically emphasizes decision-making and the implications surrounding various decisions (Peterson et al., 2012; Visser et al., 2016), for example deciding the type of donor or disclosing to the child(ren) a donor was involved. Fertility services were created for heterosexual couples experiencing difficulties conceiving and the heteronormative structure continues to be upheld in fertility services (Ehrensaft, 2008; Rausch & Wikoff, 2017). For example, fertility services and counseling are most commonly referred to as infertility services and counseling, though female partners may not be seeking services specifically for infertility. The resources and education available is often related to infertility as well, or targets heterosexual couples (Alang & Fomotar, 2015; Cherguit et al., 2012; Ehrensaft, 2008; Fields & Scout, 2015; Hayman et al., 2013.2; Nelson, 2008). Another example is that during fertility counseling counselors explore the decision to share with their child(ren) if a donor was used or not. Female partners do not have a choice if their child(ren) know they used a donor to conceive. Fertility counseling has attempted

to be more inclusive and enhance multiculturalism competency in recent years (Rausch & Wikoff, 2017). However, these advances may not be specifically beneficial for female partners (Rausch & Wikoff, 2017).

Female partners are reluctant to seek counseling services during family formation due to concern for child well-being, perception about their ability to be parents, and stigma related to mental health (Alang & Fomotar, 2015; Visser et al., 2016). In addition, they are reluctant to disclose negative feelings during the conception process due to conception being considered a medical task (Cherguit et al., 2012; Wyverkens et al., 2014). Female partners have endorsed feeling screened for parenthood during fertility counseling and have reported the desire to have separate counseling beyond the screening process (Visser et al., 2016). Female partners have indicated a need for counseling at later stages of family formation, rather than during the conception process (Rausch & Wikoff, 2017; Visser et al., 2016). Specifically, female partners have indicated a desire for counseling to disclosure topics related to fear of rejection from their child(ren), future contact from the donor, legal concerns following birth, and family legitimacy concerns (Rausch & Wikoff, 2017; Visser et al., 2016). Inclusive paperwork, posters, pamphlets, and rainbow stickers are not enough to create a safe space for queer seeking counseling because even with these gestures, the space can be inhibited with individuals that are unaware or hostile towards queer people (Heyes et al., 2015). For example, female partners share a waiting room with heterosexual females who are experiencing infertility, while female partners are potentially experiencing more excitement and success in their fertility services (Ehrensaft, 2008; Heyes et al., 2015). In conclusion, there is limited research available about the counseling experiences of female partners during family formation (Rausch & Wikoff, 2017; Visser et al., 2016; Yager et al., 2010). Without an understanding of the experiences female partners encounter during

counseling, it is impossible to generate inclusive practices, advocate for change, and challenge homophobia in services provided.

2.7. Summary

In conclusion, female partners experience a plethora of unique barriers and challenges when considering parenthood. Female partners are also at higher risk of physical and mental health concerns due to minority stress which can be exasperated by barriers and challenges, specifically related to homophobia and heterosexism. Female partners expect to experience homophobia and heterosexism when engaging in family formation and will often associate negative experiences with homophobia. When considering parenthood, female partners consider a multitude of factors including division of parental roles, method of conception, type of donor, legal considerations regarding child custody and family legitimacy, and more. Female partners have reported feeling isolated, excluded, and invisible throughout the process of negotiating these factors of family formation. Yet, individuals receiving third-party fertility services are required to attend counseling.

Many counselors report feeling uncomfortable or underprepared to work with queer individuals, and there is limited research available for counselors to refer to when working with queer couples and families. However, most counselors will work with queer individuals throughout their career. This begs the question, are counselors prepared and competent to provide counseling services to female partners during family formation? If there is limited research available regarding counseling queer couples and even scarcer research on female partners engaging in family formation, how will counselors familiarize themselves with competencies to enhance their understanding of the unique experiences they have? Female partners are reluctant to seek counseling and are still required if they want to create a family

using third-party fertility services. This study explored how counselors can engage in culturally sensitive and affirmative services when working with female partners during family formation to enhance service outcomes and challenge female partners' expectation of homophobia and heterosexism.

3. METHODOLOGY

3.1. Introduction

In Chapter One, the researcher considered the historical context of female partners' experiences engaging in family formation, illuminated the limitations in current research, and proposed a study examining the how female partners experience counseling services during family formation. The researcher further analyzed, synthesized, and conceptualized these barriers and challenges, while focusing on the implications in Chapter Two. In this chapter, the researcher outlines the proposed methodology for the study including the framework of the study, participant selection, procedural implementation, and limitations. To better understand the framework of this study Feminist Theory will be introduced before further describing this study.

3.2. Feminist Theory

Feminist Theory recognizes the importance of the lived experiences of marginalized populations with the goal being to discover subjugated knowledge (Hesse-Biber, 2007). Experience is informed by specific circumstances, conditions, values, and relations to power (Hesse-Biber, 2007; Sprague, 2005). Listening to the experience of marginalized populations allows for a more encompassing understanding of knowledge (Hesse-Biber, 2007). Feminist Theory views knowledge as partial, situated, subjective, power imbued, and relational (Hesse-Biber, 2007; Westmarland, 2001). Knowledge is achieved through understanding the specificity and uniqueness of marginalized populations' lives (Hesse-Biber, 2007). Feminist Theory strives towards activism to change basic structures of oppression (Hesse-Biber, 2007; Westmarland, 2001).

There is no one Feminist Theory, rather there are a multitude of feminist lenses incorporating basic principles including relationship, power differentials, resistance and transformation, and intersectionality (Hesse-Biber, 2007; Westmarland, 2001). Feminist Theory emphasizes egalitarianism, meaning that relationships should be created with shared value between individuals (Brown, 2012). Each individual is an expert and collaborates to create shared knowledge. In addition, a central focus in Feminist Theory is power. More specifically, empowerment within dominant ideological structures. Privilege and social location confer experiences in society, advantaged or disadvantaged (Brown, 2012 ; Gannon & Davies, 2007; Hesse-Biber, 2007). In order for marginalized populations to shift to empowerment, privilege and social location must be examined, deconstructed, and reconstructed (Brown, 2012; Gannon & Davies, 2007; Hesse-Biber, 2007). The reconstruction is the process of resistance and transformation. The final principle of Feminist Theory is intersectionality. Intersectionality refers to the multiple identities that an individual simultaneously balances such as race, gender, religion, ability, and affectional orientation (Brown, 2012; Gannon & Davies, 2007; Hesse-Biber, 2007).

Feminist Theory informed the proposed study of counseling female partners during family formation and is grounded in the feminist principles of relationship, power differentials, resistance and transformation, and intersectionality. Feminist Theory aligns with this study because female partners are a marginalized population with intersecting identities whose experiences are missing in fertility counseling research. In addition, this study integrates a Feminist Theory framework with an Interpretative Phenomenological Analysis (IPA) design as female partners engaging in fertility counseling is a particular lived experience. Interpretative Phenomenological Analysis emphasizes the in-depth exploration of a particular lived experience

which is expressed in its own terms, rather than being expressed in predetermined categories (Smith, Flowers, & Larkin, 2012). Feminist Theory empowers individuals by examining and challenging societal norms and expectations in order to have more diverse representation of experiences. Therefore, Feminist Theory and IPA are complementary. Furthermore, Feminist Theory and IPA both encourage a researcher-participant relationship to be equal and allow for the researcher and participant to make meaning of the experiences being shared. Interpretative Phenomenological Analysis will continue to be discussed in the next section.

3.3. Research Design

This qualitative study employs an Interpretative Phenomenological Analysis (IPA) design. Interpretative Phenomenological Analysis aims to explore, in-depth, the lived experiences of individuals in particular circumstances or events (Smith & Osborn, 2008). The emphasis is placed on how individuals are making sense and creating meaning of their lived experiences, which is what researchers are interested in understanding (Smith & Osborn, 2008). It is assumed that individuals are the experts on their experiences and can actively interpret experiences in their lives (Pietkiewicz & Smith, 2012).

Interpretative Phenomenological Analysis is rooted in three foundations: phenomenology, hermeneutics, and ideography (Pietkiewicz & Smith, 2012). More specifically, IPA pulls from phenomenology a focus on identifying essential components of experiences, or phenomena, that are unique to specific individuals (Pietkiewicz & Smith, 2012). Hermeneutics refers to the process of understanding the emotional and psychological mindset of the individual and the language used to communicate their experiences (Pietkiewicz & Smith, 2012). Interpretative Phenomenological Analysis applies a dual interpretation process because the individuals are making meaning of their experiences, and the researcher attempts to decode the

meanings from the individual's perspective (Pietkiewicz & Smith, 2012). Lastly, ideography refers to the in-depth examination of individual cases and the individual's unique perspectives (Pietkiewicz & Smith, 2012). Researchers focus on particulars versus generalizations (Pietkiewicz & Smith, 2012).

Due to the foundations of IPA, the lived experiences of individuals are central, and researchers are concerned with eliciting rich, detailed, first-person accounts of the experiences under investigation (Pietkiewicz & Smith, 2012). In order to elicit the depth required for IPA, researchers typically recommend between three and eight participants (Smith et al., 2012). In addition, IPA researchers strive for homogenous samples (Pietkiewicz & Smith, 2012). Smaller homogenous sample sizes allow the researcher to immerse themselves in the experiences of the participants and to analyze similarities and differences between cases (Pietkiewicz & Smith, 2012). As mentioned, the individual lived experience is central to IPA research and the goal is not to identify generalizations but rather particulars of individual experiences. Therefore, there is a specific rigor to analyzing individual cases prior to analyzing similarities and differences between individuals. The more IPA studies are conducted on a specific experience, the more understanding and knowledge are available to make generalizations (Pietkiewicz & Smith, 2012).

3.4. Research Questions

The purpose of the study was to explore the experiences of female partners receiving third-party fertility treatments. More specifically, the researcher aimed to identify the perceived implications of counseling services during the family formation process and to develop implications for counseling practices specific to female partners during family formation. The overarching question of this study was "How do female partners experience counseling during family formation?" As part of exploration, the researcher wanted to know more about the

potential role of counseling in female partner family formation by understanding their experiences during family formation and counseling services, if applicable. Specifically, the overarching question informed the researcher about the lived experiences of female partners during family formation, including potential homophobia and heterosexism experienced, their level of satisfaction and how they perceived the services received, topics addressed, and potential counselor areas of strength and weakness. The secondary research questions were (a) what perception did female partners have of their providers(s)?, (b) what expectations did the female partners have of counseling during family formation?, and (c) how do female partners perceive their providers' ability to provide culturally sensitive and affirmative counseling services when working with female partners during family formation?

3.5. Participants

Participants involved in this study were recruited via convenience and snowball sampling with requested assistance from statewide counselors enrolled in the state counseling association listserv, counseling professionals enrolled in American Counseling Association-related listservs, professional colleagues of the researcher, and regional and national queer support organizations. Additionally, this researcher used recruitment methods seeking specific participant criteria to gain comprehensive information about female partners' experiences when engaging in family formation. Inclusion criterion for participants included: (a) participants self-identified as female, (b) participants identified as queer, including but not limited to, lesbian, bisexual, pansexual, or demisexual, (c) participants were coupled and both partners agreed to participate in interviews, and (d) participants must have, as a couple, received third-party fertility services to conceive at least one child together. A total of three couples, or six individual participants, were recruited and saturation was reached, meaning additional participants were not recruited.

3.6. Procedures

Prior to conducting this study, the researcher obtained Institutional Review Board (IRB) approval (HE18183). After initial IRB approval the researcher amended participant inclusion criteria to expand inclusion of more individuals. The initial inclusion criteria included: (a) participants self-identity as female, (b) participants self-identify as queer, (c) participants are couples and both partners agree to participate in interviews, (d) participants, as a couple, attended counseling services (psychiatric evaluation or fertility counseling) to receive third-party fertility services to conceive at least one child together, and (e) participants live in a 350 mile radius of the researcher. Inclusion criterion c was edited to remove the condition of counseling services due to the variances in state and facility requirements surrounding these services. Inclusion criterion d was removed entirely in order to enhance inclusivity of participants. These inclusion criteria amendments were approved by the IRB and did not impact participants previously participating in the study.

Upon IRB approval, the researcher conducted face-to-face and video/phone interviews. The researcher recruited participants by contacting statewide and national counselors, colleagues, and queer support organizations via verbal communication, e-mail, and flyer. The researcher contacted statewide and national counselors via the state counseling association listserv and American Counseling Association-related listservs. In addition, the researcher contacted regional and national support organizations requesting to share information and display a flyer inviting participants to the study. As mentioned, the researcher verbally and/or via e-mail contacted these individuals to provide information regarding this study, the inclusion criteria, and to provide a flyer for potential display. They were asked to provide the researcher's information to potential participants via the flyer. Once participants volunteered to participate in this study,

this researcher explained the study, screened potential participants for eligibility by asking about the inclusion criteria, and discussed questions and concerns the potential participants had.

Participants were asked to participate in a 60-90 minute semi structured face-to-face or video/phone interview. Participants chose a location that was comfortable, convenient, and private for the interview, as well as the method of interview that was most convenient if interviewing at a distance. Prior to the scheduled interview participants were provided a copy of the interview questions (Appendix E) and informed consent (Appendix D). The researcher verbally reviewed informed consent and confidentiality prior to beginning the interview and encouraged the participant to ask any questions they had. To ensure additional participant confidentiality, this research required a signature waiver. The signature waiver provided additional confidentiality because the participant's information is not documented on any paperwork, including informed consent. Once the participant verbally indicated understanding and agreement with informed consent, the interview began. The researcher provided the participant with an additional printed copy of informed consent (Appendix A) for their records, when face-to-face interviews occurred. The semi structured interview included questions pertaining to their experiences of services received during family formation (Appendix E). More specifically, questions included open-ended questions about their perceptions of the services they received, their satisfaction with the services they received, and, their suggestions for counselors working with female partners during family formation, and the themes they identify in their experiences of counseling during family formation.

The interviews were audio recorded using two recording devices, to ensure proper recording, and the researcher had a notebook for field notes, which was utilized periodically during the interview. At the conclusion of each interview the researcher conducted additional

field notes relating to the interview experience and observations. The audio recordings were transferred to a password protected flashdrive and the audio recordings were deleted from the recorders. The interviews were transcribed by the researcher and electronically saved to the same flashdrive as the audio recordings, which is password protected. This flashdrive was stored in a locked container that also included field notes and printed transcripts. This researcher collected data for approximately one month in order to interview three couples, or six individuals. Prior to the initiation of this study, this researcher obtained Institutional Review Board (IRB) approval from North Dakota State University by completing the formal process outlined by North Dakota State University.

3.7. Reflexivity Statement

In relation to qualitative research, the issues of researcher bias are addressed to promote the ideal of trustworthiness. For the proposed study, the researcher is a 28-year-old White individual who identifies as a cisgender female and is working toward a doctorate in counselor education. The researcher identifies as queer and is married to her female partner. She is at the level of complete disclosure of her affectional orientation within her personal and professional lives and participates in activities hosted by queer community organizations. The researcher and her partner have periodically discussed the potential of creating a family throughout the past four years, although have not explored options with professionals or made advancements towards creating a family. They have engaged in discussions emphasizing concerns about access to services; methods of conception and donor criteria; alternatives to conception; parenting concerns; and concerns of family, community, and healthcare support. Currently, they are not considering family formation and do not plan to create a family. The researcher identifies

concerns with becoming a parent for personal reasons and due to concerns of homophobia and heterosexism in the rural community she currently lives.

This researcher has experienced homophobia and heterosexism based on her affectional orientation. For example, physicians asking how she knows she is not pregnant, an employer asking her to not to have a public relationship with her partner, and family members not attending her wedding due to her marrying a woman. This researcher has also experienced sexism based on her gender. This researcher, must then note, that she holds the assumption that queer women have unique experiences based on their intersectional identities that include experiences of homophobia, heterosexism, and sexism. In addition, this researcher holds the assumption that queer women engaging in family formation via third-party fertility services are predominantly more privileged identities (i.e. white, educated, upper middle-class women) due to financial means, access, and societal positioning. Therefore, the researcher is assuming that the sample size for this study will be homogenous and will be illuminating the experiences of a subgroup of female partners engaging in family formation.

In addition to personal experience as a queer female, this writer has engaged in professional activities advocating for queer human rights. The researcher was a volunteer staff member for a state facilitated Safe Zone Project, which was a grant funded project aiming to provide cultural competency training to various institutions in the state. Also, the researcher has presented at state, regional, and national conferences related to LGBQQA issues including cultural competency training, female partner family formation, and supervising LGBQQA counselors-in-training. This researcher has the assumption that individuals, couples, and families should have equal human rights and privileges as persons identifying with societally normed identities.

Lastly, this researcher identifies as a feminist and will be conducting this study through a feminist framework. This researcher assumes that there is no one truth and that knowledge is subjective. In addition, this researcher assumes that researcher bias cannot be absent in research. Rather, this researcher believes that researcher bias will be present throughout the formation and execution of this study because the researcher assumes that knowledge is created through experiences and meaning. Through consistent self-reflection this researcher will have to evaluate personal values, attitudes, beliefs, and experiences and their connection to this study.

3.8. Data Analysis

The researcher transcribed the audio recorded interviews, changing all identifiable information, and used Interpretative Phenomenological Analysis to further identify, analyze, and report themes. This researcher engaged in a double analysis process, meaning the data was analyzed two separate times. The first analysis was of each individual case, meaning that individual participant themes were identified for each of the six participants. Once each individual case had been analyzed, the researcher analyzed the themes a second time by analyzing the data of all participants as whole. After the double analysis process the researcher reviewed the themes of the individuals and entire participant group to report similarities and differences. The researcher employed the analysis process on each individual case by repeating the same analysis process. The researcher read each transcription and listened to each audio recording three times prior to beginning to identify themes.

To identify themes this researcher utilized IPA. Interpretative Phenomenological Analysis is comprised of six steps outlined by Smith et al. (2012): (a) reading the first transcript as a whole (b) taking general notes, (c) culling emergent themes from the first case, (d) searching for connections across themes, (e) transitioning to the next transcript (and later transcripts), and

finally (f) searching for patterns across the participants' transcripts. The researcher read the transcriptions twice, on the third reading of the transcriptions the researcher began writing notes in the margins to begin identifying themes. After the third reading of the transcriptions, the researcher began to code data by underlying and naming themes. Once themes were identified and named, the researcher reviewed the transcriptions an additional time to ensure all themes were identified and named.

The researcher then reviewed the themes by writing possible themes on pieces of blank paper or a whiteboard and wrote each theme on a post-it and placed it with an initial overarching theme. Once the researcher categorized all of the themes into possible overarching themes, the researcher evaluated them for appropriateness and representation by reading though the themes and context surrounding the theme in the transcript. The researcher reviewed themes to ensure they were represented and were organized into possible subthemes. Finally, the researcher defined and named the themes. As mentioned, this process occurred individually for each participant. Once themes were identified for each participant, the researcher analyzed similarities and differences in themes between individuals. Finally, the researcher identified themes for the entire participant sample and analyzed for similarities and differences between couples.

3.9. Trustworthiness

This researcher had a committee that was comprised of one Associate Professor and one Assistant Professor that are both employed in the field of Counselor Education and Supervision. The Associate Professor is heterosexual female who does not have children. She has conducted research that illuminates the power differentials of women in professional settings and has been involved in community LGBTQAA activities. The Assistant Professor is a heterosexual female

that conceived a child via In Vitro Fertilization. She has attended fertility counseling and has awareness of the third-party conception process. Both committee members identify as feminists.

This study employed several strategies for trustworthiness. This researcher engaged in reflexive journaling to identify and address researcher bias and to document thoughts and insights throughout the progression of research. Reflexive journaling demonstrated credibility and authenticity during this study. In addition to reflexive journaling the researcher conducted field notes. Field notes were conducted during and at the conclusion of each interview to increase dependability of the data collected. Along with field notes, the researcher kept an audit trail to record the systematic processes of data collection and analysis. The audit trail was available for the researcher's committee. The researcher's committee also engaged in triangulation of investigators. After the data analysis process the committee members reviewed and interpreted the themes identified by this researcher to strengthen the design. Lastly, this researcher demonstrated transferability through thick description and confirmability was demonstrated by bracketing the researcher's assumptions.

3.10. Priori Limitations

There were numerous priori limitations to this study including limited access to counselor data, limited geographical representation, and assumptions regarding the counseling experiences of female partners during family formation. First, the researcher had limited access to counselor data. This researcher did not interview counselors working with female partners, rather only the female partners participating in third-party fertility services to explore their experiences, and did not have access to information regarding the counselors' theoretical orientation, perception of preparedness, access to or completion of cultural competency training, level of experience, specialty areas, or additional information. Furthermore, this researcher chose a design,

Interpretative Phenomenological Analysis, which typically employs a homogenous sample (Pietkiewicz & Smith, 2012) to gain an in-depth understanding of particular experiences.

Finally, limitations existed with regard to the assumption that female partners will experience homophobia and heterosexism when receiving services, specifically counseling, during family formation. Homophobia and heterosexism can be difficult constructs to identify due to structural oppression. Individuals experiencing homophobia and heterosexism may be desensitized to certain degrees of homophobia and heterosexism due to everyday minority stress. Also, it may be difficult to differentiate between homophobia and heterosexism and other factors that may contribute to negative experiences in counseling such as counselor incompetence or counselor disposition. These priori limitations identified are important to consider when preparing for, conducting, and examining the results of this study.

3.11. Summary

Chapter Three described the methodology for this study by outlining participant selection, procedural implementation, and known limitations. The researcher proposed a qualitative study utilizing an Interpretative Phenomenological Analysis design to explore the in-depth experiences of female partners receiving services during family formation. The researcher employed convenience and snowball sampling to invite participants, female partner couples, to participate in the study which included semi-structured interviews. The researcher recorded and transcribed the interviews and analyzed themes. In Chapter Four, the researcher reports the findings of this study.

4. RESULTS

4.1. Introduction

In Chapter One, the researcher shared the historical context of female partners' experiences engaging in family formation and proposed a study to examine female partners' experiences when receiving counseling services during family formation. The barriers and challenges of female partner family formation were further explored, with an emphasis on counseling implication in Chapter Two. In Chapter Three, the researcher outlined the methodology for a qualitative study intended to explore the in-depth experiences of female partners receiving services during family formation. The results of this study are presented in this chapter.

4.2. Research Questions

The question "How do female partners experience counseling during family formation?" was the overarching question that guided the data collection and data analysis. In addition, the following questions were secondary questions that aided in data collection and analysis process:

1. What perception did female partners have of their providers?
2. What expectations did the female partners have of counseling during family formation?
3. How do female partners perceive their providers' ability to provide culturally sensitive and affirmative services when working with female partners during family formation?

The researcher addressed these questions in data collection via semi-structured interviews with participants evidenced by the interview questions (Appendix E).

4.3. Participants

To recruit participants, the researcher e-mailed nine professional colleagues, four listservs targeting counselors and counselor educators, two local LGBQQA organizations, and 18

LGBQQA Facebook organizations specific to LGBQQA parents and lesbians trying to conceive to provide them with information pertaining to the study including inclusion criteria and asking them to share the information with potential participants (Appendix B). In addition, the researcher attached a flyer to the e-mail for convenient sharing of information and potential advertisement (Appendix C). Participants were asked to contact the researcher directly via e-mail or phone to communicate interest in participating in the study.

Five couples e-mailed the researcher and expressed their interest in participating in the study. One couple replied to a counseling listserv, one replied to a direct e-mail as a colleague, and three replied to Facebook posts. Two couples decided not to participate in the study, due to unknown reasons, leaving a total number of three interviewed couples, or six participants. All six participants met the inclusion criteria (identified as female, identified as queer, coupled with a female partner with both partners willing to participate, and partner received third-party fertility services to conceive at least one child together). The researcher did not request demographic information from participants due to small sample size and to maintain additional privacy. However, participants ranged from age 32 to age 48, and all couples identified as married at the time of the interviews.

Couple one, Merilou and Jessie, lived in the Midwest United States and conceived one child via IUI using an unknown donor outside of the United States. They received fertility services with a local Obstetrics and Gynecology (OBGYN) provider and were not required to receive counseling services prior to receiving third-party fertility services. However, Merilou and Jessie both indicated that they have established services, individually, with psychiatrists that provided treatment prior, during, and after their family formation process. At the time of the interview their child was approximately 20 months old and was present during the face-to-face

interview, which occurred at their residence. Merilou and Jessie reported experiencing one miscarriage prior to the birth of their child. Furthermore, Merilou disclosed that she had attempted to conceive a child in a previous relationship that was unsuccessful using IUI and was unable to attempt conception again due to a medically necessary hysterectomy. Both Merilou and Jessie have completed graduate education. In addition, they have been coupled for five years.

Couple two, Terra and Dani, lived in the Southwest United States and conceived one child via IUI using an unknown donor in the United States. They received fertility services at the only local fertility clinic in their community and were required to attend one fertility counseling session prior to receiving third-party fertility services. Dani indicated that she has established individual services with a counselor and had been receiving services prior to and during their family formation process. Terra and Dani indicated that they did not receive additional counseling services individually or as a couple for family formation. At the time of the interview their child was approximately five years old and was present during the video interview, which occurred in their residence. Terra and Dani reported that pregnancy occurred on the first IUI attempt. However, they indicated that approximately a year and a half ago, they attempted IUI once and were unsuccessful. Both Terra and Dani have completed graduate education. In addition, they have been coupled for over a decade.

Couple three, Teagan and Sara, lived in the Northeast United States and conceived one child via Frozen Embryo Transplant (FET). They received fertility services at a fertility clinic located approximately an hour and a half drive from their residence and were required to attend one psycho-educational appointment with a counselor prior to receiving third-party fertility services. At the time of the interview they were six weeks pregnant. They participated in a

phone interview, which occurred at their residence. Teagan and Sara reported experiencing six unsuccessful IUIs and an unsuccessful IVF prior to conception. Both Teagan and Sara completed graduate education. In addition, they have been coupled for over a decade.

In summary, all six participants self-identified as queer females, completed at least one graduate degree, are married, and have conceived at least once child together in the context of their relationship with another female. In addition, all participants were in a relatively similar age range and represented differing regions of the United States.

4.4. Procedures and Results

4.4.1. Procedures

To conduct the study, the researcher utilized Interpretative Phenomenological Analysis (IPA) as outlined by Smith et al. (2012): (a) reading the first transcript as a whole, (b) taking general notes, (c) culling emergent themes from the first case, (d) searching for connection across themes, (e) transitioning to the next transcript (and later transcripts), and finally (f) searching for patterns across the participants' transcripts. These steps were completed after six interviews to collect data: generating individual case emergent themes and super-ordinate themes and then generating emergent themes and super-ordinate themes across all participants. To prepare for the semi-structured interviews, the researcher defined the presenting problem; determined the goals and purposes; defined the focus; recruited and selected participants; determined the participation methods; developed the schedule, communication plan, and format; and gained IRB approval.

After receiving e-mail inquiries from potential participants, the research replied with an initial e-mail, which included a copy of the informed consent, interview questions, and researcher availability to schedule interview. The potential participants were asked to review the

documents and, if still interested, reply with their availability to schedule an interview. In addition, in the initial e-mail the researcher asked clarifying questions to evaluate inclusion criteria, if not included in the potential participant's original e-mail. Three couples, six participants, agreed to participate in individual semi-structured interviews and scheduled interviews. The participants were interviewed individually and were audio recorded for data analysis.

4.4.2. Results

This researcher was interested in how the participants experienced and perceived counseling during family formation. Through the participants' interviews, the researcher acknowledged that counseling is one piece of a large puzzle and that there are opportunities beyond the conception process for counselors to be helpful during female partner family formation. In order to know how counseling was experienced, we must first understand the overall experience of female partner family formation including family preparation, family issues, and provider competency.

4.4.3. Theme One: Family Preparation

First, a large piece of the family formation process for the participants was research. Several participants described their research efforts, which included Internet searches and involvement in Facebook groups specific to female partner family formation. Terra indicated she began researching prior to the first appointment at the fertility clinic, "We did our own research, but I still felt like I had a lot of questions" while Merilou engaged in research throughout the family formation process, "We had to do a lot of research on our own to figure out the ICI, IUI, and all that sort of stuff but I don't know what the doctor could have necessarily done." As mentioned, several participants endorsed the importance of Internet searches and

involvement in Facebook groups. For example, Jessie describes how she received the majority of her education on family formation from Facebook groups, “I would say that the self-education includes a lot of different things like knowing what kind of sperm you’re going to get, knowing your own cycles...the main component of my self-education, I would say would be Facebook groups honestly.” Whereas, Dani emphasizes that Internet searches were a key component in gathering information about family formation, “First looked online...we did our own research.”

In addition to participants researching family formation on their own, they also expressed struggling to gain information from providers. Teagan describes her frustration with wanting more information and guidance from providers, “I just needed somebody to like hold my hand and tell me that, and I, I felt like I needed to kind of figure it out myself.” And Sara recalls specifically asking providers for additional information, yet providers were not forthcoming, “We tried to get clarification about what’s the purpose of it, we, we couldn’t.” More specifically, several participants described not having enough information available to them regarding the process of family formation. For example, when describing the need to engage in independent research, Jessie recalled the limited information her provider gave, “They told us about how, you know, your cycles work, ah, kind of just general education about family planning.” Terra also shared the continued impact of not having access to additional information to prepare her for family formation, “There totally could have been questions that could have been asked specifically for us, that we could have, topics that we could have explored that didn’t, topics that we think about, that we prepared ourselves.” Lastly, Sara explained her struggle with having limited information throughout the family formation process:

They could have warned us, like you know, it’s an emotional process...there’s a whole host of things they could have told us about that would have been helpful. We had to learn...I wish we would have known about the, like, the private Facebook groups...like

the two week wait, that would have been helpful information. Like when, how do you tell, when do you involve family members

4.4.4. Theme Two: Family Issues

Furthermore, beyond the desire to have more information family issues were identified as a more important piece of the process that counselors can address including develop skills to cope with grief, manage financial burdens, navigate legal concerns, explore decision making, discuss parenting styles, and build social support. Participants identified that discussing potential complications during fertility, addressing the need for a support system, and navigating the plethora of decisions would have been beneficial during the family formation process.

All couples experienced difficulties during conception including failed conception attempts and miscarriages. They also indicated that they did not anticipate or feel prepared to cope with conception difficulties. Jessie described how addressing potential conception difficulties would have been helpful, “That miscarriage with a counselor, probably would have been a good thing to talk about. Um, just knowing what to expect...things could happen, things to expect how to process all that.” While Dani also emphasized the need for coping skills to manage grief and loss, “How to cope with the fertility is not successful would have been helpful too, some coping skills, what to expect and how to handle it probably would have been helpful too.” Also, Sara discussed the need for more preparation of difficulties and how to navigate the general family formation process, “Cluing us in that it’s going to be hard and how are you going to navigate the process with your employers...like be prepared for the fact that you’re probably going to have a no at some point...like little, little tips would have been helpful.”

Furthermore, participants indicated the need to address additional components of navigation during family formation. For example, Merilou described potential legal considerations for female partners engaging in family formation “I think they need to be aware

of laws in the state...what's the state law on that and how does that play out in real life...but like in [state] second-parent adoption for gay parents is specifically against the law.” In addition to legal considerations, Terra discussed the importance of selecting a donor “talking about open or closed person, open or closed donors, like maybe the pros and cons...I think it would have been helpful coming from a third-party who could kind of help us, um, what's the word, um explore more of that.” And Jessie summarizes the complexity of the decisions that female partners consider during family formation, “A whole bunch of different things go into, going to play when you're trying to have kids and trying to make it work.”

In addition to potential difficulties during conception and navigating the family formation process, participants described the need for support. Teagan described the importance of a support system during family formation, “figuring out the support system you're going to use and then also being open to talk with your partner about when you're going, when you're going to call it quits.” Teagan also emphasized that family is not always supportive and cannot be included in the support system during family formation, which Sara further explained “I think that's what's different for LGBQQA couples versus, you know, heterosexual couples who don't have to deal with coming out with their families losing their shit if they're having, um, if you as a lesbian couple or gay couple are having a baby...there are so many different factors that come into play.” As mentioned previously, all participants identified involvement in Facebook groups specific to female partners conceiving children and indicated this was a major source of information and support.

In addition, participants identified topics and resources that would have been more beneficial to address in counseling when engaging in the family formation process. For example, Jessie identified that it would have been helpful to process individual mental health concerns,

“especially during those rough, rougher, times. I did end up with pretty bad postpartum anxiety...so having someone to process that and talk through that would have been pretty helpful...even family planning talking about what’s this going to look like probably would have been helpful.” Though Terra indicated that it would have been helpful to have a more comprehensive knowledge of the individual steps prior to engaging in fertility services, “I wish there was more of a, like a, like a list of something where you can see the steps that you will have to go through because I knew that there would be a lot of stuff...I wish we would have had a little better idea of what we were, you know, in for.” Another example of additional topics or resources that could have been helpful during family formation was providing additional resources specific to female partners including pamphlets, books, and articles. Teagan expressed desire to have access to these types of resources, “I just think to understand the calendaring of it all because every month is different...I didn’t have enough information, like I said, if they would have given me some articles to read I would have read them.”

4.4.5. Theme Three: Provider Competency

Lastly, participants shared their experiences receiving services throughout family formation including perceptions of providers, heteronormative culture, counseling services, and provider competency. The majority of participants indicated high regard for their primary providers including identifying their providers as supportive. For example, Terra described not being able to choose her fertility specialist due to living in a rural area and expressed relief regarding her experience with the provider, “We couldn’t choose our specialist, so, but it turned out to be awesome because he was a really, really awesome doctor but we didn’t have a choice.” While Merilou expanded on how her provider was supportive by describing the provider as “really open and honest and decent.” Although, overall, participants recalled positive

experiences with their providers, each couple did acknowledge at least one negative experience with supplemental providers. Jessie shared an experience with a weekend on-call provider she saw for insemination, “he was totally, he was insensitive...he was like, don’t expect this to take...he probably just didn’t read the chart and didn’t know who were and just thought maybe that I was coming in with my mother to have this done.” And Terra described a negative experience with a provider that was proximately closer than the provider during her first fertility treatment, “I was crying because I felt like it was, I already knew it was going to be unsuccessful. I just didn’t feel the confidence and the support that I did with our doctor in [state]...I just kind of felt like they didn’t care, like we were just a number, just an appointment...the doctor was so rude and so disrespectful.”

Although participants did not specifically associate these negative experiences with heteronormative culture or discrimination, participants did identify experiences based on pressure from heteronormative culture systematically. Sara described the influence of policy on female partners engaging in family formation and the additional financial barrier when insurance does not cover fertility services, “if you’re a heterosexual couple and the reason that, if male infertility is a problem, like low sperm count, if the sperm is the problem and you need, and the sperm is deemed medically necessary then insurance covers it. I’m like but it technically is medically necessary for us because we don’t have any.” Terra also expressed frustration with heteronormative culture in fertility clinics and described having to engage in diagnostic testing for infertility, “unless a heterosexual couple has fertility problems then they don’t have to pay to get pregnant but we do...when you’re pregnant you have to have lots of visits but I had to have a lot more visits and I felt like my privates weren’t privates, they were public all the time.” While Sara and Terra identified heteronormative culture’s influence on their family formation process,

Jessie appeared less cognizant of the its presence, “[provider], was just like, I would think that she would act the way she was with any couple, I didn’t feel like she was singling us out, you know, I just felt like a normal person, like, I didn’t feel like she had given us any special treatment or told us anything different that she, if it was a straight couple coming in for fertility treatments.” This is viewed as heteronormative due to the denial and invisibility of uniqueness of female partners’ experiences. Female partners have unique challenges and experiences during family formation and cannot simply be treated like heterosexual couples.

In addition to negative and heteronormative experiences with fertility providers, participants described their experiences receiving counseling services. Two couples, or four participants, were required to engage in some form of counseling prior to receiving fertility services. However, all couples were asked to describe their expectations of counseling when engaging in family formation, their perceptions of how counseling could have been helpful, and to identify attributions of a competent counselor when working with female partners during family formation. Overall, participants indicated that they did not expect counseling to have a role in the family formation process. For example, Jessie indicated “I didn’t even consider [counseling] an option really...it wasn’t really an expectation or thought that even crossed my mind.” Conversely, participants that were required to attend counseling services endorsed perceiving counseling as checkbox to complete. Terra shares her thoughts regarding required counseling services, “I just saw it as one of the steps to get to the ultimate goals...let’s get this done because you told it’s what we have to do...so we came in, I think with low expectations. I didn’t, I didn’t expect to get anything out of it other than clearance.” And Teagan echoes Terra’s message of obligation and low expectations by stating, “I don’t know that I was counting on that

counselor to give me anything besides the approval to move forward but I don't know what she's basing her approval on."

Furthermore, participants required to attend counseling services did not have the privilege to choose their counselor, rather, the fertility clinics had established counselors. Participants shared negative experiences with counseling related to counselors' lack of preparedness to work with female partners during family formation. Teagan described the counseling session she attended as a bad first date and expressed her frustration with the experience, "It was like a painful date and I was telling her my life story but she wasn't talking about anything, about the whole process or anything like, I thought I was going to get some education...it was a total waste of time...we didn't get anything out of it...when is this over? Like, what boxes are you checking off?" Similarly, Sara expressed frustration regarding the counseling session, "[Clinic] requires the couple that uses third-party ingredients that they have to go through psychoeducation...that was the biggest waste of a day in my life...maybe not for a nongay couple this would have been a really great experience but for us it was just an utter, utter, waste of time." While Dani struggled to recall her experience with fertility counseling, "I don't remember anything...it was real brief," which may also indicate a lack of helpfulness.

In addition to perceiving counseling services received as unhelpful, there appears to be a connection to perceiving the counseling services as potentially beneficial to heterosexual couples, as noted Sara's previous quote. This is also evident when Terra indicated "I think it was generic counseling. I don't think it was focused on same-sex at all." This identified potential benefit for heterosexual couples was perceived as a lack of competency for working with female partners engaging in family formation. Sara indicated, "I was also shocked that they weren't prepared for dealing with, like how to help a lesbian couple through it" and continued to explain

the lack of competency by stating “I don’t think she understands LGBT family planning, or like, because like a lot of her questions were like ‘how long have you been trying?’” While Terra shared a similar experience with her counselor’s competency, “How prepared was she for same-sex? I would say not at all because it seemed very generic...but I feel like a hetero couple would have gotten the same questions...she just wasn’t prepared I guess to ask or support same-sex couples.”

Lastly, participants identified how counselors can communicate more competency when working with female partners engaging in family formation. More specifically, participants described competent counselors as having awareness. Sara emphasized the need for counselors to have awareness of intersectionality and discrimination, “They need that awareness that there’s other layers and multiple identities that need to be taken into consideration and layers of, you know, like discrimination that you have to be aware of that can happen and how are you going to navigate that.” While, Dani echoed the message for counselors to have awareness of intersectionality, “To be open to all the different factors involved...be open with not only the sexual orientation of the relationship but the family dynamics and everything financial, education level of the couple, just everything.” Merilou also indicated competent counselors need to have an expanded awareness, “Somebody who’s not going to be tied into their worldview of what gay is and what family is and what life is...I don’t want somebody telling me what my world is, what my expectations are, what my life should be according to them.”

Beyond awareness, participants identified the importance of language when working with female partners and the need for more understanding of relationships dynamics outside of heterosexual relationships. Merilou described the importance of language for understanding family identities, “They’d have to respect our language, you know, how we identify each other,

identify our community, identify our world because it's like I use the term lesbian or dyke or whatever but not everybody does." And Jessie indicated concern for finding a counselor that understands the uniqueness of female partner relationships, "I feel like that's not a whole lot of actual counselors...then being a subset of a population, like finding a counselor that can be open to counseling an LGBT couple." Related to Merilou and Jessie's recommendations for competent counseling services when working with female partners, Terra further expresses the need for counselors to understand the uniqueness of female partner family formation:

Somebody who's informed about how our experience is different from other people, like heterosexual couples' experiences...being open to other people's life experiences and just being aware...she probably really didn't have awareness of what they would be, to, um, you know, talk about it, to address those things to help us because it would have been helpful but she just, I think just wasn't, didn't know enough to help us...I think it's important for [counselors] to be prepared with different kinds of couples, like what obstacles could occur in the same-sex couples...have more awareness and ask those particular questions

Using Interpretative Phenomenological Analysis, the researcher identified themes addressing counseling's role in female partner family formation including family preparation, family issues, and provider competency. These above findings are one piece of the large puzzle when working with female partners engaging in family formation and address the research questions outlined in the study. However, when analyzing the data, the researcher identified emerging themes beyond the research questions. The following section discusses emerging themes to explore an additional piece of the puzzle for counselors to consider when working with female partners engaging in family formation.

4.5. Interpretation

The purpose of the study was to explore the experience of female partners receiving third-party fertility services, to identify perceived implications of receiving counseling services during female partner family formation, and to develop implications for counseling practices

specific to female partners engaging in the family formation process. There is scant current research available regarding counseling's role, association, and obligation with female partner family formation. As reported in the previous section, participants outlined a variety of implications for counseling including specific topics and areas needing to be addressed, challenges needing to be explored, strengths and weaknesses of experienced counseling services, and how to enhance counselor competency when working with female partners during family formation. These findings will be further explored in the next chapter when discussing implications for counselors.

In addition, as the study was conducted it became apparent to the researcher that additional themes emerged based on the in-depth narratives shared by the participants regarding their experience as a whole with third-party family formation. These emerging themes move beyond a simplistic understanding of what counseling's role is and moved toward a deeper understanding of how counselors can conceptualize and support couples engaging in female partner family formation. This researcher identified emerging themes for each participant, then identified super-ordinate themes across all participants, Table 1, provides an overview of the participants' themes and the overarching super-ordinate themes. Each participant identified components of the super-ordinate themes and subthemes; however, the importance of the themes varied between each participant. For example, Merilou reported individual themes more consistently related to disconnection whereas Jessie reported individual themes more consistently related to integrity. Yet, both identified to some extent with disconnection and integrity. First, the individual themes are discussed for each participant and the super-ordinate themes are discussed.

Table 1

Individual Themes and Super-Ordinate Themes

Participant	Individual Themes	Super-Ordinate Themes
Merilou	Emotional Discrepancies Role Confusion Autonomy	Disconnection Relational Imaging Autonomy
Jessie	Autonomy with a subtheme of ambivalence Integrity	Autonomy Integrity Belonging
Terra	Belonging with subtheme of supportive vs. unsupportive Autonomy	Belonging Autonomy
Dani	Role Development Unmet Needs	Relational Imaging Autonomy
Teagan	Autonomy with subtheme of shame Belonging	Autonomy Belonging
Sara	Emotional Discrepancies Heteronormative Awareness	Disconnection Belonging Autonomy

Note: Table depicts individual themes identified and their connection to the super-ordinate themes identified across all participants.

4.5.1. Merilou

Three themes emerged in Merilou's experience with family formation: (a) emotional discrepancies, (b) role confusion, and (c) autonomy. First, emotional discrepancies explain the rollercoaster of emotions experienced during family formation. Merilou shared a variety of emotions associated with her family formation process. She described feeling heartbroken during miscarriages, nervous, scared, and excited to become a parent, and the balance of feeling included and excluded as a social mother. For example, Merilou describes how her previous experience with her own miscarriage impacted her family formation process with Jessie; especially, after Jessie had a miscarriage.

But you know having been. they think, pregnant and having gone through that to lose a child or potential child was, it was heartbreaking. It was, it was like am I going to go through all of this again and not have a child. It was, it was I almost didn't want to even try again because I was so afraid that it would end badly again. Sigh. It was heart-wrenching.

Next, role confusion was identified as an additional individual theme and is defined by the turmoil Merilou experienced during parenthood identity development. Merilou's turmoil included her age and age-related physical abilities and the desire to be a biological mother through birth. Merilou discussed her age-related concerns in regard to her role as parent with a young child, but also she described the impact of being mislabeled as Jessie's mother and their child's grandmother and she expressed confusion on how to address such mislabels. For example, below Merilou describes her concern about her age and raising a child:

being 46 at the time when [daughter] was conceived you know. I am not the most healthy physical person I've got a lot of arthritis and joint issues so it's like am I going to be able to do what I want to do and need to do to take care of a kid am I going to, um, I going to be too old.

Merilou also described confusion and hurt surrounding the development of her parental identity. More specifically, Merilou spoke about complex feelings surrounding her hysterectomy and her desire to fulfill the woman's role of having a child.

it's like I'm excluded from a part of what women's roles are or are expected to be and the role that I wanted to fulfill you know...but this was one that I had wanted to fill and I couldn't. So it was like, kind of, like a blow to the ego, more so than anything, because I couldn't do what I wanted to do to be a woman or what a woman should be.

Lastly, Merilou indicated the importance of autonomy in her family formation process. She demonstrated personal power throughout the decision-making process. For example Merilou chose to engage in psychiatric services to maintain her own personal wellness before, during, and after family formation. Also, Merilou found pride in engaging in individual research

to gain education of the family formation process. Below Merilou openly expresses her experience with depression and her decision to maintain wellness:

Both [Jessie] and I battle with depression, so we both have our own psychiatrists and we're getting psychiatric counseling. That way um, we went in and talk to our perspective shrink about stuff...am I ready for this?, you know, and my shrink was fantastic. He says "you got this."

4.5.2. Jessie

Two themes emerged in Jessie's experience with family formation: (a) autonomy and (b) integrity. First, Jessie explained her experience with decision making during family formation and identified that the plethora of decisions can be overwhelming. For example, Jessie describes feeling overwhelmed with decisions related to the sperm donor and the importance of self-education:

When you go on to like, ah, a sperm bank you are inundated with tons of donors and tons of sperm types...you basically need to, like, educate yourself because you're like, oh that's a lot.

As she continued to express the desire to have personal power and freedom during the family formation, ambivalence emerged as a subtheme. Jessie indicated concern about conservative views where she resides, yet she appeared to tolerate heteronormative culture. For example, Jessie identified that she wondered if providers assumed Merilou was her mother or when people actively mislabel Merilou as her mother, she chose to not address the assumptions. Jessie continued to endorse ambivalence surrounding language as she spoke about the negotiation for parental names, for example:

I wouldn't say that I actually, I still don't really even like that. I mean it's not like, my favorite so I don't know, but it fits I guess so I don't know, that's how I guess that's one of our languages things and then I just always I'm mama.

Also, she described her experience with family formation as positive, although she identified multiple negative experiences. Later she noted the discrepancy herself and stated, “So it’s not all roses, you know, like I was kind of making it sound.”

In addition to autonomy, Jessie valued integrity in the family formation process by engaging in individual research, which included Internet searches, Facebook groups, and books. She consistently described the importance of self-education as a way to empower her navigation of the family formation process. Jessie describes the importance of self-education as “It’s just a process, you just need to do your research and figure it out. Know your ins and outs.”

4.5.3. Terra

Two themes emerged in Terra’s experience with family formation: (a) belonging and (b) autonomy. Terra often spoke about a conflict between feeling supported and feeling unsupported. She described support as not feeling judged about her queer relationship, while simultaneously describing the invisibility she experienced by providers and family when engaging in family formation. For example, she spoke about her family and how they do not discuss her queer relationship or that she has a child within the context of the queer relationship:

they don't really talk about it. I don't know. I kind of feel like they, in their minds they just ignore the fact, or pretend not to think about that we're two women. They just see us as people that they love but I don't think, we definitely, we don't talk about that kind of stuff. They don't talk about that kind of stuff and I think that if we did they would be uncomfortable.

Terra also highlighted her additional intersectionality as a Latina and described how having a Latino fertility provider was comforting, “I always feel like we were really respected and I don't know if it's because, and the doctor was Hispanic in [state] and he spoke Spanish and everything and he would tell us stories.” In addition to belonging, autonomy was also identified as an individual theme during Terra’s family formation process. Terra discussed her struggles to

make decisions, specifically the challenges to autonomy. Terra described experiencing constraints to autonomy such as location, limited finances, and time. Terra discussed how she was unable to choose her fertility providers due to living in rural communities. She also discussed finances and time as contributing factors to deciding to only attempt conception twice:

it was hard on me the second time when it was not successful but it's so expensive. But I mean it was hard. But they were saying it like money grows on trees for us. And we can't just do attempt after attempt after attempt and financially that wasn't our situation.

4.5.4. Dani

Two themes emerged in Dani's experience with family formation: (a) role development and (b) unmet needs. Role development refers to parenthood role development. Dani described her difficulty in transitioning into parenthood and how she ultimately engaged in family formation because Terra wanted children. She shared fear of becoming a parent due negative childhood experiences with her father, she was afraid she would become like her father.

Emotionally it was, um, it was hard at first because, um, my parents divorced. I had a very good mother, but my father was, um, not involved a lot. I was afraid of being a parent like my father.

Another emerging theme for Dani's experience was unmet needs. Dani focused on describing what she needed during the family formation process including additional support transitioning from a couple to a family and how to cope during the family formation process.

From going from, from just a couple to a family would have been helpful for me...we went from just with a focus on each other to a focus on the whole family.

4.5.5. Teagan

Two themes emerged in Teagan's experience with family formation: (a) autonomy and (b) belonging. Teagan described significant constraints to autonomy including finances, time, and available educational resources. For example, she discussed how finances influenced

decisions about method of conception and donor selection. She also discussed how timing fertility services impacted her daily life including employment and relationships with family and friends. For example, Teagan described her struggle and frustration with attempting to make plans with family:

Do we want to get together and do something and I'm like, well, we're trapped, I don't know because we don't you know, I don't know when cycle day 1 is going to be and then we're going to be doing stuff in December but I don't know for how many days, like, we ended up going for IVF on Christmas Eve day.

In addition to the constraints of finances and time when making family formation decisions, Teagan emphasized that lack of available information about the family formation process which led to an emerging subtheme of shame. Teagan described feeling stupid, incapable, and incompetent when navigating the family formation process due to the limited information provided which she described using a metaphor:

I felt like that first-generation college student who like showed up at the admissions event and was like, what, I need test scores and I need to sign up for these classes and I don't understand what a credit hour is. That's what I felt like. I just felt really stupid.

Next, Teagan expressed her understanding of her intersectional identity as a sexual minority and an individual trying to create a family. She described the inclusivity of the fertility clinic, yet also indicated sympathy for heterosexual couples experiencing infertility.

And, and you look around and you see people that probably have their own ingredients because they're male-female couples and you're like, dude wow. That's rough. I felt really bad for them.

Teagan also emphasized the importance for building a support system and described people as insensitive to female partner family formation. She also reported hurt surrounding limited family support and insight into how creating a family in the context of a female partner relationship can increase visibility of their relationship.

...how it hurt when their friends got married and everybody was excited but when they got married people shunned them...but they've come a long way now since then but realizing to that for some people this conversation could be as hurtful and painful as the coming out process with family members and what kind of support they might need because some family might say you know, "we're okay with you being together but we don't want you to procreate and have kids because we don't believe that's okay" or "we don't think the kids going to be well adjusted because of who the family role models are."

4.5.6. Sara

Two themes emerged in Sara's experience with family formation: (a) emotional discrepancies and (b) heteronormative awareness. Sara described an array of emotions throughout her experience with family formation including excitement, hopefulness, heartbreak, exhaustion, frustration, and hopelessness. She described her experience overall as a rollercoaster and conveyed immense stress related to navigating resources including time, finances, and medical procedures. She shared her experiences with multiple unsuccessful fertility treatments and the intensity of trying different methods of conception while managing the schedule of medications, appointments, and Teagan's ovulation cycle. For example, Sara describes how overwhelming and chaotic the conception process can be:

I had to bring the meds, shoot [partner] up in a parking lot because you have to hit the window because if you miss the window she could have ovulated...We followed their instructions but they don't prepare you for all of these horrendous what if scenarios and I understand they're trying not to get you anxious and worked up it's a, it's a balance of information on anxiety but that was just, that was just bad.

Sara also expressed an awareness of heteronormative culture involved in female partner family formation. She described her experiences living in the Midwest and how discrimination impacted decisions to start a family. However, after moving to the Northeast she experienced an increased sense of acceptance and safety, which allowed her to further explore decisions about family. Sara discussed the importance of affirmative fertility services and her disappointment at

how an affirmative clinic still endorses aspects of heteronormative culture systematically. She expressed that heteronormative culture is a bigger problem than even fertility services. For example, Sara describes the lack of research and data available to female partners engaging in family formation:

having somebody who understood you know, like lesbian fertility issues, like, it's a whole different ball game because we, we also have no data...it's more so on a bigger scale for me like, it's a bigger and justice that hasn't changed yet...lesbian couples that have zero health coverage and just keep trying and trying and trying and even if they do have medical issues because it's not mandated in their states so it's like, I think that's a bigger, bigger issue than us.

4.5.7. Overarching Super-Ordinate Themes: Love and Disconnection

In addition to individual participant themes, there were two overarching super-ordinate themes: love and disconnection. Each is described further.

4.5.8. Love

Love is the reason female partners are engaging in family formation, it is the foundation of family formation. Love is generally the concept that motivates couples to engage in family formation, children are viewed as a product of love between two people. Love is complicated in female partner family formation because of the physical constraints on their ability to create a product of love. All participants described love during their interviews. For example, Sara posed the question “Wouldn't it be nice to have a kid, you know, start making a family and memories?” While Terra outlined the pain associated with wanting to create a family out of love in the context of a queer relationship, “you fall in love with somebody and then you want your child to have a piece of that person, but you can't do that.” Furthermore, Merilou described how the love created within a family is priceless:

It's tough, it's a tough thing in a lot of ways but at the end, if you get a child out of it, it's worth every, every second, every moment, every pain, every financial burden, everything. It's worth it.

Love is defined by two subthemes: relational imaging and integrity. Relational images are our learned expectations of relationships, which are developed in childhood based on modeling and societal influences that impact our understanding of relationships including meaning and function (Jordan, 2010). Relational imaging accounts for individual role confusion and development and the transition from couple to family. More specifically, how the participants make sense of their position and their partner's position within the context of their relationship. This may be further complicated by heteronormative culture for female partners (i.e. gender roles or the concept of marriage). Jessie provided an example of how her relational image of a parent was being prepared and established in life:

I always knew I wanted to have kids, um, so it was just a matter of time and waiting and being able to, you know, wait until I was "ready"...I always thought that I needed to, you know, be done with my education and have a job and I'll have all the ducks in a row.

While Dani indicated concern for becoming a parent because she did not perceive herself as mother based on her relational image of motherhood, "I didn't have that motherly intuition."

Merilou and Sara also identified parental relational image, specific to age, although Merilou identified additional physical abilities associated with a parent:

Merilou: It was just a matter of, you know, me trying to convince myself that even though I'm older, I can still be a good parent...I have to adapt and do things differently because of my joint issues...I still wonder, am I missing out because I can't get down in [child's] world?

Sara: When our second nephew was born, we started kind of getting the "awe, do you want to do this?" We're not getting any younger.

In addition to relational images, integrity is a subtheme of love. Integrity is the intention of empowerment, values, and authenticity including actions to promote the intention. Integrity accounts for individual navigation of the process (i.e., expanding individual knowledge or asking

for help). For example, Merilou voiced self-empowerment regarding her personal understanding of her identity regardless of others' assumptions:

Do I call them out on it or do I not call them out on it?...I know I'm a parent. I know I'm [Jessie's] partner, spouse.

In addition to empowerment, Terra discusses the importance of incorporating values into family formation decisions. Specifically, Terra discusses how values influenced donor selection, "It was important to us that he was, like, a good person...kind of like, wanting to be environmentally friendly and seem to care about people...we tried to get an idea of their personality and what they would bring to the table." Sara echoed the importance of making decisions that align with personal values. She described how values impacted the process of selecting a provider, "We had to have an all-woman team...we wanted all women. We wanted a woman doctor...we kind of pride ourselves in this being an all-woman process...we firmly believe in empowering women in their careers." Lastly, Teagan identified that challenges and complexities of family formation can diminish quality of life and that in order to navigate the family formation process there needed to be boundaries to protect quality of life:

We both decided that we weren't going to financially run ourselves into the ground for this because that would cause extra stress, um, quality of life issues that we weren't interested in, so we decided we would give it a good shot for maybe a year, year-and-a-half and then we would walk away with whatever we would walk away with.

4.5.9. Disconnection

The second overarching super-ordinate theme was disconnection. Disconnection is the crack in the foundation; it is the distance between cultures such as queer and heterosexual. Disconnection is the conflict between love being an emotional process and love existing as a medical process for female partners engaging in family formation. Heteronormative culture, heterosexism, homophobia and marginalization contribute to disconnection by cultivating

hopelessness and isolation (Jordan, 2010). Merilou described the conflictual emotional disconnection she experienced during the family formation process, “It was a whole bunch of different emotions. It was joyful, trepidation, nervous, fear, uh, all these things and I was worried about what happens.” While Sara also described an array of emotions during the family formation process, she also described how disconnecting those emotions can be due to the logistics of the conception process:

I would describe it was as kind of a rollercoaster because, like we were not prepared for a lot of it...because, you know, you get your hopes up, and each cycle is kind of this rollercoaster...you’re excited but you’re exhausted with trying to manage all the moving parts and pieces...legitimately pushed me to my breaking point.

Furthermore, disconnection was enhanced by the medicalization of the conception process. Female partners required third-party assistance to conceive a child and in the participants’ process that meant services from fertility specialists. Jessie described being ready to start a family but having to wait because of the inclusion of fertility services:

We just call and tell them we’re ready and show up and do it...I was actually a little bit disappointed by the HSG, like, dang it, like we have to do something before we can even get started, so like, that whole hurdle was a little bit of a disappointment.

While Teagan expressed feeling responsible for barriers to conception due her stress levels related to the medicalized conception process:

Is that cause I’m freaked out and I’m just not relaxed, and am I stressed? Is that why I can’t get, is that why my period isn’t right? So, it’s all about how do I relax and all this to happen, and then it should happen.

Terra also reported experiencing disconnection during the family formation process. She described her experience with receiving fertility services as a show for everyone to watch because of multiple medical tests and visits to providers. She indicated, “not only is it expensive but it’s intrusive and uncomfortable and just ugly.” Conversely, Merilou shared her excitement

about choosing a donor and identified that disconnection played a role in selecting potential hereditary characteristics:

I want this qualification, I want this qualification, I want this qualification, now who meets that? And it's like being able to pick your perfect spouse, in a way, but in this case a perfect parent who doesn't have to be a parent.

Disconnection is defined by two subthemes: autonomy and belonging. Autonomy and belonging represent disconnections, struggles and challenges that impact various areas of the family formation process and individual lives of the participants. Autonomy is personal power and freedom. It is present when female partners are confronted with decisions, during the family formation process such as donor selection, who will become pregnant, conception method, etc. Autonomy is also the personal power and freedom to choose how to manage resources such as time and money. Autonomy is comprised of the conflict between personal power and freedom and homophobia and discrimination, as homophobia and discrimination create an absence of autonomy.

Participants described experiencing barriers to autonomy, more specifically they discussed how resources confined their ability to make decisions. For example, Terra indicated the role finances had on family formation, "we had to pay cash for all of our appointments, um, and I got pregnant the first time, with the first insemination. So, we were lucky because it was very expensive." Teagan also described how finances, specifically insurance coverage, impacted conception decisions, "well, insurance says we only need to do two, so why don't we save a few bucks because frozen sperm and IUI only has a like 2% success rate anyway."

In addition to finances, participants described the role time had in limiting their autonomy during family formation. Jessie describes the pressure to plan and work around cycles in order to promote a smooth process and avoid additional financial burdens.

You need to keep track of your cycle, you know, a good couple months so, to, you know, exactly when you ovulate. If you send out the wrong time because if you're, you're going to send at the wrong time you're going to have a problem. You're going to waste a lot of money.

While Sara emphasizes the lack of freedom available to individuals engaging in fertility services and how easily the process can become inconvenient and chaotic:

You can't plan your life more than two weeks an advance...like they literally tell you day to day because they're doing this testing and the medication didn't show-up because of an issue with the truck and we needed it because it was one that prevented ovulation...we had to drive in the middle of the night to [city] to the emergency pharmacy, it was just a shit show.

Furthermore, legislation and policy can impact female partners' family formation process. Specifically, legal considerations and navigating the rights of each person involved in the process can be limiting to autonomy. Merilou describes donor considerations and possible concerns to address.

Whether we were going to use a known donor or unknown donor and if we're going to use a known donor, how do we protect ourselves but how do we protect the known donor as well...who gets to name, to name the baby, what are his financial responsibilities, if any, how is he going to be referred to when the kid is born.

Belonging is the second subtheme of disconnection. Belonging is the existence and acceptance in a culture. It encompasses the conflict between feeling supported and unsupported at the intersections of their lives (i.e., being daughter, partner, mother, colleague). Participants shared their struggles to live between identities and endorsed feeling unsupported at various times of their conception process. For example, Sara recalls an experience with a colleague that questioned her need to miss work to be present for the conception procedure at the fertility clinic:

I was saying to [colleague], of all the times it looks like we're going to be going the second day of classes and in my world that is not the day to take off...and [colleague] said "why do you need to go?" and I'm like, that was the only, and I'm like, typically both parents are there for conception, just saying

Also, Teagan expressed how having a child can change people's perceptions of your relationship and potentially further out female partners. Having children can impact relationships and further create isolation for female partners.

Cause now we're, we're outing ourselves even more as a couple by having a child for all the people who thought we were, you know, good friends or roommates now suddenly, this baby makes it a little bit more real. We're forcing people to confront that we are a couple.

4.6. Summary

The purpose of Chapter Four was to present the results of the Interpretative Phenomenological Analysis study and answer the research questions. Three couples, or six individuals, participated in semi-structured interviews to explore their in-depth experiences with family formation. Individual emerging themes were identified, as well as emerging themes across all participants. Two super-ordinate themes were identified: love and disconnection. Love was comprised of two subthemes including relational imaging and integrity. Disconnection was comprised of two subthemes including autonomy and belonging. In the following chapter, the researcher explores the results in light of female partner family formation literature; reports the limitations of the study, and offers implications and suggestions for counselors.

5. DISCUSSION

5.1. Introduction

In Chapter One, the researcher reviewed literature related to female partner family formation and proposed a study exploring the lived experiences of female partners receiving third-party fertility treatment and engaging in family formation. More specifically, the study focused on the perspective role counseling has in the process of family formation. In Chapter Two, literature related to the female partner family formation process was reviewed including potential implications to the counseling process. From there, the researcher outlined the methodology of the Interpretative Phenomenological Analysis study in Chapter Three and presented the results in Chapter Four. In this chapter, the researcher discusses the results in light of female partner family formation literature, outlines the limitations of the study, and offers implications and suggestions for counselors.

5.2. Discussion of Results

The results are discussed with respect to each research question, including the overarching questions and three secondary questions. To avoid redundancy, the researcher addresses the super-ordinate themes, love and disconnection, in the implication section of this chapter. While discussing the research question results, it is important to reiterate that the researcher focused on exploring counseling's role in female partner family formation and the research questions aligned with this purpose. However, the researcher identified emerging themes, love and disconnection, when analyzing the data collected. These emerging themes did not change the research questions, rather enriched implications for counselors working with female partners engaging in the family formation process.

How do female partners experience counseling during family formation? To answer the overarching research question, participants were asked questions about their experiences, or lack of experiences, with fertility counseling including the referral process, additional counseling services potentially sought during the family formation process, topics discussed and topics that would have been helpful to discuss, and perceived barriers counselors should be aware of when providing services to female partners engaging the family formation process. Participants predominantly discussed accessibility concerns, specifically related to time constraints and finances, as potential challenges to receiving counseling services. These challenges were not specifically addressed in available literature regarding female partner family formation. However, the lack of available literature to support these identified challenges could indicate that fewer female partners are attending counseling services partly potentially due to accessibility. All participants identified that the financial burden of third-party fertility counseling services was a potential barrier to attending unrequired counseling services, especially as insurance companies do not often provide coverage for female partner fertility services or couples counseling in general.

Participants continually identified the importance of obtaining information regarding the conception process, needing assistance in navigating the conception process including decision-making and legal considerations, exploring and building supportive networks that include other female partner couples trying to have children or that have had children together, and preparing for potential complications related to fertility services such as miscarriages during counseling sessions. These topics were consistent with available literature, more specifically, female partners describe the family formation process as a “rollercoaster ride” due to the multitude of decisions, limited social support, financial stress, and additional barriers to family formation

(Patterson & Riskind, 2010; Rausch & Wikoff, 2017; Somers et al., 2017; Wojnar & Katzenmeyer, 2013). Female partners must make decisions related to family formation including method of conception, donor selection, and how to navigate heteronormative and homophobic healthcare systems (McManus et al., 2006; Rausch & Wikoff, 2017; Yager et al., 2010).

In addition, all participants indicated their family formation process began with conversations between partners and research including Internet searches and online groups targeting female partners trying to conceive. However, often female partners continued to feel unprepared when initiating and receiving fertility services and desired additional resources specific to female partner family formation. Previous research suggests that female partners engage in lengthy discussions surrounding family formation decisions, often over the duration of years, and conduct research via the Internet (Hayman et al., 2013). One participant specifically mentioned the importance of their fertility clinic providing a webpage specific to LGBT family formation, while multiple other participants reiterated the support they found on online groups specific to female partners trying to conceive.

What perceptions did female partners have of their providers? To answer the first question, the researcher asked questions that explored the participants overall experience with fertility services including questions regarding language and perceived challenges experienced when engaging in the family formation process. Female partners are constricted by language surrounding their relationship and sexual identities which continue to constrict their identities as parents (Abelsohn et al., 2013; Brown & Rerlesz, 2008; Miller, 2012; Wall, 2011). Participants identified that the use of language was important throughout the family formation process. Specifically, it was important that providers utilize appropriate language when referring to the female partners, their identities, and their developing family. One couple in particular outlined

their struggle to define the social mother's terminology, while other couples were waiting for their child's input. Language has an impact on how individuals define and create their meaning in the world (Julian, Duys, & Wood, 2014), which can be based in heteronormative culture.

Heteronormativity is one of the most difficult challenges of navigating queer relationships (Biagglo, Coan, & Adams, 2008; Connolly, 2008; Degges-White & Marszalek, 2008; Hayman et al. 2014) because it can cultivate additional stress on the relationship or sexual minority stress (Connolly, 2008; Holley, 2016; Lewis et al., 2012). Due to minority stress, sexual minority females have a higher risk of experiencing a variety of emotional, behavioral, and health problems (Abelsohn et al., 2013; Alang & Fomotar, 2015; Borneskog et al., 2013; Fields & Scout, 2015; Lewis et al., 2012; Rausch & Wikoff, 2017). All participants identified experiencing emotional, behavioral, or health problems during the family formation process including suicidal ideation and suicide attempts, postpartum anxiety, symptomology related to past trauma, German measles, and pregnancy induced hypothyroidism. It was outside the scope of the study to investigate the origin of these emotional, behavioral, and health problems; however, it is worth mentioning that participants also endorsed experiencing heteronormative culture throughout the family formation process. Participants, in general, endorsed positive experiences with providers while simultaneously describing experiences with heteronormativity. Participants appeared to have an insensitivity to experiencing heteronormativity and contributed a positive experience to the absence of homophobia and discrimination.

What expectations did female partners have when attending counseling for family formation? To answer the second question, participants were asked questions regarding their expectations of providers and counseling during the family formation process. More specifically, participants were asked to discuss their perception of the role counseling, may or

may not, have in the family formation process. All participants identified that they did not expect counseling to be included in the family formation process. Two couples were required to attend fertility counseling and indicated that it was unhelpful and that they desired the counseling session to be focused on providing psychoeducation or exploring challenges unique to female partners engaging in family formation. Participants identified that they were unable to choose their counselor; rather, they were referred to a specific counselor by their fertility specialist. Participants indicated that they perceived the counseling session to be an arbitrary requirement in the family formation process. However, as mentioned previously, participants identified a variety of topics that they believe would be helpful to discuss with a counselor when engaging in the process of family formation. Three participants had established individual counseling services, unrelated to family formation, prior and during the family formation process. These individuals identified that they inadvertently discussed family formation with their counselors, specially related to stress management. They also endorsed having a positive rapport built with their counselors, while they did have the opportunity to choose them.

How do female partners perceive their providers' ability to provide culturally sensitive and affirmative services when working with female partners during family formation? To answer the final question, participants were asked questions to prompt discussion of their experiences with culturally sensitive and affirmative providers, including their perception of providers preparedness, how providers communicated competency, and suggestions for ways providers can be more culturally sensitive and affirmative when working with female partners during family formation. Queer couples often interpret counselors' inability or unwillingness to address topics within their relationship as lack of acceptance or perceived heterosexism (Grove & Blasby, 2009). However, this was inconsistent with the results

of the study. Participants attributed dissatisfaction related to counseling services to the counselor's level of competency including understanding female partner's experiences, individual level of awareness, and perceived preparedness to work with diverse populations. The lack of competency standards in the counseling field addressing services provided to queer couples and families could negatively impact the level of satisfaction couples and families report when receiving counseling services (Rutter et al., 2010). Participants identified a need for more culturally sensitive and affirmative counseling services during the family formation process. Specifically, participants indicated that counseling providers provided services that were standard for all individuals receiving fertility services and noted that they thought the counseling services would benefit a heterosexual couple experiencing infertility more so. Participants identified appropriate language and awareness and openness as traits for a culturally sensitive counselor. In addition, they identified the importance for counselors to have access to information specific to female partner family formation to enhance competency and to provide resources to female partners.

5.3. Limitations

There are a number of limitations that are important to acknowledge, including the inclusion criteria, sample size, transferability, and cultural considerations. First of all, the researcher noted language constraints when referring to female partners including their affectional orientation, gender identity, relationship identity, and family identity. In addition, to these language constraints there are language barriers related to fertility counseling as there is no standard terminology to refer to the counseling provided prior to receiving third-party fertility services (i.e., psychoeducational counseling, psychiatric evaluation, fertility counseling). Furthermore, the requirement of fertility counseling varies depending upon state and facility

policy. These limitations contribute to an overall limitation in defining inclusion criteria for recruitment.

Along with this, the sample size presents a limitation to the findings. The researcher utilized Interpretative Phenomenological Analysis methodology, which encourages a smaller sample size and a more homogenous sample due to rigor of data analysis (Smith et al., 2012). Therefore, due to the small sample size saturation may not have been reached on any specific theme or topic identified in the study. Transferability is also a limitation of the study, as the study focused on female partners engaging in third-party family formation, meaning the findings of the study are not theoretically transferrable to other targeted populations such as female partner adoption or surrogacy, male partner family formation, or heterosexual infertility counseling. Also, the result interpreted using IPA are not meant for developing generalizations (Smith et al., 2012).

Lastly, cultural considerations provide a potential limitation to the study. Female partners have intersectional identities that influence their experiences including, but not limited to, race, ethnicity, gender identity, religion, and ability. Acknowledging the intersectional identities of female partners will provide a more encompassing representation of their lived experiences. For example, one cultural consideration not addressed in the study but emerged was that all participants earned graduate degrees prior to engaging in the family formation process. This level of education may have impacted participants' willingness to participate in the study or may have played a role in their access to physician assisted third-party fertility services. In addition, having graduate level education might have impacted how participants created meaning of their experiences and communicated those experiences during the interview

process. Taken together, it is important that when reporting these results counselors and researchers carefully consider the inherent limitations of the study.

5.4. Implications

5.4.1. Counselors

In the process of conducting this study, a number of implications arose for counselors. These implications are based on the six participants' recommendations and the two super-ordinate themes of the study (love and disconnection). In order to foster love, relational images and integrity need to be addressed. In order to heal disconnection, autonomy and belonging need to be addressed. Based on the participants' suggestions and the two super-ordinate themes of the study, four implications are offered for counselors: (a) address relational images, (b) promote integrity, (c) encourage autonomy, and (d) cultivate belonging. First, counselors can address relational images with female partners, which means counselors will aid in the exploration of expectations and meaning in relationships. Relational images are learned expectations of relationships, which are developed in childhood based on modeling and societal influences (Jordan, 2010). Relational images impact our understanding of relationships including meaning and function (Jordan, 2010). Relational imaging includes the associations given to specific roles within the context of relationship such as parent, spouse, partner, mother, child, etc. Facilitating dialogue surrounding relational images will enhance the understanding of each individual's interpersonal worldview and potentially help shift negative relational images; for example, counselors can address potential heteronormative culture through processing relational images.

Alongside addressing relational imaging, counselors can promote integrity when working with female partners engaging in family formation. In order to promote integrity, counselors can facilitate dialogue about values including what is important to the couple as they engage in the

family formation process. The goal is to empower the female partner couple in their family formation journey, which includes aiding in the navigation through action. Help the couple create an action plan for aspects of the family formation which could include a specific calendar to track appointments and various components of the conception process (i.e., cycles or medications), creating a list of questions for their provider or a list of steps that outline the conception process, or encourage them to come prepared to each session with specific homework regarding the family formation process such as coping skills to manage stress or grief and journaling about their boundaries for the conception process (i.e., when to stop trying).

Furthermore, counselors can encourage autonomy for female partners through providing psychoeducation, discussing decision-making, and addressing homophobia and discrimination within the family formation process. Counselors should be prepared to provide female partners with specific information related to their family formation process including pamphlets, books, websites, relevant laws and affirmative attorney contact information, and appropriate referrals, if needed. Counselors should explore pros and cons of various decisions through the family formation process including donor selection, method of conception options, and language within the family. Also, counselors should be prepared to address and process potential complications throughout family formation including waiting periods, miscarriages, and fertility difficulties. Lastly, counselors can cultivate belonging for female partners engaging in family formation. Specifically, counselors need to be willing and able to discuss heteronormativity with female partners and the potential impact it has on their family formation process. A key component of cultivating belonging is addressing support networks and difficulties associated with intersectionality. Counselors should explore the couple's connection to support networks and offer additional options as needed, such as Facebook groups specific to other female partners

trying to conceive. Also, counselors need to address how couples will handle potential changes in support throughout the family formation process.

5.4.2. Counselor Educators

Furthermore, in the process of conducting this study a number of implications arose for counselor educators. The role of counselor educators is to teach and train future counselors to work ethically in the profession. The Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling (2009) states that counselors are ethically obligated to provide culturally sensitive and affirmative counseling services to LGBQQIA individuals. Therefore, counselor educators have an ethical responsibility to teach and train culturally sensitive future counselors who can affirmatively work with LGBQQIA populations, including female partners during family formation. This is further indicated by the findings of the study, as all six participants indicated the importance of counselor awareness. Based on the counselor implications identified, one primary implication is offered for counselor educators: cultivate awareness. In order for counselors to address relational images, promote integrity, encourage autonomy, and cultivate belonging when working with female partners during the family formation process, they must have awareness.

Counselor educators can cultivate awareness in a multitude of ways. First counselor educators can incorporate more diversity specific to LGBQQIA populations. For example, the uniqueness and challenges of female partner family formation can be included in coursework such as family counseling and couples and marriage counseling. Counselor educators can engage students in difficult dialogues regarding LGBQQIA populations. Dialogues can be initiated using discussion prompts or questions, journal articles, and video clips that focus on LGBQQIA issues. For example, counselor educators could show a video, like “If Lesbians Said

the Stuff Straight People Say” by BuzzFeed, and then engage in a conversation about stereotypes or the importance of language. In addition, counselor educators need to teach students how to facilitate difficult conversations. Modeling difficult conversations is vital; however, counselor educators also need to teach skills (i.e., empathy, humility, curiosity) to students that will aide them in their own facilitation of difficult conversations with clients and beyond.

Secondly, counselor educators can encourage, or require, students to read and apply the Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling’s (ALGBTIC) competencies for working with LGBQQIA populations. Also, counselor educators can encourage students to participate in Safe Zone training via university, community, or online training. Safe Zone training promotes awareness and education to help foster LGBQQIA allies. Lastly, counselor educators can encourage community involvement through activities (i.e., Pride) and connecting with local LGBQQIA organizations. Often local LGBQQIA organizations will coordinate community activities, provide resources, and deliver information.

Counselor educators are obligated to educate students on intersectionality and to promote awareness of diversity. More specifically, counselor educators need to broaden students’ understanding of normative societal constructs such as family and gender roles. Counselor educators can challenge students’ awareness by providing recommendations for literature (fiction or nonfiction), journal articles, resources, trainings, and videos related to LGBQQIA issues, including female partner family formation.

5.5. Future Research

There is scant research available regarding female family formation and future research is needed as female partner family formation continues to increase. Researchers could further explore the results of the study and more closely research the super-ordinate themes. In addition,

female partners are underrepresented in infertility research including quantitative data. There is also limited quantitative data regarding female partners participating in fertility and counseling services. More broadly, counseling competency standards need to be explored and further developed for working with LGBQQA populations. Similarly, LGBQQA couples and family counseling need to be further researched to develop guiding practices and implications.

5.6. Conclusion

The purpose of this study was to explore the experiences of female partners receiving third-party fertility treatments. More specifically, the researcher sought to identify perceived implications of counseling services and to develop implications for counseling practices specific to female partners engaging in family formation. Two super-ordinate themes emerged, with four subthemes, which reflect and further the current body of literature surrounding female family formation. The two super-ordinate themes of the study lead to a number of implications for counselors. Taking advantage of the results of the study, counselors may truly begin to understand the complexity of female partner family formation and discover treatments that advocate for and enhance cultural competency and affirmative services, beyond the counseling room.

REFERENCES

- Abelsohn, K. A., Epstein, R., & Ross, L. E. (2013). Celebrating the “other” parent: Mental health and wellness of expecting lesbian, bisexual, and queer non-birth parents. *Journal of Gay & Lesbian Mental Health*, 17 (4), 387-405. doi: 10.1080/19359705.2013.771808
- Alang, S. M., & Fomotar, M. (2015). Postpartum depression in an online community of lesbian mothers: Implications for clinical practice. *Journal of Gay & Lesbian Mental Health*, 19, 21-39. doi: 10.1080/193.2014.910853
- Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling (ALGBTIC) (2009). ALGBTIC competencies for counseling LCBQIQA. *The Center for Counseling Practice, Policy, and Research*, 1-28. Retrieved from <http://www.algbtic.org/competencies.html>
- American Pregnancy Association (2017). *Donor Insemination*. Retrieved from <http://americanpregnancy.org/infertility/donor-insemination/>
- Baetens, P., Camus, M, & Devroey, P. (2002). Counselling lesbian couples: requests for donor insemination on social grounds. *Reproductive BioMedicine Online*, 6 (1), 75-83. doi: 10.1016/S1472-6483(10)62059-7
- Ben-Ari, A., & Livni, T. (2006). Motherhood is not a given thing: experiences and constructed meanings of biological and nonbiological lesbian mothers. *Sex Roles*, 54, 521-531. doi: 10.1007/s11199-006-9016-0
- Bernstein, A. C (2000). Straight therapists working with lesbians and gays in family therapy. *Journal of Marital and Family Therapy*, 26, 443-454. doi: 10.1111/j.1752-0606.2000.tb00315.x

- Biagglo, M., Coan, S., & Adams, W. (2008). Couples therapy for lesbians. *Journal of Lesbian Studies*, 6, 129-138. doi: 10.1300/J155v06n01_12
- Borneskog, C., Sydsjo, G., Lampic, C., Bladh, M., & Svanberg, A. S. (2013). Symptoms of anxiety and depression in lesbian couples treated with donated sperm: A descriptive study. *An International Journal of Obstetrics and Gynecology*, 120, 839-846. doi: 10.1111/1471-0528.12214
- Borneskog, C., Lampic, C., Sydsjo, G., Bladh, M., & Svanberg, A. S. (2014). How do lesbian couples compare with heterosexual in vitro fertilization and spontaneously pregnant couples when it comes to parenting stress? *Acta Paediatrica*, 103, 537-545. doi: 10.1111/apa.12568
- Bos, H. M. W., van Balen, F., & van den Boom, D. C. (2005). Lesbian families and family functioning: An overview. *Patient Education and Counseling*, 59, 263-275. doi: 10.1016/j.pec.2004.10.006
- Brown, L. S. (2010). *Feminist Therapy*. Washington, DC: American Counseling Association.
- Brown, R., & Perlesz, A. (2008). In search on a name for lesbians who mother their non-biological children. *Journal of GLBT Family Studies*, 4 (4), 453-467. doi: 10.1080/15504280802191574
- Carpinello, O. J., Jacob, M. C., Nulsen, J., & Benadiva, C. (2016). Utilization of fertility treatment and reproductive choices by lesbian couples. *Fertility and Sterility*, 106 (7), 1709-1277. doi: 10.1016/j.fertnstert.2016.08.050
- Cherguit, J., Burns, J., Pettle, S., & Tasker, F. (2012). Lesbian co-mothers' experiences of maternity healthcare services. *Journal of Advanced Nursing*, 69 (6), 1269-1278. doi: 10.1111/j.1365-2648.2012.06115.x

- Connolly, C. M. (2008). A feminist perspective of resilience in lesbian couples. *Journal of Feminist Family Therapy*, 18 (1/2), 137-162. doi: 10.1300/J086v18n01_06
- Degges-White, S., & Marszalek, J. (2008). An exploration of long-term, same-sex relationships. *Journal of LGBT Issues in Counseling*, 1 (4), 99-119. doi: 10.1300/J462v01n04_07
- Diamond, L. M. (2016). Three critical questions for future research on lesbian relationships. *Journal of Lesbian Studies*, 21 (1), 106-119. doi: 10.1080/10894160.2016.1143756
- Dionisius, S. (2015). Queer matters: Family-building processes of lesbian couples using donor insemination. *Scandinavian Journal of Social Theory*, 16 (3), 283-301. doi: 10.1080/1600910X.2015.1091781
- Ehrensaft, D. (2008). Just Molly and me, and donor makes three: Lesbian motherhood in the age of assisted reproductive technology. *Journal of Lesbian Studies*, 12 (2-3), 161-178. doi: 10.1080/10894160802161331
- Fields, C. B., & Scout (2001). Addressing the needs of lesbian patients. *Journal of Sex Education and Therapy*, 26 (3), 182-188. doi: 10.1080/01614576.2001.11074412
- Gannon, S., & Davies, B. (2007). Postmodern, poststructural, and critical theories: In S. N. Hesse-Biber (Ed), *Handbook of Feminist Research: Theory and Praxis* (71-106). Thousands Oaks, CA: SAGE Publications, Inc.
- Green, M. S., Murphy, M. J., Blumer, M., & Palmanteer, D. (2009). Marriage and family therapists' comfort level working with gay and lesbian individuals, couples, and families. *The American Journal of Family Therapy*, 37 (2), 159-168. doi: 10.1080/01926180701441429

- Grove, J., & Blasby, S. (2009). The therapeutic encounter in same-sex counselling – the client's perspective. *Counseling and Psychotherapy Research*, 9 (4), 257-265. doi: 10.1080/14733140903012903
- Grove, J., Peel, E., & Owen-Pugh, V. (2013). Client discourses on the process of seeking same-sex couple counselling. *British Journal of Guidance & Counselling*, 41 (5), 573-586. doi: 10.1080/03069885.2013.778388
- Hayman, B., Wilkes, L., Jackson, D., & Halcomb, E. (2013). De novo lesbian families: Legitimizing the other mother. *Journal of GLBT Family Studies*, 9, 273-287. doi: 10.1080/1550428X.2013.781909
- Hayman, B., Wilkes, L., Halcomb, E. J., & Jackson, D. (2013). Marginalised mothers: Lesbian women negotiating heteronormative healthcare services. *Contemporary Nurse*, 44 (1), 120-127. doi: 10.5172/conu.2013.44.1.120
- Hayman, B., Wilkes, L., Halcomb, E., & Jackson, D. (2014). Lesbian women choosing motherhood: The journey to conception. *Journal of GLBT Family Studies*, 11, 395-409. doi: 10.1080/15504X.2014.921801
- Hayman, B., & Wilkes, L. (2016). De novo families: Lesbian motherhood. *Journal of Homosexuality*, 64 (5), 577-591. doi: 10.1080/00918369.2016.1194119
- Hesse-Biber, S. N. (2007). Feminist research: Exploring the interconnections of epistemology, methodology, and method: In S. N. Hesse-Biber (Ed), *Handbook of Feminist Research: Theory and Praxis* (1-26). Thousands Oaks, CA: SAGE Publications, Inc.
- Heyes, C., Dean, M., & Goldberg, L. (2015). Queer phenomenology, sexual orientation, and health care spaces: Learning from the narratives of queer women and nurses in primary

- health care. *Journal of homosexuality*, 63 (2), 141-155. doi:
10.1080/00918369.2015.1083775
- Holley, S. R. (2016). Perspectives on contemporary lesbian relationships. *Journal of Lesbian Studies*, 21 (1), 1-6. doi: 10.1080/10894160.2016.1150733
- Johnson, S. M. (2012). Lesbian mothers and their children: The third wave. *Journal of Lesbian Studies*, 16 (1), 45-53. doi: 10.1080/10894160.2011.557642
- Jordan, J. V. (2010). *Relational-Cultural Therapy*. Washington, D.C.: American Psychological Association.
- Julian, N., Duys, D. K., & Wood, S. M. (2014). Sexual identity formation of women who love women: A contextual view point. *Journal of LGBT Issues in Counseling*, 8 (2), 189-205. doi: 10.1080/15538605.2014.895665
- Kimberly, C., & Williams, A. (2017). Decade review of research on lesbian romantic relationship satisfaction. *Journal of LGBT Issues in Counseling*, 11 (2), 119-135. doi: 10.1080/15538605.2017.1310009
- Kranz, K. C., & Daniluk, J. C. (2008). Living outside of the box. *Journal of Feminist Family Therapy*, 18 (1-2), 1-33. doi: 10.1300/j086v18n01_01
- Lavner, J. A. (2016). Relationship satisfaction in lesbian couples: Review, methodological critique, and research agenda. *Journal of Lesbian Studies*, 21 (1), 7-29. doi: 10.1080/10894160.2016.1142348
- Lewis, R. J., Kholodkov, T., & Derlega, J. D. (2012). Still stressful after all these years: A review of lesbians' and bisexual women's minority stress. *Journal of Lesbian Studies*, 16 (1), 30-44. doi: 10.1080/10894160.2011.557641

- Maccio, E. M., & Pangburn, J. A. (2012). Self-reported depressive symptoms in lesbian birth mothers and comothers. *Journal of Family Social Work*, 15 (2), 99-110. doi: 10.1080/10522158.2012.662860
- McManus, A. J., Hunter, L. P., & Renn, H. (2006). Lesbian experiences and needs during childbirth: Guidance for health care providers. *JOGNN*, 35, 13-23. doi: 10.1111/J.1552-6909.2006.00008.x
- Miller, K. L. (2012). What will they call you? Rhetorically listening to lesbian maternal narratives. *International Journal of Listening*, 26 (3), 134-145. doi: 10.1080/10904018.2012.712471
- Nelson, F. (2008). Lesbian families. *Journal of Gay & Lesbian Social Services*, 10 (1), 27-46. doi: 10.1300/J041v10n01_02
- Nordqvist, P. (2011). Origins and originators: Lesbian couples negotiating parental identities and sperm donor conception. *Culture, Health, & Sexuality: An International Journal for Research, Intervention and Care*, 14 (3), 297-311. doi: 10.1080/13691058.2011.639392
- Patterson, C. J., & Riskind, R. G. (2010). To be a parent: Issues in family formation among gay and lesbian adults. *Journal of GLBT Family Studies*, 6 (3), 326-340. doi: 10.1080/1550428X.2010.490902
- Pelka, S. (2009). Sharing motherhood: Maternal jealousy among lesbian co-mothers. *Journal of Homosexuality*, 56 (2), 195-217. doi: 10.1080/00918360802623164
- Peterson, B., Boivin, J., Norré, J., Smith, C., Thorn, P., & Wischmann, T. (2012). An introduction to infertility counseling: A guide for mental health and medical professionals. *Journal of Assisted Reproduction and Genecology*, 29, 243-248. doi: 10.1007/s10815-011-9701-y

- Pietkiewicz, I., & Smith, J. A. (2012). A practical guide to using phenomenological analysis in qualitative research psychology. *Psychological Journal*, 18 (2), 361-369. doi: 10.14691/CPPJ.20.1.7
- Rausch, M. A., & 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. doi: 10.1080/15538605.2017.1346494
- Rutter, P. A., Leech, N. N., Anderson, M., & Saunders, D. (2010). Couples counselling for a transgender-lesbian couple: Student counselors' comfort and discomfort with sexually counseling topics. *Journal of GLBT Family Studies*, 6 (1), 68-79. doi: 10.1080/15504280903472816
- Skinner, M. D., & Goodfriend, W. (2009). Perceptions of positive relationship traits in gay and lesbian couples. *Journal of Homosexuality*, 56 (3), 319-335. doi: 10.1080/00918360902728749
- Smetana, D. J., & Bigner, J. J. (2008). Therapeutic experiences of lesbian couples. *Journal of Couple & Relationship Therapy*, 4 (1), 23-49. doi: 10.1300/J398v04n01_02
- Smith, J. A., & Osborn, M. (2008). Interpretative phenomenological analysis: In J. A. Smith (Ed), *Qualitative Psychology: A Practical Guide to Research Methods* (53-80). Thousands Oaks, CA: SAGE Publications, Inc.
- Smith, J. A., Flowers, P., & Larkin, M. (2012). *Interpretative Phenomenological Analysis: Theory, Method, and Research*. Thousand Oaks, CA: SAGE Publishers, Inc.
- Somers, S., Van Parys, H., Provoost, V., Buysse, A., Pennings, G., & De Sutter, P. (2017). How to create a family? Decision making in lesbian couples using donor sperm. *Sexual & Reproductive Healthcare*, 11, 13-18. doi: 10.1016/j.srhc.2016.08.005

- Sprague, J. (2005). *Methodologies for Critical Researchers: Bridging Differences*. Walnut Creek, CA: AltaMira Press.
- Wall, M. (2011). Hearing the voices of lesbian women having children. *Journal of GLBT Family Studies*, 7 (1-2), 93-108. doi: 10.1080/1550428X.2011.537231
- Visser, M., Gerrits, T., Kop, F., van der Veen, F., & Mochtar, M. (2016). Exploring parents' feelings about counseling in donor sperm treatment. *Journal of Psychosomatic Obstetrics & Gynecology*, 37 (4), 156-163. doi: 10.1080/0167482X.2016.1195806
- Westmarland, N. (2001). The quantitative/qualitative debate and feminist research: A subject view of objectivity. *Forum: Qualitative Social Research*, 2 (1), 1-11. doi: dx.doi.org/10.17169/fqs-2.1.974
- Wojnar, D. M., & Katzenmeyer, A. (2014). Experiences of preconception, pregnancy, and new motherhood for lesbian nonbiological mothers. *JOGNN*, 43, 50-60. doi: 10.1111/1552-6909.12270
- Wyverkens, E., Provoost, V., Ravelingien, A., De Sutter, P., Pennings, G., & Buysse, A. (2014). Beyond sperm cells: a qualitative study on constructed meanings of the sperm donor in lesbian families. *Human Reproduction*, 29 (6), 1248-1254. doi: 10.1093/humrep/deu060
- Yager, C., Brennan, D., Steele, L. S., Epstein, R., & Ross, L. E. (2010). Challenges and mental health experiences of lesbian and bisexual women who are trying to conceive. *Health and Social Work*, 35 (3), 191-200. doi: 10.1093/hsw/35.3.191

APPENDIX A. IRB APPROVAL



February 15, 2018

Dr. Jill Nelson
School of Education

Re: IRB Determination of Exempt Human Subjects Research:
Protocol #HE18183, "Two Females, One Family: Exploring Counselors' Role during Third-Party Family Formation"

Co-investigator(s) and research team: Jessica Danielson, Jodi Tangen
Certification Date: 2/15/2018 Expiration Date: 2/14/2021
Study site(s): varied
Locations Sponsor: n/a

The above referenced human subjects research project has been certified as exempt (category #2b) in accordance with federal regulations (Code of Federal Regulations, Title 45, Part 46, Protection of Human Subjects). This determination is based on the original protocol submission (received 2/12/2018) with revised consent (received 2/14/2018).

Please also note the following:

- If you wish to continue the research after the expiration, submit a request for recertification several weeks prior to the expiration.
- The study must be conducted as described in the approved protocol. Changes to this protocol must be approved prior to initiating, unless the changes are necessary to eliminate an immediate hazard to subjects.
- Notify the IRB promptly of any adverse events, complaints, or unanticipated problems involving risks to subjects or others related to this project.
- Report any significant new findings that may affect the risks and benefits to the participants and the IRB.

Research records may be subject to a random or directed audit at any time to verify compliance with IRB standard operating procedures.

Thank you for your cooperation with NDSU IRB procedures. Best wishes for a successful study.
Sincerely,

A handwritten signature in purple ink that reads "Kristy Shirley".

Kristy Shirley, CIP, Research Compliance Administrator

For more information regarding IRB Office submissions and guidelines, please consult http://www.ndsu.edu/research/integrity_compliance/irb/. This Institution has an approved FederalWide Assurance with the Department of Health and Human Services: FWA00002439.

INSTITUTIONAL REVIEW BOARD

NDSU Dept 4000 | PO Box 6050 | Fargo ND 58108-6050 | 701.231.8995 | Fax 701.231.8098 |
ndsu.edu/irb Shipping address: Research 1, 1735 NDSU Research Park Drive, Fargo ND
58102

APPENDIX B. RECRUITMENT SCRIPT

Hello (name),

I am a Counselor Education and Supervision doctoral candidate at North Dakota State University and I am currently working to complete my dissertation under the supervision of Dr. Jill Nelson and Dr. Jodi Tangen. I would like to invite you to share the following information with couples that might be interested in participating in a 60-90 minute interview with me to discuss their experiences with counseling during family formation, more specifically the potential role counseling has in the family formation process. The purpose of this study is to explore the experiences of female partners participating in counseling services when receiving third-party fertility treatment, to identify the perceived implications of counseling services received by female partners during the family formation process, and to develop implications for counseling practices specific to female partners during family formation.

Participants are invited to contact me if they (a) self-identify as female; (b) identify as queer, including but not limited to lesbian, bisexual, pansexual, or demisexual; and (c) are coupled with at least one child conceived together and both partners are willing to participate in an interview individually. Attached is a flyer that can be shared with couples that may be interested in participating in this study or with colleagues that know couples that may be interested in participating in this study. My contact information is available on the flyer and interested couples can contact me to schedule an interview. In addition, my contact information is available below.

Thank you for your time and help.

Jessica Danielson, MS, LPC, NCC
PhD Candidate – Counselor Education and Supervision
President – ND Association of Counselor Education and Supervision
701.269.0932 – jessica.danielson.1@ndsu.edu

APPENDIX C. RECRUITMENT FLYER

ARE YOU IN A FEMALE PARTNER RELATIONSHIP?

DO YOU HAVE CHILDREN TOGETHER?

THEN YOU ARE INVITED!

Who am I: I am Counselor Education and Supervision doctoral candidate at North Dakota State University working on dissertation.

Who is invited: You are invited to participate in this study if you....

- Self-identify as female
- Identify as queer, including but not limited to lesbian, bisexual, pansexual, etc.
- Are coupled with another female and have conceived at least one child together
- Both partners are willing to participate in an individual interview

What am I inviting you to do: You are invited to participate in a study that includes a 60-90 minute interview about your experiences in counseling during the family formation process

Why: The purpose of this study is to explore female partners experiences when engaging in family formation and to provide implications for counselors when working with female partners during family formation.

If you are interested in participating, please contact me at
jessica.danielson.1@ndsu.edu or 701.269.0932.

APPENDIX D. INFORMED CONSENT



School of Education
Dept. 2625 PO BOX 6050
Fargo, ND 58108-6050
701.231.7202

Two Females, One Family: Exploring Counselors' Role during Third-Party Family Formation

This study is being conducted by:

Jessica Danielson, MS, LPC, NCC	701.269.0932	jessica.danielson.1@ndsu.edu
Advisor: Dr. Jill Nelson	701.231.74.15	jill.r.nelson@ndsu.edu
Co-Advisor: Dr. Jodi Tangen	701.231.7676	jodi.tangen@ndsu.edu

You are being invited to participate in this study because you are a female and have engaged in family formation with another female. There will be approximately 4-8 participants invited to participate in this research study. These participants will be females that have engaged in family formation with another female.

The purpose of this study is trifold: (a) to explore the experience of female partners participating in counseling services when receiving third-party fertility treatments, (b) to identify the perceived implications of counseling services received by female partners during the family formation process, and (c) to develop implications for counseling practices specific to female partners during family formation.

You are invited to participate in a 60-90 minute face-to-face or a phone/video interview. During the interview you will be asked questions regarding the conception process of child(ren) and, if applicable, your experiences with a psychiatric evaluation and/or fertility counseling during family formation. The interview will be audio recorded and transcribed (written out) for information interpretation. You are invited to choose the most convenient location for your interview; private spaces (such as your work office, a library study room, or an office at North Dakota State University Community Counseling Center) are encouraged to keep you information confidential.

During the interview, you may experience a small amount of discomfort due to the questions that are asked about your personal experiences. In addition, privacy cannot be promised; however, we will keep private all research records that identify you. Your information will be combined with information from other people taking part in the study. When we write about the study, we will write about the combined information that we have gathered. It is not possible to identify all potential risks in research, but the researcher has taken reasonable safeguards to minimize any known risks to you.

You are not expected to get any benefit from being in this research study. However, the research study will increase the knowledge available about the experiences of female partners engaging in counseling during family formation.

Your participation in this research is your choice. If you decide to participate in this study, you may change your mind and stop participating at any time without penalty or loss of benefits to which you are already entitled. Instead of being in this research study, you can choose not to participate. If you withdraw before the research is over, your information will be removed at your request and we will not collect additional information about you.

Before you decide whether you would like to participate in this study, please ask any questions that come to mind now. Later, if you have questions about the study, you can contact Jessica Danielson at 701.269.0932 or jessica.danielson.1@ndsu.edu.

You have rights as a research participant. All research with human participants is reviewed by a committee called the *Institutional Review Board (IRB)* which works to protect your rights and welfare. If you have questions about your rights, an unresolved question, a concern or complaint about this research you may contact the IRB office at 701.231.8995, toll-free at 855-800-6717 or via email (ndsu.irb@ndsu.edu).

You are freely making a decision whether to be in this research study. Your consent to participate in this study indicates:

1. you have read and understood this consent form
2. you have had your questions answered, and
3. you have decided to be in the study.

By participating in this interview, you are providing consent for responses to be used in this study. You will be given a copy of this consent form to keep at the time of the interview.

APPENDIX E. INTERVIEW QUESTIONS

Interview Questions

1. Overall, how would you describe your experience with fertility counseling?
2. What were your expectations of fertility counseling?
3. What topics were discussed most often during fertility counseling?
4. What topics would have been helpful to discuss during fertility counseling?
5. How would you describe the structure of the fertility counseling sessions?
6. How would you describe the relationship developed with your counselor?
7. Describe the effectiveness of your counseling and how prepared you believe your counselor was to discuss your concerns?
8. What barriers, if any, did you experience during fertility counseling?
9. How would you describe the referral process to fertility counseling?
10. How did language influence your experience in fertility counseling?
11. How could your experience with fertility counseling be improved?
12. Was there information you wished you knew before or after the birth of your child(ren)?
13. Have you sought counseling services, in addition to fertility counseling, related to family formation? If so, describe your experience and how it might have differed from fertility counseling.