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Fall 11-2005

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Lori E. Ross

Leah Steele

Beth Sapiro

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Perceptions of Predisposing and Protective Factors for Perinatal Depression in Same-Sex Parents

Lori E. Ross, PhD, Leah Steele, MD, PhD, and Beth Sapiro, BSc

Increasing numbers of women are choosing to have children in the context of same-sex relationships or as “out” lesbian or bisexual individuals. This study used qualitative methods to assess perceived predisposing and protective factors for perinatal depression in lesbian, gay, bisexual, and queer (LGBQ) women. Two focus groups with LGBQ women were conducted: 1) biological parents of young children and 2) nonbiological parents of young children or whose partners were currently pregnant. Three major themes emerged. Issues related to social support were primary, particularly related to disappointment with the lack of support provided by members of the family of origin. Participants also described issues related to the couple relationship, such as challenges in negotiating parenting roles. Finally, legal and policy barriers (e.g., second parent adoption) were identified as a significant source of stress during the transition to parenthood. Both lack of social support and relationship problems have previously been identified as risk factors for perinatal depression in heterosexual women, and legal and policy barriers may represent a unique risk factor for this population. Therefore, additional study of perinatal mental health among LGBQ women is warranted. *J Midwifery Womens Health* 2005;50:e65–e70 © 2005 by the American College of Nurse-Midwives.

keywords: homosexuality, lesbian, parenting, postpartum depression, risk factors, qualitative research

INTRODUCTION

Depression during pregnancy and the postpartum period is a common health concern, affecting 10% to 15% of women.^{1–4} However, research on perinatal mental health has been conducted in heterosexual samples and does not address unique issues that may determine mental health in lesbian and bisexual mothers. We used focus group methodology to identify variables perceived by lesbian, gay, bisexual, and queer (LGBQ) mothers to be predisposing or protective factors for depression and other mental health problems during the perinatal period.

Background

Social stigmatization is a risk factor for mental disorders among marginalized populations,^{5–7} including LGBQ people.^{8–11} A recent meta-analysis found that lesbian and gay individuals were 2.4 times more likely to suffer from mood, anxiety, and substance-related disorders than were heterosexuals.⁹ In heterosexual women, the perinatal period has been associated with an increased risk for psychiatric illness.¹² To our knowledge, no studies have investigated the prevalence or determinants of perinatal distress for LGBQ mothers. Rather, studies of lesbian families have examined mental health in mothers of older children. For example, lesbian mothers of toddlers and school-age children have equivalent levels of depressive symptoms relative to heterosexual control groups.^{13–16}

Research on lesbian families has indicated that they may differ from heterosexual families in ways that could be relevant to perinatal mental health. LGBQ mothers may be more likely than heterosexual women to lack support from members of their families of origin and may face stress due to homophobia.¹⁷ Lack of social support is among the strongest risk factors for postpartum depression.¹⁸ The impact of social discrimination on perinatal mental health has not been studied a great deal, although there is some evidence linking perceived discrimination to perinatal depression in ethnic minority mothers.^{19,20} Other characteristics of women in same-sex partnerships may protect against perinatal distress, including low rates of unplanned pregnancies and equal division of child care labor.^{17,21} Both unplanned pregnancy²² and dissatisfaction with division of labor²³ have been associated with postpartum depression in heterosexual samples.

METHODS

Two focus groups were conducted in downtown Toronto in November 2003. Focus group methods were used to enable members of the population of interest to share their experiences with each other and with the researchers, and in so doing, describe in their own words perceived predisposing and protective factors for mental health problems. Focus groups are a useful method to investigate people's understandings of illness, particularly where information about the population's conceptual frameworks and priorities is desired.²⁴ Because of their capacity for identifying shared knowledge, focus groups are thought to be particularly useful for research with minority or marginalized populations.²⁵

Address correspondence to Lori E. Ross, PhD, Women's Mental Health & Addiction Research Section, Centre for Addiction & Mental Health, 250 College Street, Toronto, Ontario M5T 1R8 Canada. E-mail: l.ross@utoronto.ca

Participants were recruited via e-mail and paper flyers distributed through service providers and list serves for the lesbian, gay, and bisexual and parenting communities in Toronto and the surrounding area. To be eligible to participate, participants were required to 1) identify their sexual orientation as other than heterosexual (including lesbian, gay, bisexual, two-spirit, and queer) and 2) to be the biological or nonbiological mother of a child less than 3 years of age or to be an expectant mother. Adoptive parents, bisexual women parenting with male partners, and women with children over 3 years of age were excluded. In total, 57% of interested women were eligible to participate; the most common reason for ineligibility was that the youngest child was over 3 years of age. No eligible participants declined to participate; however, 7 eligible participants were unable to attend the focus groups due to scheduling conflicts ($n = 4$), illness ($n = 1$), or difficulty traveling to Toronto ($n = 2$).

A total of 17 women participated: 7 women in the focus group for biological mothers and 10 women in the focus group for nonbiological mothers. Two participants in the nonbiological parents group had partners who were pregnant at the time of the focus group; all participants in the group for biological parents were currently parenting. Focus groups were 1.5 hours in length, and were facilitated by the first author. The groups were semistructured, and participants were asked to discuss three categories of experiences during the transition to parenthood: those found to be stressful or difficult, those found to be positive or helpful, and those using health and social services. The discussion guide was developed by the authors in consultation with community partners and allowed participants to define and discuss other topics thought to be relevant. Data related to stressful and positive experiences are reported in this manuscript. All participants gave written informed consent to participate, and the research was approved by the local institutional review board.

Analysis

Focus groups were tape recorded and transcribed verbatim. After the accuracy of the transcripts had been verified, they were analyzed by using thematic content analysis. Data from both focus groups were coded into themes indepen-

dently by two authors. The text management software package QSR N6 was used to organize text during coding. Themes coded were primarily identified from the data but were also informed by existing literature on lesbian families. Any discrepancies between the two coders were resolved through discussion.

RESULTS

Participants had a mean age of 34.0 years (range 22–43 years) and were currently parenting children with a mean age of 6.2 months and 11.9 months for the biological and nonbiological parents, respectively. Fourteen (82%) of the participants were lesbian, with the remaining participants identified as gay, bisexual, or queer. Sixteen (94%) of the participants were Caucasian, and one participant identified herself as being of black and native Canadian descent.

Three main categories were identified: social support, the couple relationship, and legal and policy issues.

Social Support

Potential sources of support included members of the families of origin, neighbors and colleagues, the lesbian and gay community, and other LGBTQ parents (Table 1). Participants described the support they received from these important people in their lives to be a very positive element of their transition to parenthood, but they found it stressful when potential support people did not provide the expected support or were openly disapproving of their decision to have a child.

At the time of the focus groups, most participants had supportive relationships with their families of origin. However, several women reported that their families initially had reservations about their decision to have children and provided limited support early in the perinatal period. A minority of participants reported that their parents initially had religious or moral objections to their decisions to have children.

Nonbiological mothers reported that some members of the family of origin did not consider the nonbiological mother to be a “real” parent. For example, two participants reported that their family members continued to pressure them to bear a child, despite having young children at home or a partner who was pregnant. Women also spoke of their parents’ struggles to understand their roles as grandparents to children with whom they have no biologic relationship.

Participants described decision making about whether to disclose their sexual orientation to neighbors, colleagues, and others to explain their families. Participants were concerned about the impact of their disclosure or nondisclosure on their children as they aged. There was consensus that full disclosure was ultimately better for children so that they learn not to feel ashamed of their families or be afraid to disclose themselves.

Some participants were surprised at the lack of support they received from the lesbian and gay community. For

Lori E. Ross, PhD, is a Research Scientist in the Women’s Mental Health & Addiction Research Section of the Centre for Addiction & Mental Health, Toronto. She is also Assistant Professor in the Department of Psychiatry, University of Toronto, and in the Department of Psychiatry & Behavioural Neurosciences, McMaster University, Hamilton, Ontario.

Leah Steele, MD, PhD, is a Postdoctoral Fellow in the Health Systems Research and Consulting Unit of the Centre for Addiction & Mental Health, Toronto. She is also a family physician and research scholar in the Department of Family & Community Medicine, St. Michael’s Hospital, University of Toronto, Toronto, Ontario.

Beth Sapiro, BSc, is a Master’s candidate at the Ehrenkranz School of Social Work at New York University.

Table 1. Examples of Significant Statements Related to the Impact of Social Support and Lack of Social Support

| Potential Source of Support | Participant Comments |
|-----------------------------|---|
| Family of origin | "There was this lag of 24 hours of . . . questions, of 'are you sure?' and 'I'm not sure about this' . . . And then 24 hours later, everything sort of calmed down. But . . . my brother had a baby totally unexpectedly, and even in that case, where they weren't really financially ready to have a baby, or they hadn't gotten married yet . . . there was none of that questioning of it." (Shelley*, Biological mother) |
| Neighbors and colleagues | "When the neighbors stop you, who you've never talked to before and you probably won't see again, do you bother [coming out] or not?" (Lily, Biological mother) |
| Lesbian and gay community | "We got a lot of negative feedback within the lesbian community about using a known donor. There was kind of an assumption that we were being naive, and setting ourselves up and, you know, if we really thought it through, we wouldn't use a known donor." (Julie, Nonbiological mother) |
| Other lesbian parents | "She has friends there, physically there, who can help her out, who know about us. And she can talk about the whole situation, not just the little parts that official people get to know about . . . every kind of advice, from 'why are my breasts hurting so much today' to 'legally, what can we do however many years from now to smooth things along the way' . . . just having someone there when you have a question, who has been through something similar before and who also knows and likes you as a friend—who they are by default supportive—is really, really helpful." (Donna, Nonbiological expectant mother) |

*Pseudonyms have been used throughout.

example, one couple felt that members of the community were trying to impose their own values or political ideologies on what the mothers perceived to be very private choices, such as whether to use a known or anonymous sperm donor. Biological mothers emphasized that there are few places where they are able to be visibly part of the gay community when their children are with them. This is because children were not allowed to enter most of the restaurants in the "gay village" of Toronto due to smoking by-laws.

The participants' primary sources of support were other LGBQ women who were either parenting or in the process of trying to become parents. The participants who described belonging to a network of other LGBQ parents had most often connected with them through services such as the "Dykes Planning Tykes" course, offered in downtown Toronto. Women living outside of Toronto reported limited opportunities to connect with other LGBQ parents.

Couple Relationship

Issues relevant to the couple relationship included partner support, negotiating parenting roles, and barriers to involvement for the nonbiologic parent (Table 2).

There was consensus among biological mothers that they were more supported by their partners than were their heterosexual friends or relatives. They reported being very satisfied with the amount of support received from their partners. However, the extensive involvement of both partners resulted in strain at times, because each task had to be negotiated to ensure equal opportunity to bond with the child. Most biological mothers felt that achieving equal division of labor warranted the stress involved in this negotiation, but in a minority of cases, the nonbiological mother desired a more active role than the biological mother desired her to have.

The majority of nonbiological mothers described the

Table 2. Examples of Significant Statements Related to the Impact of Issues Related to the Couple Relationship

| Couple Issue | Participant Comments |
|------------------------------------|--|
| Partner support | "I went to the mother's group, and I found that I couldn't relate a lot to any of the other mothers in the beginning, because a lot of it was about what husbands weren't doing. And I've never been in that situation because my partner was doing all that: you know, getting up in the night doing some feedings, and helping me with the housework, and getting whatever done that had to be done . . . So I found that I couldn't relate to a lot of that." (Cheryl*, Biological mother) |
| Negotiating parenting roles | "I think it's probably a stress that we as the two-mother family sort of experience more of, and I didn't realize. . . . I didn't even consider it until we were in the midst of it. Realizing that I wanted to be as active a mother as [my partner] was. And it caused some tension between us . . . it was just something again that we had to negotiate that I didn't see with any of our straight couples at all because the guy just backed right out of it." (Deborah, Nonbiological mother) |
| Barriers for nonbiological parents | "I have a joke about [my partner] having no problems in terms of postpartum depression, but me actually experiencing that. I'm really having a hard time going back to work . . . I took 3 weeks off as soon as she was born, and I was fully involved in all the decision making . . . and then suddenly, I'm back at work and have no real input. I think that was hard, that suddenly [my partner] was making the decisions, because she was the one there all day, and I didn't have the opportunity to say 'why don't we try this today?' . . . It's just so hard to go to work. I mean, I'm still having a hard time going to work." (Kristin, Nonbiological mother) |

*Pseudonyms have been used throughout.

Table 3. Examples of Significant Statements Related to the Impact of Legal and Policy Issues

| Legal/Policy Issue | Participant Comments |
|-------------------------|--|
| Second-parent adoption | "It's incredibly discriminatory that a man who is not able to conceive should be able to put his name on the birth certificate if they use a donor but I couldn't . . . it's just incredibly discriminatory." (Deborah*, Nonbiological mother) |
| Parental leave | "I think [the policy change enabling nonbiological mothers to take parental leave] has been really helpful for me because I took 6 months off with our second kid, and that kind of helped me . . . my anxiety around 'how do I fit into this?' really changed . . . I found that really helpful, because I wasn't as worried about having to go back to work, knowing that I would have the second 6 months off." (Lynne, Nonbiological mother) |
| Impact on mental health | "My primary issues are what's coming at us, what we're having to deal with. And to very greater or lesser degrees, we are all handling and dealing with it, and it takes a toll." (Susan, Nonbiological mother) |

*Pseudonyms have been used throughout.

barriers to their involvement as an equal parent that they perceived to be stressful for them. Foremost among these were her partner's choice to breastfeed and the necessity that she return to work. Several mothers worried that these barriers could have implications for the extent to which they were able to bond with their children, but these worries appeared to alleviate with time: discussion among mothers with older children (particularly those who had begun to take solid foods) indicated that they felt strongly bonded with their children, and in one case, more strongly bonded than the participant perceived her partner (the biological mother) to be.

Legal and Policy Issues

Participants described a number of ways in which the legal system created barriers for them (Table 3). In fact, most participants identified these issues as primary determinants of their mental health, primarily as sources of stress.

Nearly all of the nonbiological parents had completed or were in the process of completing second-parent adoptions to have a legally recognized relationship with their child(ren). During the time women are waiting for their second-parent adoption to go through (sometimes several months), the nonbiological parent has no legal relationship with her child. There was consensus that it was unfair that they were required to go through this process when heterosexual parents who conceived with use of donor insemination were not.

Women who were forming families with an involved known donor worried about potential custody battles, because the contracts they had drawn up with their donors were not enforceable in court, due to the "best interests of the child" standard applied to custody disputes in Canada. Furthermore, current precedent in Ontario is that only two parents are recognized to have a legal relationship with their child, so that a known donor cannot be recognized as a legal parent if the nonbiological mother intends to legally adopt her child. One nonbiological mother had unintentionally waived her potential parental rights to her child by agreeing that the donor would not be required to relinquish his rights. These legal barriers necessitated consultation with lawyers, which became a financial burden for many participants.

Government policies were perceived to be unfair because they recognized participants' families when it was financially beneficial to the government (i.e., in paying taxes) but not in ways that protected their families (e.g., barriers to parental rights for nonbiological mothers). This was particularly an issue as a result of the change in family law permitting same-sex marriage in Ontario, which occurred approximately 6 months prior to these focus groups. To the surprise of most of the participants, legal marriage did not alter the requirement for second-parent adoption.

Although most interactions with the government were frustrating or stressful, participants reported some situations in which policies were potentially protective. For example, one participant was glad to find that, unlike in the United States and in some Canadian provinces, her provincial health insurance plan would cover medical costs associated with insemination. Parental leave for nonbiological mothers was also described as a positive recent policy change.

DISCUSSION

Two of the themes identified in this study, social support and the couple relationship, have been associated with perinatal depression in heterosexual women.^{18,26} However, the context in which these variables create or buffer distress in LGBQ women differs from that of heterosexual women. Much of the lack of support described stemmed from discriminatory attitudes held by individuals whom participants had hoped would have provided support. Although participants did not name "homophobia," they described experiences of discrimination, which concur with previous reports that lesbian and gay parenting evokes homophobic responses.^{27,28} Other LGBQ parents were described as a primary source of support. Increases in social support are thought to protect heterosexual women from postpartum depression.²⁹⁻³¹ Further study should determine whether support from those with shared experiences of discrimination can buffer distress during the perinatal period.

The finding of substantial involvement of the nonbiological parent is consistent with other studies of lesbian families.^{21,32-34} Heterosexual women perceive their male partners to provide less instrumental support than they would like,³⁵⁻³⁷ and dissatisfaction with division of labor is

associated with postpartum distress,^{23,38,39} suggesting that lesbian mothers may be at an advantage in this respect. However, negotiation is required to enable both parents to participate equally. Couple issues are, therefore, likely to be qualitatively different in same-sex parents than heterosexual parents.

The third theme, legal and policy issues, distinguishes same-sex parents from their heterosexual counterparts. Participants described numerous social, legal, and financial barriers that had to be overcome to parent. This is consistent with other North American studies describing the impact of institutionalized heterosexism on lesbian families, as in the lack of access to tax advantages and family health insurance.^{40,41} However, legal and policy issues for lesbian parents must be interpreted in a geographic context. Canada and other areas where research on lesbian families is primarily conducted (e.g., California) have relatively progressive social climates for gay and lesbian people. Therefore, the impact of legal and policy barriers on lesbian and bisexual mothers internationally could be even greater than suggested by this study.

These results are drawn from a small sample and restricted to one geographic region. Homogeneity in sexual orientation, ethnocultural background, and relationship status among participants also limit the extent to which conclusions can be generalized. Furthermore, the focus group methodology used in this study cannot provide evidence of cause and effect, nor can it provide statistically generalizable findings.⁴² However, a strength of qualitative methods, including focus groups, is in the generation of research questions for further study. These focus groups have highlighted variables that LGBQ women perceive to be important predisposing or protective factors for distress during the perinatal period. Future research should examine whether they are indeed predictive of mental health status during the perinatal period by using larger, more diverse samples, and a combination of quantitative and qualitative research methods.

The authors thank the women and their families whose participation made this work possible and Dr. Emma Robertson-Blackmore for her helpful comments on an earlier version of the manuscript. They also thank Rachel Epstein, MA, of the LGBT Parenting Network, David Kelley Program, Family Service Association of Toronto, for her invaluable assistance throughout the research process and for her review of a previous draft of this manuscript. This research was supported by the Lesbian and Gay Community Appeal Foundation of Toronto. Dr. Lori Ross is supported by a Career Scientist Award from the Ontario Ministry of Health and Long-Term Care and the Ontario Women's Health Council.

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