
Article:
Darwin, Z orcid.org/0000-0001-8147-0669 and Greenfield, M (2019) Mothers and others: The invisibility of LGBTQ people in reproductive and infant psychology. Journal of Reproductive and Infant Psychology, 37 (4). pp. 341-343. ISSN 0264-6838

https://doi.org/10.1080/02646838.2019.1649919

JRIP Editorial

Title
Mothers and Others: The invisibility of LGBTQ people in reproductive and infant psychology

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Main text (word count: 998)
Queer people's experiences of conception, pregnancy, birth and parenting are under-recorded, under-researched, and under-heard. Research on pregnancy continues to be 'centered within a heteronormative framework' (Charter, Ussher, Perz and Robinson, 2018) and this needs to change, to address the invisibility of LGBTQ people.

The numbers of LGBTQ people having babies is unknown in most countries due to universal data rarely being collected on the gender or sexual orientation of those who are pregnant, or their partners. Indeed, in many parts of the world, such a requirement could compromise safety or family life. In the UK, data from fertility clinics (HFEA, 2019) and birth registrations (via the Office of National Statistics) identify that lesbian couples are one of the fastest growing groups within maternity services, with fertility treatment and live births increasing by 15-20% in this group, year on year for the past decade. Fertility treatment in UK clinics involving surrogacy has shown a similar increase but it is not known what proportion of intended parents are heterosexual couples and what proportion are gay men because fertility clinic statistics assume a female patient and report statistics as 'male partner', 'female (same-sex) partner', 'no partner' or 'surrogacy'. No figures are available for transgender people becoming pregnant or impregnating their partners. Referrals to UK Gender Clinics have however risen every year, have risen proportionally more for trans men than trans women, and given that the literature shows many trans men wish to be parents (Riggs, Power, and von Doussa, 2016), pregnant trans men may also be a growing population with maternity services. How characteristics/minority groups are recorded has implications for the ability to commission or adapt services to meet local needs and implications for how people are identified for research purposes.

Over the years, the Journal of Reproductive and Infant Psychology has contributed significantly to the literature on LGBTQ parents – predominantly lesbian couples and in relation to assisted conception and donor conception, with some investigations into support for family diversity in different countries, and a smaller amount of research into gay men's reproductive psychology, both in the context of being sperm donors and of having their own children through surrogacy. However, following the patterns in the wider literature, few of the published articles relating to LGBTQ reproduction examine birth experiences or focus on perinatal mental health. Much progress has been made in the area of paternal perinatal mental health but continuing to adopting a heteronormative approach in this area risks conflating gender and role. For example, which aspects of paternal perinatal mental health are linked to being a 'man' or 'father', and which to being a co-parent or (often) secondary caregiver?

There is a growing body of evidence in relation to lesbian women's experiences of reproductive and maternity care, but research addressing the birth experiences and psychological health of lesbian mothers has been limited, and has focused on postnatal

depression. Researched even less has been the experiences and psychological health of bisexual women who have male partners at the time of their pregnancy (Goldberg, Ross, Manley, and Mohr, 2017). In addition, research has not captured the complexity of family forms; for example, that with a lesbian couple, the children may be biologically connected to a non-birth parent, or that both partners may be (or may attempt to be) birth parents within that family. We have not yet developed shared language in research or practice to adequately describe reproductive histories outside of a cis birth mother's; this applies too in a heterosexual context, where there is a lack of scientific description to describe men's histories, using language such as 'first-time fathers' or 'subsequent fathers' which do not capture perinatal loss, or having children with different partners.

Studies do exist of trans men's experiences of pregnancy, but this is a recently emerging field of research, with the earliest literature dating back only to 2014. The literature primarily focuses on the structural and psychological barriers that trans men who wish to become pregnant may face (Charter, Ussher, Perz and Robinson, 2018), and on the lack of reliable medical information available to them (Light, Obedin-Maliver, Sevelius and Kerns, 2014). To date, no research into trans men's experiences of giving birth has focused on mental health, and none of the research has included their partners' experiences.

Similarly, research into gay men's experiences of parenting through surrogacy has focused on the children's developmental outcomes, and the complex politics of surrogacy. No research focusing on gay men's experiences of or involvement in the actual surrogate pregnancy and birth has been undertaken, and information on the new fathers' perinatal mental health is scarce.

Trans women who experience pregnancy and birth will usually do so as the partner of a cis woman, and their perinatal experiences as a trans woman are therefore enmeshed with their perinatal experiences as a lesbian partner. No research into lesbian birth experiences has identified trans women's experiences separately from cis women's, and we could find no literature about trans women's perinatal experiences.

Invisibility in research is mirrored in policy. For example, the National Maternity Review in England emphasises the importance of perinatal mental health but unfortunately assumes that all new mothers will have been pregnant themselves, thus excluding lesbian co-mothers from the category of 'new mothers' (NHS England, 2016). Similarly, the new commitment in the NHS Long Term Plan (NHS England, 2019) to offer mental health assessment and signposting to 'fathers/partners of women accessing specialist perinatal mental health services' does not fully address the diversity of family forms, either in recognising non-male non-birth parents as parents (rather than solely partners) or that birth parents may not be women.

The law, policy, health systems and health professionals are struggling to keep up with the realities of how families are being made. As researchers, we need to ensure people's voices are heard, address the visibility of minority groups, deepen our understanding of reproductive and infant psychology, and identify implications for policy and practice where the gender of at least one of the parents differs from societal expectations.

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