AIMS For a better birth...

He's not the mother

AIMS Journal, 2017, Vol 29 No 2

Mari Greenfield looks at language, LGBT and inclusion

When lesbian, gay, bisexual and transgender (LGBT) people have children, the language commonly used by those providing maternity care can be either inclusive or exclusive, as can the assumptions that lie behind that language. In this article I am going to talk about both my experiences as a lesbian mother who has given birth and about the experiences of other LGBT parents, including parents I have worked with as a doula, and as reported in academic texts and the press. There are examples of good practice and poor practice.

How do LGBT people conceive?

In order to understand the barriers that LGBT parents might face, it is important to understand that LGBT people may create families in different ways. For the purposes of this article, which is about birth, I am going to leave aside options that include adoption, and having children from a previous relationship. Lesbians and bisexual women may have babies as a single parent, or as part of a couple. Single lesbian and bisexual women are likely to face the same assumptions and language barriers as single heterosexual women. Therefore, in this article, I will concentrate on LGBT people having babies within a same-sex relationship, or as an 'out' transperson (or both).

Lesbian/bisexual women couples may have conceived using sperm from a fertility clinic, or they may have conceived using sperm from a 'known donor'. Their intentions may be to raise the baby with the two women as the only parents, or if using a known donor, there may be additional parents involved in a variety of roles in the baby's life.

Gay and bisexual men may become parents through a co-parenting relationship with a single woman, or a lesbian/bisexual woman couple. They may also become parents through surrogacy. Their role in their baby's life may include the baby living full-time or part-time with them, or not living with them at all. It may be that only the genetic father is intended to have a role as a father, or it may be that he and his partner are intending to have an equal parenting role. Transmen and transwomen may also become parents. This may be as the partner of a genetic parent, or through being the genetic parent themselves. They may be in same-sex or opposite-sex relationships when they become parents, or they may be single.

What are LGBT people's experiences of giving birth?

The academic literature shows that there are specific issues faced by LGBT parents during birth.

Similarly, press accounts show that the experience of being the non- biological mother can include being dismissed and not treated as the mother, as Montbaston (2017) says to the point where:

'I ended up in tears saying that I felt I constantly had to justify that I was the baby's mother'.

Montbaston's experience also included people assuming she, as the more feminine presenting partner 'should have' been the pregnant one. Post birth, her experience was that when she did introduce herself as the mother, and talked about her partner, it was assumed that she had given birth, and her partner was a man, even when she said

'My partner is a woman. She had a baby on Sunday' (Montbaston, 2017)

This impacted whether she was allowed to go and get food from the trolley for her partner, who was assumed to be a man, and therefore not allowed to have the hospital food. For Montbaston this lack of recognition as a partner and parent was distressing. For Montbaston's partner, it meant a newly postpartum woman who was not able to get out of bed was likely to be denied food.

Research by Maccio and Pangburn in 2012 links these experiences of non-inclusion to a slightly elevated level of post-partum depression in lesbian birth and 'co-mothers'. This finding is reinforced by the work of Abelsohn, Epstein and Ross in 2013, which found that 'non-birth lesbian, bisexual and queer' parents' mental health in the perinatal period was affected by four groups of factors;

- biology, connectedness, and relatedness
- social recognition, including recognition from Maternity Services
- social support
- changes during pregnancy, which should be discussed by the maternity care provider

This means that maternity care providers getting the support right for LGBT parents has an impact on physical and mental health of the genetic and birth parents, non- birth parents, and the baby in very real ways.

What problematic assumptions might those involved in perinatal care make?

Most people conceive within a heterosexual relationship, with the woman giving birth. Recognising that this is a majority experience is fine, but assuming that this means that all people conceive this way leads to the difficulties like those above.

It is problematic for lesbian/bisexual women couples when maternity care providers assume the woman's partner will be a man, and the genetic parent of the child. It is problematic for gay/bisexual men when it is assumed that they will not be involved as a father, or that only the genetic father will be involved, or when it is assumed that his partner will definitely be involved (as this may not be the case).

In the circumstances of a gay/bisexual man/couple becoming parents through surrogacy, healthcare providers need to recognise that the birth choices are still the birthing woman's to make. However, all

involved may have decided that the postnatal decisions are for the father/fathers to make (or they may have not decided this). Clarity is needed, for the parents, and the healthcare providers.

For transmen and transwomen having children, the problems may become even more complex. Transitioning can include taking hormones, and sometimes having surgery, which can affect the person's ability to be a genetic parent in the future. In the UK, the NHS has the discretion to offer to freeze eggs or sperm prior to transition, but can also refuse to do so. The number of applications which are accepted/refused are not known. This year, Cross, a 20 year old pregnant transman, chose to be public about the fact that the NHS's refusal to freeze his eggs led him to have few choices;

1. Never be a genetic parent, or
2. Wait many years to medically transition, or
3. Have a baby as a single father at a younger age than he would have ideally chosen.

Cross chose the last option, but in an article by Dale (2017), expressed unhappiness that he had been put into this situation, when he would have preferred to have had the choice to become a parent later on, and possibly as part of a couple.

Choices about birth may also affect the transitioning process for some transpeople. Research by MacDonald et al (2016) into transmen's experiences of birth and infant feeding suggested that more than one man had: '*actively withheld his desire to have children from his surgeon, worried that any questions about breastfeeding would hamper his chances of obtaining the surgery.*'

Further difficulties can be experienced simply getting access to services. MacDonald himself reports that during his second pregnancy, after 'worrying symptoms' led him to need to go straight to the hospital, he was denied access to the obstetric unit by a security guard, and had to: *'come out to them as transgender and explain a lot of my backstory in the middle of a hallway alongside other people who were also trying to get past the security desk... that didn't feel particularly safe.'*

Most of the difficulites discussed above stem from the same group of assumptions. These are that:

- It will be a woman giving birth
- If she has a partner, he will be a man
- These two will be the only parents of the baby
- Genetic parents, legal parents, and those raising the baby are the same, and the terms are interchangeable.

How does the language used reflect these assumptions?

Many forms, computer records, and written policies relating to pregnancy and birth will have a space for 'mother' and one for 'father'. Sometimes, they genuinely do want the details of the two genetic parents – for example NHS forms which calculate the probable height the child will be as an adult, or which record likely allergies. Other times, the details actually sought will be about who will have care of the child, or

who will be present at the birth, or who will have legal responsibility for the child.

In recognition of the latter situation, some NHS Trusts have replaced 'father' with 'partner' on some policies and forms. Where such substitutions have not been made on forms, some individual practitioners will substitute 'partner' for 'father' when talking to women, if they are aware that the parents are a same-sex couple. This is well-intentioned, but not always helpful. For example, in my own first pregnancy my midwife, in an attempt to be inclusive, asked my partner about her family health history, which was entirely irrelevant to the risk factors for our baby, but did lead to a referral to a consultant for a genetic condition that exists in my partner's family!

Other problems exist for gay men becoming parents. The substitution of the word 'partner' for 'father' may exclude gay men who are not the partner of the birthing woman. Also, when surrogacy involves egg donation to a gestational surrogate, simply having one space for 'mother' in forms may not be accurate. Health details of both the egg donor and the surrogate may influence the pregnancy and birth.

It is problematic for transmen when it assumed that only women can become pregnant, and that pregnant people will all use terms such as 'mother' and female pronouns such as 'she' and 'her'. It is problematic for transwomen who are genetic parents when it is assumed that the person who supplies the sperm that creates the baby will use male pronouns, and the terms 'man' and 'father'. In some cases, this can lead to real difficulties, such as for Yuval Topper-Erez, a transman, and his husband, who struggled to register the birth of their baby in Israel. The problems arose because legally, male parents could only be recorded as 'father', and two biological fathers could not be listed on a birth certificate.



For some transpeople, the language used for body parts can reinforce any underlying dysphoria. For example, MacDonald et al's (2016) research showed that many transmen preferred to term their nursing relationship as 'chestfeeding', rather than 'breastfeeding', as 'breast' denotes gender. However, different people will prefer different terms, and (as with partner for father), simply substituting one term for another will not necessarily improve the experiences of all LGBT parents.

How could we improve our language?

Inclusion is something which many maternity care providers are striving to achieve, which is very welcome. Moves towards greater inclusion in language can be seen in the common adoption of the term 'partner', rather than terms such as 'husband' and 'father'. However, as shown above, it cannot simply be a case of replacing these terms, because the realities of LGBT parenting do not conform to a two parent, two genders, model. Improving our language needs to start from the recognition that there may be more than two parents, and different parents may have different roles (genetic parents, legal parents, parents who are raising children). Equally, in LGBT families, a parent's gender does not necessarily denote their role.

This makes it difficult for those supporting LGBT families, as there are not always simple substitutions that can be made to improve the language used.

The answer to this difficulty may be a process of rethinking how we approach our own understandings of the perinatal family:

- Be aware of what assumptions you have. We all have assumptions, but being aware of what they are is a necessary first step to being open to alternative possibilities.
- Don't be afraid to ask questions, but think about whether they are necessary.

If you don't know whether the baby's genetic health history is known, it is fine to ask if it is. Equally, if you are not sure what pronouns a person prefers, ask. However, questions about why parents decided how to conceive/who was to carry the child/for non-medically relevant details of transition are not actually necessary, and can be upsetting.

- Think about gendered terms.

For convenience, we can slip into using terms such as 'the mother' and 'the father', but these can be problematic for LGBT families. 'The mother' implies there is only one mother, and assumes that the person who is pregnant is going to identify as a woman and a mother. There may be one mother, two mothers, or no mothers when LGBT people have children, and the same is true for 'the father'. Using names instead of roles can avoid this.

- Think about what you actually need to know.

As mentioned above, simply substituting one term for another does not lead to inclusion, and can lead to inappropriate questions and/or referrals. Before asking a question, think about what you actually want to find out, and then phrase the question accordingly.

- Ask open questions.

'Who are the baby's parents?' and 'who gave birth?' are much better questions than 'who is the real mother?' or 'where is the mother?'

- When you have been told something, record it.

Asking about someone's gender, pronouns, or who their partner is once is perfectly fine, and often welcome. However, once that information has been obtained, the same question should not be asked repeatedly, or by multiple people.

This process can be applied by individual professionals to their interactions with clients. It can also be applied by organisations, in particular as an aid to work through and improve their forms, recording systems, policies and practices.

MacDonald (2015), urges those involved in maternity care not to choose between celebrating women, and ensuring we include all pregnant people. He advocates being 'generous with our ink' and ensuring we include everyone. In the context of LGBT inclusive language, we could add the suggestion to those involved in maternity care to be 'generous with our questions' – star ting with a generous approach to questioning our own assumptions.

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References

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