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Enhancing Counselors' Cultural Competency When Working With Lesbian-Headed Families During the Processes of Family Formation, Conception, Pregnancy, and Birth

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Abstract

Recent research indicates that there is an increase of lesbian-headed families who are choosing to start families. As a result, lesbians are increasingly more visible in maternity health care services. There is limited research available regarding lesbian family formulation and even more scarce is research on implications of practice for counselors working with lesbian-headed families. As lesbians increasingly opt to start families, there will be a growing need for lesbian-affirmative counselors that can address various concerns and challenges specific to lesbian-headed families. The purpose of this article is to enhance counselors' cultural competency when working with lesbian-headed families to better facilitate discussions surrounding family formation, conception, pregnancy, and birth.

Keywords: lesbian families, lesbian mothers, fertility counseling

According to a survey conducted in 2013 by the U.S. Census Bureau, there are 373,976 reported lesbian couples in the United States. Of this population, 22.82% of these lesbian couples reported having children in their household, with 20.71% having biological children in their household (U.S. Census Bureau, 2013). These results suggest that thousands of lesbian women each year seek fertility treatments in the United States. As lesbians increasingly opt to start families within the context of same-sex relationships (Hayman, Wilkes, Halcomb, & Jackson, 2015) and become more visible in the maternity health care system, practicing counselors are more likely to be confronted with the unique challenges that lesbian-headed couples may be experiencing.

Lesbians considering becoming mothers have a range of decisions to make, and competent counselors can aid in the facilitation of critical discussions surrounding family formation and motherhood. More specifically, some lesbians have identified that being a mother was previously excluded from their lesbian identity development based on personal, familial, and societal expectations (Hayman et al., 2015). The purpose of this article is to enhance counselors' cultural competency when working with lesbian-headed families to better facilitate discussions surrounding family formation, conception, pregnancy, and birth. Cultural competency is the understanding and appreciation for unique barriers, challenges, and strengths of underrepresented populations (Yager, Brennan, Steele, Epstein, & Ross, 2010).

Due to new social and medical developments over the last several decades, lesbian-headed families are more visible, as are the multitude of unique challenges they can experience during family formation, conception, pregnancy, and birth (Ben-Ari & Livni, 2006). Social developments that have impacted the rights and well-being of lesbian-headed families include the women's liberation movement (Ben-Ari & Livni, 2006), the lesbian, gay, bisexual, and transgender (LGBT) civil rights movement (Ben-Ari & Livni, 2006), the elimination of "don't ask don't tell" (Miller, 2012), and the public support of LGBT rights by President Barack Obama (Miller, 2012). In addition to these social developments, technological developments in conception and infertility procedures have impacted lesbian couples and their possibilities for starting families (Ben-Ari & Livni, 2006). These social and medical developments have helped to increase the number of children being born into lesbian-headed families (Abelsohn, Epstein, & Ross, 2013). To better understand current implications specific to lesbian-headed families, we will discuss family formation, conception, and pregnancy.

Family Formation

Family formation is when a couple begins to discuss and negotiate the processes of conception, pregnancy, birth, and parenting (Wojnar & Katzenmeyer, 2013). This article refers specifically to lesbian family formation. Opting to start a family as a lesbian couple involves additional processes and choices that most heterosexual couples may not encounter due to our heteronormative society, such as: constraints within maternity health care systems with heteronormative infrastructures, the chance of decreased support or total rejection from various support systems, the cost of assisted reproductive technologies, and societal stigmatization for raising children in a same-sex household (McManus, Hunter, & Renn, 2006). If a lesbian couple opts to start a family, several additional considerations need to be negotiated and discussed, including which partner will conceive their child, what method of conception will be used, where conception will take place (in their home or using maternity health care facilities; McManus et al., 2006) and what their family model will "look like."

When determining which partner will conceive the child, there are several factors to consider such as each partner's age, employment security, desire to conceive, and reproductive health (Wojnar & Katzenmeyer, 2013). Other lesbian couples may negotiate by alternating who conceives during each pregnancy (Pelka, 2009). Once the lesbian couple has decided which partner will conceive their child, they decide on a method of conception (Wojnar & Katzenmeyer, 2013).

Methods of conception include vaginal insemination, intrauterine insemination, and in vitro fertilization (IVF; Pelka, 2009). Vaginal insemination is when sperm is placed vaginally, mimicking the conception process of heterosexual intercourse (Hayman et al., 2015). Vaginal insemination can be completed at home or medically (Hayman et al., 2015). Intrauterine insemination is when sperm is placed directly in the uterus and requires medical assistance from a physician (Mayo Foundation for Medical Education and Research, 2015). IVF is when embryos are implanted in the uterus and requires medical assistance from a physician (Mayo Foundation for Medical Education and Research, 2015).

Selecting the Method of Conception

Selecting a method of conception can be dependent on multiple variables; one of the primary variables is whether the lesbian couple is interested in a known donor or an unknown donor (Hayman et al., 2015). Lesbian couples opting for known donors have more options, including vaginal insemination, while lesbian couples opting for unknown donors are limited to intrauterine insemination or IVF (Hayman et al., 2015). In addition, local regulations on accessing fertility treatments may exclude lesbian couples from accessing IVF (Hayman et al., 2015).

When choosing a conception method, the lesbian couple must consider the laws and legislation regarding parenthood (Abelsohn et al., 2013). For example, if the lesbian couple knows the male donor, he has legal parental rights of the child unless he forfeits his legal parenting rights (Abelsohn et al., 2013). Therefore, many lesbian couples choose to have anonymous male donors when conceiving (Nordqvist, 2011). It should be noted, however, that equal parenthood recognition is not always granted to the non-biological mother or co-mother (Ablesohn et al., 2013). Co-mothers may have to seek legal and/or adoption services in order to be granted equal parenthood recognition (Maccio & Pangburn, 2012).

Legal equal parenthood recognition does not necessarily fill the gap in societal perceptions of lesbian-headed families, especially regarding the families and friends of the lesbian-headed family (Ben-Ari & Livni, 2006). This is causing IVF to become increasingly popular among lesbian couples (Abelsohn et al., 2013), because both partners feel equitable biological ties to the child (Pelka, 2009). During IVF, lesbian couples can choose one partner's egg to fertilize and then implant the embryo in the other partner's uterus (Pelka, 2009). When using IVF, lesbian couples appear to have a greater sense of marital satisfaction and connection compared to other forms of assisted reproductive technologies (Borneskog, Lampic, Sydsjo, Bladh, & Svanberg, 2014). This issue will be discussed further in the pregnancy and birth section.

Once the lesbian couple has chosen a form of conception, they must negotiate what their family model will "look like." In the United States, the idealized family model is the nuclear family containing a mother, a father, and two children, preferably a son and a daughter (Ryan & Berkowitz, 2009). There is an absence of representation of lesbian-headed families within our media and culture, leaving lesbian-headed families without role-models (Ben-Ari & Livni, 2006). Without mainstream representation of lesbian-headed families, many lesbian-headed families struggle with defining roles and balancing gender identities (Pelka, 2009). Lesbian-headed families typically define their roles as egalitarian. But without mainstream representation of lesbian-headed families, society

has difficulty accepting their egalitarian family model, therefore leading to reduced support and increased stigmatization (Ben-Ari & Livni, 2006).

Conception

When the lesbian couple has moved past negotiation and discussion of which partner will conceive their child, what method of conception will be used, where conception will take place, and what will their family model “look like,” they may opt to start the conception process. During the conception process, lesbian couples may have increased feelings of fear and anxiety (Borneskog, Lampic, Sydsjo, Bladh, & Svanberg, 2013). The maternity health care system is one of the primary concerns of lesbian couples (Hayman, Wilkes, Halcomb, & Jackson, 2013). Even before lesbian couples schedule their first appointment for conception services, they are less likely to have shared health insurance plans that will cover conception procedures (Maccio & Pangburn, 2012). Also, health insurance plans may not cover conception procedures for lesbians unless they are considered infertile (Wojnar & Katzenmeyer, 2013). Health care visits and conception procedures can easily become a financial burden for lesbian couples and could decrease marital satisfaction and connectedness (Wojnar & Katzenmeyer, 2013).

The main challenge that lesbian couples experience during the conception process is homophobia in maternity health care systems (Ryan & Berkowitz, 2009). Homophobia in health care might be experienced through exclusion, heterosexual assumption, inappropriate questioning, and refusal of services (Hayman et al., 2013). Exclusion is a form of homophobia in the maternal health care system that does not provide the equal treatment, care, or services to same-sex couples compared to their heterosexual counterparts (Pelka, 2009). Examples of exclusion may include medical professionals not allowing the co-mother to participate in health-related procedures but allowing fathers in heterosexual relationships to participate, only supplying informational materials targeting heterosexual parents, and using inappropriate terms such as sister, cousin, and friend to identify co-mothers (Hayman et al., 2013). Heterosexual assumption is a form of homophobia in the maternal health care system in which medical professionals assume the lesbian birth mother is heterosexual (Wojnar & Katzenmeyer, 2013). Examples of heterosexual assumptions may include medical professionals asking about the husband or father and asking about infertility concerns during conception when not seeking infertility services (Hayman et al., 2013). For example, lesbians seeking fertility services do not have other options for fertility, regardless of fertility or infertility status, other than going to an infertility clinic. Whereas heterosexual counterparts are able to attempt conception in other forms prior to seeking infertility services. Lesbians seeking fertility services are not, necessarily, seeking the services due to infertility but rather for only family formation. Also, inappropriate questions may include medical professionals asking questions about male role models, parenting concerns, and what method the lesbian couple chose for conception (Pelka, 2009). Another type of homophobia is refusal of services. Refusal of services is a form of homophobia in the maternal health care system that denies lesbian couples partial or full access to conception services, including refusal by individual medical professionals and due to legislation at-large (Hayman et al., 2013).

Homophobia in the maternity health care system may put lesbian couples at higher risk for emotional complications, especially postpartum depression (Borneskog et al., 2013) and continues to foster feelings of marginalization, stigmatization, and

discrimination (Hayman et al., 2013). Homophobia in the maternity health care system can also increase marital dissatisfaction and connectedness among lesbian couples (Ben-Ari & Livni, 2006). Co-mothers are often not included on maternity health care forms, staff are uncomfortable or unsure of how to address the co-mother (due to lack of consistent terminology), and there is a lack of resources specific to co-mothers (Miller, 2012). Research has suggested that upon conception, the co-mother may begin to feel jealous and resentful towards her partner (Pelka, 2009). Co-mothers may also begin to feel jealous and resentful due to fears of not bonding with their child and the uncertainty of parenthood (Pelka, 2009). However, the maternity health care system may further isolate and exclude the co-mother, causing more relationship stress and tension (Miller, 2012).

Pregnancy and Birth

Concerns regarding marital dissatisfaction and connectedness continue as the pregnancy progresses (Miller, 2012). Co-mothers may become increasingly more anxious, depressed, jealous, angry, or resentful due to concerns regarding biological connectedness to their child and potential legal issues with parenthood (Abelsohn et al., 2013). In addition to relationship concerns among the lesbian couple, they may be noticing a lack of support from friends and family due to their decision to have children (Ben-Ari & Livni, 2006). There are a multitude of reasons their friends and family are not supportive, including that bearing children with a same-sex partner is solidifying their sexual orientation (Ben-Ari & Livni, 2006). Also, same-sex couples have reported that there is a decrease in support from the LGBT community when couples decide to start families (Abelsohn et al., 2013). The LGBT community may perceive a couple starting a family as striving to belong to the heterosexual community (Abelsohn et al., 2013). Both the mother and co-mother may experience additional stressors individually and as a couple, especially marginalization, stigmatization, and discrimination, which increase the risk of mental illness (Alang & Fomotar, 2015). After birth, both the mother and co-mother are at higher risk of postpartum depression (Alang & Fomotar, 2015).

Implications for Practice

As lesbians increasingly opt to start families and become more visible in the maternity health care system, practicing counselors are more likely to be confronted with the unique challenges that lesbian couples may be experiencing. To serve these women in a welcoming and helpful way, counselors must become culturally competent, inclusive, curious, active learners.

To enhance counselors' cultural competency when working with lesbian-headed families during the processes of family formation, conception, pregnancy, and birth, counselors need to have an understanding and appreciation for the unique barriers and challenges lesbian couples endure (Yager et al., 2010). Culturally competent counselors working with lesbian couples continually evaluate their personal awareness of values, biases, and prejudices regarding lesbian couples (Maccio & Pangburn, 2012). Culturally competent counselors are also continuing to build their knowledge regarding cultural differences and institutional barriers (Maccio & Pangburn, 2012). Attending routine and special topic educational workshops and conference sessions regarding working with

lesbian clients will help maintain and progress cultural competency (Maccio & Pangburn, 2012). If your agency or community does not offer working with lesbian client topics at workshops or conference sessions, be an advocate for gaining access to workshops and conference sessions that do include topics related to working with lesbian clients (McManus et al., 2006).

In addition to cultural competency, be prepared to have a welcoming atmosphere for possible lesbian clients (Maccio & Pangburn, 2012). Creating a welcoming atmosphere can include: ensuring forms and paperwork are inclusive; depicting various symbols supporting LGBT rights throughout the building; having LGBT magazines in the waiting room (e.g., *Curve*, *Out*, *Attitude*); providing LGBT specific informational brochures alongside other brochures; allowing blank spaces on forms for questions relating to marital status, sexual orientation, and gender; and, if possible, registering as a LGBT-affirmative counselor in your community. Other ways to be prepared to work with lesbian clients are to have lists of local LGBT-friendly health care practitioners, attorneys and legal specialists, and other community-based resources specific to LGBT individuals (Maccio & Pangburn, 2012). Even though counselors cannot be prepared for everything, it is important that they educate themselves on specific institutional barriers, including local and federal legislation, affecting lesbian couples and their ability to start families (McManus et al., 2006).

Counselors can also educate themselves on evidence-based practices relating to lesbian-specific issues or general practices that may overlap such as infertility and couples counseling (Yager et al., 2010). Regardless of the amount of training and preparation counselors have completed, they should be comfortable addressing sexual orientation openly with lesbian clients (McManus et al., 2006). When working with lesbian clients on concerns specific to family formation, conception, pregnancy, and birth, counselors need to be aware of heteronormative society and consider how the lesbian couple is functioning in a heteronormative maternity system (Yager et al., 2010). Also, it is vital to validate the individual experiences of the lesbian couple (Maccio & Pangburn, 2012). Encouraging involvement of previously and currently supportive friends and family during the counseling process can be important when reestablishing or strengthening the lesbian couple's support system (Maccio & Pangburn, 2012). Involving friends and family can also facilitate conversations to create more understanding among the lesbian couple's support system (Maccio & Pangburn, 2012).

When working with lesbian couples and lesbian-headed families, the counselor should clarify the family model and acknowledge the specific roles of both the mother and co-mother (Borneskog et al., 2014). Often when lesbian couples are seeking counseling services, there is evidence of mental illness, such as depressive and anxiety related-disorders; however, it is imperative to consider that mental illness is a mask for concerns related to rejection, isolation, discrimination, and invisibility or hypervisibility (Alang & Fomotar, 2015). In fact, if a counselor notices a high influx of lesbian couples due to specific concerns, the counselor can create a variety of resources such as a group or an online group discussion board (Yager et al., 2010).

Conclusion

As human rights legislation continues to evolve in the United States, lesbians are becoming more visible in communities. Recent research indicates that there is an increase of lesbian-headed families who are choosing to start the family formulation process. As a result, lesbians are increasingly more visible in maternity health care services. There will be a growing need for culturally competent counselors to work with lesbian couples throughout the processes of family formation, conception, pregnancy, and birth due to the unique challenges lesbian-headed couples experience during these processes.

Counselors should understand the implications of heteronormativity on lesbian couples' family formation, conception, pregnancy, and birth, especially in relation to mental illness and marital dissatisfaction and connectedness. Homophobia does still exist and is visible in the maternity health care system. To help reduce homophobia in the maternity health care system, new and consistent terminology needs to be implemented for lesbian couples seeking conception services and for co-mothers involved in the conception process. Counselors can be advocates for lesbian couples, especially when allied with culturally competent health care professionals.

In conclusion, this article has outlined unique challenges specific to lesbian couples during family formation, conception, pregnancy, and birth. The purpose of this article was to enhance counselor cultural competencies when working with lesbian couples that are experiencing these unique challenges. It is important that counselors be prepared to work with lesbian couples and know how to access appropriate trainings and additional information related to working with lesbian couples. It is also important to note that there is limited research available regarding lesbian family formulation and even more scarce research on implications of practice for counselors working with lesbian-headed families. The majority of research found was conducted outside of the United States and was published in a medical journal. Further research is needed on the specific experiences of lesbian couples during family formation, conception, pregnancy, and birth and the implications for counselor practice.

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