The Transition to Parenthood for Lesbian Couples

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ABSTRACT. While there is a slowly growing literature on lesbians with older children, the literature on the transition to parenthood for lesbian couples is scant. The current study examines aspects of the transition to parenthood experience for 29 lesbian couples. Specifically, this study explores aspects of couples' decision-making regarding alternative insemination (e.g., who would carry and bear the child, donor type), perceptions of social support across the transition to parenthood, and availability and use of legal safeguards (such as wills, powers of attorney, and coparent adoptions by nonbiological mothers). Future studies should explore how single lesbians manage the transition to parenthood. Research on lesbians and gay men who are pursuing parenthood through adoption is also needed.

KEYWORDS. Lesbian mothers, lesbian couples, transition to parenthood, parenthood decision, alternative insemination, legal issues

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The transition to parenthood for lesbian couples is a neglected yet important area of research. Understanding the experience of lesbian women as they become parents is increasingly significant given that between 1.5 and 5 million lesbians are currently raising children (Allen & Demo, 1995; Lewin, 1993; Patterson, 1995a). Some of these women became mothers in the context of heterosexual unions; however, since the 1980s, increased access to donor insemination has allowed many lesbians to pursue parenthood, resulting in a lesbian *baby boom* and a consequent increase in the number of children born to lesbian couples (Gartrell, Hamilton, Banks, Mosbacher, Reed, Sparks, & Bishop, 1996; Gartrell, Banks, Hamilton, Reed, Bishop, & Rodas, 1996; Gartrell, Banks, Reed, Hamilton, Rodas, & Deck, 2000; Patterson, 1992).

Although several clinicians have written books based on their experiences working with lesbian women and couples who are considering parenthood (e.g., Martin, 1993; Pies, 1987), very little empirical research examines lesbian couples' transition to parenthood experience (Gartrell et al., 1996, 1999, 2000). We know very little about the experiences of lesbian couples as they prepare for and take on the role of parent although scholars of family diversity (e.g., Allen, Fine, and Demo, 2000) have underlined this area as one of growing importance.

There is, however, a slowly growing body of literature on lesbian couples with children (Patterson, 1992; Tasker & Golombok, 1997) as well as a number of studies that have focused on lesbian and gay couples without children (Kurdek, 1993, 1994). It is important to note that much of the research on lesbian parenting has been stimulated by concerns that the children of gay and lesbian parents are less well-adjusted than the children of heterosexual parents (Braeways & van Hall, 1997); in turn, this research has largely focused on children's development and outcomes. Some attention has been paid to lesbian mothers' own emotional well-being but only insofar as to compare these women's mental health with that of heterosexual mothers. Several studies have found no differences in the psychological health of lesbian and heterosexual mothers (Falk, 1989; McNeil, Rienzi, & Kposowa, 1998; Patterson, 1992, 1997) with others reporting enhanced psychological health for lesbians in the areas of self-confidence and self-esteem (e.g., Rothblum & Factor, 2001). Some research has sought to identify the factors or conditions that optimize mental health among lesbian women and mothers. It appears that openness about one's sexual orientation is associated with enhanced well-being among both lesbian parents (Rand, Graham, & Rawling, 1982) and lesbian nonparents (Ayala & Coleman, 2000; Morris, Waldo, & Rothblum, 2001). Social support from family (Ayala & Coleman, 2000; Oetjen & Rothblum, 2000) and friends (Oetjen & Rothblum, 2000) also appear to reduce lesbians' risk for depression.

Lesbian couples' relationship quality has also been the subject of research. In general, lesbians and gay men report high relationship satisfaction relative to norms for relationship satisfaction for heterosexual couples (Patterson, 1995a; Peplau & Cochran, 1990). Identified correlates of relationship quality for lesbian couples include feelings of having equal power in the relationship, sharing decision-making, and placing high value on the relationship (Kurdek, 1994, 1995; Peplau, Padesky, & Hamilton, 1983). Interestingly, although lesbian couples value egalitarian child rearing (Dunne, 1998, 2000), only about half of lesbian couples studied appear to have achieved it (e.g., Brewaeys, Devroey, Helmerhorst, van Hall, & Ponjaert, 1995; Wendland, Byrn, & Hill, 1996). There is evidence that when children are young, biological mothers are somewhat more involved in child care and nonbiological mothers spend more time in paid employment (Patterson, 1995c). An equal division of labor appears to be in both the parents' and child's best interests; for example, Patterson (1995c) also found that lesbian parents were more satisfied and children were more well-adjusted when child care was more evenly divided between parents.

The only prospective transition to parenthood study known to date is the National Longitudinal Lesbian Family Study (NLLFS), which was initiated in 1986 by Nanette Gartrell and her colleagues. This pioneering study follows 84 lesbian families, 70 of whom include a co-mother as well as a birth-mother (154 mothers in total). At the time of the first interview, 62% of the women in Gartrell's sample were having their first child, while 38% were already parents. This study constitutes the first longitudinal investigation of lesbian families in which the children were conceived by donor insemination and which includes data from before couples have given birth. The researchers project that they will interview these families at various stages of the child's development over a 25-year period.

To date, this research has yielded three publications (Gartrell et al., 1996, 1999, 2000), which report on the researchers' interviews with mothers prenatally, when the target children are two years old and when the target children are five years old respectively. In their 1996 paper, Gartrell and her colleagues report descriptive data regarding several domains including demographics, pregnancy preferences and motivations, and social support. Results revealed that the NLLFS sample is largely Caucasian, relatively well-educated, and, at the time of the first interview, women in couples had been together for a mean of 6 years.

When asked about their preferences regarding alternative insemination, 47% of the sample preferred an unknown sperm donor, 45% preferred a known donor, and 8% reported that they had no preference.[1] As a whole, women had strong support networks: most women were in regular contact with their families of origin, and most (78%) expected at least some people in their family to accept their child. Moreover, the majority of women reported having a best friend outside of the family, and most expected that existing friendships would be either enhanced (35%) or would not change (27%) after the birth.

In their 1999 paper, Gartrell and her colleagues report data from the second interview, when the target children were two years old. Foci of this interview included health, parenting issues, legal supports, and social support. Most children had been born vaginally (68%), and most were covered by health insurance (94%). Seventy-five percent of the two-mother families reported sharing child care equally; in the other 25%, child care was shared but the biological mother was considered the primary parent. Forty-three percent of children carried both mothers' last names, while the remaining 57% carried the biological mother's last name only. Most women sought legal protections: 67% of families had wills, and 61% had powers of attorney for the child's medical care; all eligible nonbiological mothers (mothers living in counties where coparent adoption was legal; n = 16) had officially adopted their children. With regard to social support, 69% of women felt that having a child enhanced their relationship with their own parents. Contact with one's own parents had increased for 55% of women, and 77% reported that their parents were very excited about their grandchild, although biological mothers tended to rate their own parents as closer to the target child than nonbiological mothers rated their own parents. With regard to support from friends, a quarter of women reported the loss of some friendships, often with lesbians who were not parents themselves.

Finally, in their (2000) paper, Gartrell and her colleagues report on a number of domains including women's relationships, parenting experiences, and social support. By this time point, 31% of the original 73 couples had divorced (15% of divorces occurred between Time 2 and Time 3). Child custody was shared in 10 of these families, the biological mothers retained sole custody in 7, and primary custody in 6. Biological mothers were more likely to have sole or primary custody if the nonbiological mother had not officially adopted the child indicating the power of coparent adoptions to increase the likelihood of shared custody in the case of relationship termination among lesbian couples. With regard to parenting, of the 50 original couples who were still together at this time point, 29 were sharing child rearing equally. In 17 couples, biological mothers did more, and in four couples, nonbiological mothers performed a greater proportion of child care. Turning to family support, 14% of birthmothers in continuous relationships said their parents did not acknowledge their partners as co-mothers. Moreover, 17% of biological mothers and 13% of nonbiological mothers in continuous relationships reported that their parents did not treat their child as a full-fledged grandchild.

While the current study was designed to build on Gartrell and her colleagues' research, it differs from their study in several fundamental ways. First, and most importantly, a criterion for the current study was that both women were transitioning to parenthood for the first time. The NLLFS sample included women who were giving birth for a second or third time; only 62% of prospective birth mothers were pregnant for the first time. Second, two additional requirements of the current study–that women must be in committed relationships, and at least one parent must be returning to work after the birth of the child–were not criteria for inclusion in the NLLFS. Third, the current study is focused on a short period of time–a month before to three months after the arrival of women's first child. In the NLLFS, there was no standard time for the first interview (women were interviewed at some point during the process of insemination or during the pregnancy) and the second interview was not conducted until the child was 2 years old. In addition, to its credit, the NLLFS is far more long-term.

Thus, the current study included 29 couples that were preparing to give birth to their first child via alternative insemination. (The study also sought to include couples that were preparing to adopt their first child; however, because of the small number of adoptive couples that were ultimately obtained, their data are not presented here.) Both partners were interviewed before the birth of their first child (in the last trimester, typically 1 month before the due date) and 3 months after their baby was born. Effort was made to recruit participants who were diverse with respect to age and geography, and, to the extent possible, with respect to race, ethnicity, and social class.[2]

The data in the current paper come from a larger study that assessed multiple domains, including the decision-making process regarding becoming a parent, employment, social support, the division of labor, relationship quality, and mental health. It is important to note that two papers using these data are currently under review for publication: (1) Goldberg and Sayer's paper examines the relationship

between various predictors and new mothers' relationship quality; and (2) a paper by Goldberg and Perry-Jenkins explores the implications of these data for theory on families and gender. These two papers focus on processes during the transition to parenthood, whereas the current paper focuses on selected dimensions of the transition to parenthood experience and is much more descriptive in nature. Specifically, the major topics that this paper addresses and the questions that it seeks to answer are as follows:

Demographics. On a purely demographic level, what does this sample of lesbian couples look like? Specifically, how old are these first-time mothers? How many years, on average, have they been a couple? How many have had commitment ceremonies? What are these women's resources, in terms of education and income?

Becoming a Parent. First, among couples who pursued alternative insemination, how did couples decide who would carry and bear the child? Understanding how this decision is made is of interest given that some nonbiological mothers experience feelings of exclusion and concerns about bonding with their child early on (Goldberg & Perry-Jenkins, under review; McCandlish, 1997), particularly during breastfeeding (Gartrell et al., 1999). In a retrospective study of lesbian couples' transition to parenthood, respondents cited a variety of reasons for their decision-making including preference (who wanted to carry), infertility, and health reasons (Reimann, 1998). It is important to establish whether these data are supported by prospective research with lesbian couples.

Also of interest was the types of sperm donors used by these women, i.e., what percentage used a known donor, an unknown donor, or an ID-release ("Yes") donor (the donor's identity is released to the child at some specified time point). How costly was the process? How easy or difficult did women find the insemination experience? Though some studies have begun to explore some aspects of lesbians' decision-making regarding alternative insemination (Gartrell et al., 1996; Wendland, Byrn, & Hill, 1996), more research on the multiplicity of decisions and feelings faced by these women is needed.

Finally, how many of these couples experienced homophobia or unfair treatment by health care providers? Research by Perrin and Kulkin (1996) found that lesbian couples with children report homophobic experiences with pediatric health care providers. Of interest is to what extent women face unequal or discriminatory treatment at the insemination and prenatal care stage.

Support. Bronfenbrenner (1983, 1988, 1999) and others have emphasized the role of context in development and the importance of studying individuals within their ecological niches in order to understand the contexts that shape individuals. According to Bronfenbrenner's ecological model, we exist and develop within multiple and interacting contexts with influences ranging from those in the most distal, macro-level settings (i.e., culture, social class) to those in the proximal setting (i.e., the family, work). Lesbian couples face potential lack of support on all levels of the social system: from their workplaces, from their families and friends, from their neighborhoods, from their larger communities, from the medical and health care establishment, from the legal system, and from society at large. Thus, relevant contexts include these women's friends, their immediate families, their extended families, their workplaces, and social and legal institutions– namely, laws regarding same-sex marriage and adoption by gay parents, and general legal protections (or absence thereof) for same-sex partners and their children. Consideration of these contexts is particularly important during the transition to parenthood which is a time of change and stress (Cowan & Cowan, 1988).

Research indicates that support from both family and friends is associated with enhanced well-being among lesbians (Ayala & Coleman, 2000; Oetjen & Rothblum, 2000). Social support also appears to be a buffer against depression during the transition to parenthood, among heterosexual women (Beck, 2001; Lee, 1997). Given that lesbian couples face many of the same stressors that heterosexual women face across the transition to parenthood (decreases in personal and couple time, negotiation of roles and responsibilities), and possibly some additional stressors (complex decision-making about what type of donor to use and about who should carry the baby), lesbians' experiences of social support are of particular interest. Specifically, how much support do biological and nonbiological mothers experience from their own families, their partner's families, and their friends, before and after they become a parent? It is possible that having a child acts to neutralize family members' homophobia or discomfort with their daughter's (or niece's, or sister's) sexual orientation such that family members are experienced as more supportive once the child is born. However, it is possible that this increase in support occurs only among the family members of the biological mother; indeed, research indicates that relatives of the nonbiological mother may experience hesitation about acknowledging kinship with a child that is not biologically related to them (Patterson, 1996). It is expected that support from friends will remain

relatively stable or decline slightly across the transition to parenthood. Many lesbians, faced with lack of acceptance from their own families, find alternative sources of support (Kurdek & Schmitt, 1987); in this way, friends, particularly other lesbians and other lesbian couples, often become family or kin (Weston, 1991). Of course, if these women's friends are not also parents there is the possibility that parenthood could serve to alienate them from their community at least temporarily.

Support can also be conceptualized at the institutional level. Institutional-level support such as formal workplace policies or legal supports are particularly important for lesbians whose relationships and families are not typically formally recognized at the state and federal level. Of interest here is what proportion of these lesbian mothers-to-be receive formal workplace supports (e.g., domestic partnership benefits, paid maternity leave), supports that may ease their transition to parenthood? Also of interest is what percentage of these couples can and do pursue second-parent adoptions (legal adoption by the nonbiological mother) as a means of legitimating the nonbiological mother's parental status? Gartrell (1999) found that nonbiological mothers who pursued coparent adoptions felt greater legitimacy as parents, indicating the important and powerful role of legal supports in transforming one's parental identity. Finally, how many of these women pursue other means of legal protection, e.g., wills and powers of attorney?

STUDY GOALS

The goals of the current study were multifold. First is to provide a comprehensive description of a sample of lesbian couples embarking on parenthood for the first time. A second goal of this paper is to explore potentially challenging decisions that lesbian couples pursuing parenthood via insemination inevitably face. There is a dearth of research exploring how couples decide who will carry the child (Reimann, 1998); similarly, little research has explored how and why women come to choose an unknown or known donor. Here, special attention is paid to the complex intra- and inter-personal dynamics involved in these decisions. Specifically, do couples experience greater struggle with the decision about who will bear the child than the decision about how they will have the child, or vice versa? A final goal of this paper is to describe women's perceptions of social support from various sources and at various levels across the transition to parenthood given that support from one's families, friends, workplaces, and the state that they live in may

moderate lesbians' adjustment to parenthood. Moreover, it may moder ate the degree to which the decisions involved in becoming a parent ar experienced as stressful, or are resolved effectively. Future research then, can explore the linkages between decision-making processes an support.

METHOD

Given the relative dearth of knowledge about lesbian couple transitioning to parenthood, utilization of both quantitative and qualita tive methods in the form of in-depth interviews seemed most appropri ate. Strauss and Corbin (1998) argue that in order to build well developed, integrated, and comprehensive theory, a researcher shoul make use of both qualitative and quantitative methods. Thus, quantita tive data is supplemented with qualitative data where appropriate.

The Sample

Data were obtained from 29 inseminating couples via telephone o in-person interviews at two time points: one month before their due date (Time 1) and three months after their child was born (Time 2). Members of each couple were interviewed separately. Interviews lasted approximately one hour. In addition to being interviewed all women completed a packet of questionnaires (quantitative measures) that were sent to thei home. Questionnaire packets also took about an hour to complete. Members of each couple were asked to fill out their packets separately within a week of the scheduled interview. Participants returned thei packets in postage paid, self-addressed envelopes.

Inclusion criteria were: (1) women must be in committed (living together) lesbian relationships; (2) both must be preparing to become a parent for the first time via alternative insemination; and (3) at least one partner must be returning to work full-time after the birth.

A variety of recruitment methods were used. Flyers describing the study were posted in the offices of midwives and gynecologists as well as in the waiting rooms of local hospitals. Information about the study was included in local gay/lesbian/bisexual/transgender (GLBT) community newsletters and in local Unitarian Universalist newsletters. In addition, calls for participants were posted on listservs and Websites pertaining to lesbian issues and concerns (e.g., political/activist organizations, college and community GLBT groups, and gay and lesbian-

oriented parenting groups and organizations) in order to obtain a geographically diverse sample.

A number of survey questions and open-ended questions were asked in both interviews regarding a variety of domains. Specifically, in the first interview, the major domains assessed and the questions relevant to these domains were as follows:

1. *Demographics.* Survey questions were used to obtain information regarding women's age, length of current relationship, work hours, income, educational level, and race and ethnicity.
2. *Becoming a Parent.* Women were asked the following closed-ended questions: (a) What type of donor did you use (known, unknown, ID-release); (b) How easy or difficult was the process of donor insemination (1 = very easy, 2 = easy, 3 = neither easy nor difficult, 4 = somewhat difficult, 5 = very difficult); (c) How many insemination attempts did you make; (d) What was the financial cost of becoming a parent; (e) Have you experienced homophobia from health care providers (e.g., clinics, prenatal classes, in finding child care; and (f) Has anyone been explicitly unsupportive of your choice to have a child? If so, who? Women were asked the following open-ended questions: (a) Why did you choose the type of donor you did?; and (b) How did you decide who would carry and bear the child?
3. *Support.* Women were asked about the level of support that they perceived from their own immediate family of origin (parents and siblings), their extended family of origin, their partner's immediate family of origin, their partner's extended family of origin, and their friends. Specifically, they were asked, "How supportive is [your immediate family] at the current time, now that you are about to become a parent?" (1 = unsupportive, 2 = somewhat unsupportive, 3 = neither supportive nor unsupportive, 4 = somewhat supportive, and 5 = very supportive).

Women were also asked about formal supports. Specifically, the following closed-ended questions were asked: (a) Does your company or organization provide domestic partnership benefits? (b) Does your company provide paid maternity leave? (c) Can you, in the state that you live in, pursue a co-parent adoption? Do you plan to? (d) In terms of other legal protections, have you sought wills? Powers of attorney?

At the second interview, women were again asked about the level of support they received from family and friends. They were also asked,

"Have you pursued a coparent adoption?" "How do you feel about this?" Women were also asked, "What is your child's last name?" Finally, they were asked about whether they had given birth vaginally or via C-section, and also about the type of leave (paid, unpaid, partially paid) that they had taken from work.

To answer the questions of interest, basic descriptive statistics were utilized. Specifically, frequencies, means, standard deviations, and ranges were determined for this sample (N = 29 couples, or N = 58 women). Repeated-measures ANOVAs were also conducted to examine change in social support across the transition to parenthood. Finally, qualitative data analysis was performed on open-ended questions of interest.

RESULTS

Demographic Data

Women in this sample were generally older than first-time mothers on average (Center of Disease Control, 2002) and first-time mothers in heterosexual samples (e.g., Goldberg & Perry Jenkins, 2004). In 2000, the average American woman was approximately 25 years old when she had her first child (CDC, 2002). Biological mothers in this sample ranged in age from 21 years to 47 years with an average age of 35, while nonbiological mothers were slightly older ranging in age from 24.5 years to 49 years with a mean age of 37.7 years. On average, couples had been together for about six and a half years; length of relationship ranged from 2 years to 13 years. Fifty-nine percent of the couples had had a commitment ceremony.

In terms of paid employment, 72% of biological mothers were working full-time at the time of the first interview, 17% were working part-time, and 11% (three mothers) were not working at all, while 93% of nonbiological mothers were working full-time in paid employment and two women were working part-time. Three months postnatally, only 38% percent of biological mothers were working full-time at this point with 38% working part-time, 10% (3 women) still on maternity leave but planning on returning soon (within six months), and 14% (4 mothers) not planning to go back to work for at least a year. Postnatally, 80% of nonbiological mothers were working full-time, 14% (4 women) were working part-time, 3% (1 woman) was on maternity leave but planning

to return shortly (within several months), and 3% (1 woman) had lost her job and was unemployed.

In general, the participants were highly educated and well-off financially. Considering biological mothers first, 14% had a high school diploma, 7% had an associate's degree, 7% had a bachelor's degree, 55% had a master's degree, and 17% had professional or doctorate degrees. Nonbiological mothers were similarly well-educated: 7% had a high school diploma, 7% had a vocational degree, 7% had an associate's degree, 21% had a bachelor's degree, 31% had a master's degree, and 27% had professional or doctorate degrees. Family income ranged from $48,400 to $300,000 with an average income of $100,600. Biological mothers' personal income ranged from $1,600 to $150,000 with a mean income of $43,900; nonbiological mothers tended to make somewhat more on average with personal salaries ranging from $24,900 to $300,000 with a mean income of $71,000. Fifty-five percent of the couples interviewed reported that they pooled their income, 31% reported that they had both separate and joint accounts, and 14% had separate accounts only.

Although the sample was geographically diverse (41% were currently living on the East Coast, 21% resided on the West Coast, 21% lived in the Midwest, and 17% were living in the Southern region of the United States), it lacked racial and ethnic diversity. Except for two Korean Americans, all participants were European American. Fourteen percent of biological mothers and 10% of nonbiological mothers identified themselves as Jewish indicating some degree of religious heterogeneity.

Decision-Making About Becoming a Parent

Who Will Carry the Child? Couples' explanations or reasons for how they decided who would carry the child fell into several general categories. For 41% of couples (12 couples), desire to bear a child–to experience pregnancy and childbirth and in some cases to have a biological connection to the child–proved to be the most important determining factor in their decision. That is, among these 12 couples the biological mother was carrying the child because she had a greater desire to do so. As Jill,[3] a biological mother, said, "I wanted to be pregnant. It was really a yearning on my part. Thea had no preference. I've been the one advocating to be pregnant and have a child." Fourteen percent of couples (4 couples) cited fertility as the major determining factor: the

nonbiological mother had tried first and had been unsuccessful. Finally, in the other 45% of the sample, couples decided who would bear the child based on reasons other than desire or fertility, e.g., health reasons, career reasons, and age (in some cases both wanted to be pregnant and the older of the two was picked to go first; in other cases, it was the younger woman who was chosen because the couple felt that the older of the two would not be successful). As Sheila, a biological mother, explained, "I'm older–38. We decided I'd be the first to carry. If we do it a second time, Laurie will carry. Also, my mom had an easier time in labor than her mom, and it's supposed to be genetic."

Interestingly, the decision about who would carry the child was experienced as relatively easy by most couples. Couples in which the biological mother was carrying the child because of fertility reasons (the nonbiological mother had initially had a greater desire to bear the child but had been unsuccessful) appeared to report the most distress surrounding the decision. As Debbie, a biological mother, said, "Galit tried first. It didn't work. She really wanted to bear a child. It was stressful for a while . . . she had a *really* hard time for quite some time after several miscarriages . . . She was extremely depressed, but determined to keep going . . . I never had a particular desire to *have* the baby or give birth . . . but after a while, I just wanted her to ask *me* to try. I'm seven years younger . . . I think she'd lost sight of our mutual goal–to have a child–versus just getting pregnant." Often these couples tried for months or even years before one woman was finally successful; the process was often stressful and placed some strain on the relationship. Said Natalie, a biological mother: "We've been talking about having kids for 7 or 8 years, thinking seriously about whose womb to use, trying to decide. Amanda tried for 6 months and it didn't work. I wanted to get the ball rolling, since it took so long to get to the point of having kids. . . . Everything was so difficult. [Finally] we tried me and it worked."

Type of Sperm Donor. Women were also asked about the type of donor that they had selected, and how they had located their donor. Most women (59%) chose an unknown donor or a No donor–that is, they selected a donor whose identity could never be known to the child (and who in turn had waived all legal rights to the child). Women tended to cite legal reasons and a desire to raise the child without outside interference as their reasons for choosing an unknown donor. As Shannon, a biological mother, stated, "A known donor might make the situation awkward. We want our son to know we're his parents." Her partner, Kerri, concurred with this and also stated, "I think that it's the safest

thing to do legally." Another reason that women cited for choosing an unknown donor was that they didn't have an acquaintance or friend that they felt comfortable asking: as Anisa, a nonbiological mother, explained, "We didn't want to take the chance of someone getting involved in our lives–a man trying to take our child away. Also, we didn't have an acquaintance we felt strongly about and close to." And, likewise, another nonbiological mother explained: "We talked about it a lot, and we didn't have anyone in our lives who we felt confident about–those who we knew intimately are people that we see too often–it would just be too weird. We didn't want to deal with complicated role definitions."

Thirty-one percent of women chose a known donor, i.e., someone who donated the sperm to them personally and who often wished to maintain some level of contact with the child and the family. Women typically chose a known donor out of a desire for the child to know who their father was although this did not necessarily mean that they wished the father to be involved. Health reasons were also cited. As Rachel, a biological mother, said, "Colleen [her partner] wanted a known donor so the child could identify them. Also, we're [both] health professionals: it's good to know if something came up, if he needed blood or something, we can find them. And with a known donor, there's a better chance of fresh sperm." Women who chose a known donor necessarily faced the task of negotiating with the donor their role and level of involvement. For example, Kristine and Lisa used a known donor who was a friend. The donor agreement that they signed defined his role as that of an uncle: they expected that the donor would see the children routinely but would not be in a coparenting role at all.

Finally, 10% chose an ID-release or Yes donor. Yes donors are donors who agree to be contacted when the child is of some specified age (typically, 18 years old) or who have agreed that the parents may contact the sperm bank or agency when the child is of some specified age. The sperm bank then contacts the donor who decides whether he wishes to be contacted at that time or not. Women who chose Yes donors did so because this provided the legal security of unknown donor (Yes donors have no legal rights to the child) but offered the possibility of a relationship with the child on the parents' terms. As one nonbiological mother noted, "We searched for a long time to find something in between [a known and unknown donor]."

It is important to note that for a number of couples the donor type that was ultimately selected was not their first choice. For example, as one

biological mother explained: "[A known donor] was not our first choice. We went with an unknown donor for a while but had a negative experience with the sperm bank. We weren't comfortable with them . . . We spent months looking for the perfect donor. We bought a lot of sperm and found this perfect guy but there was this missing piece–it was like, he looks great on paper but we know nothing about him! And then it just wasn't working for months, physically. So this donor, a friend, knew we tried for some time and put it out there . . . we hadn't even considered it–it instantly made sense, the missing piece was no longer there . . . It worked the first time." Likewise, a nonbiological mother who with her partner ultimately selected an unknown donor noted, "We initially tried with two friends, a gay male couple. In that, we hoped that this child would have a sense of who his dad was and his family history. After it didn't work it was very upsetting because we were really looking forward to having the child with one of them as the donor. Now, it feels good. It's Nina's and my child; it's a more intimate experience. It's not all of our child." Similarly, Hannah, a biological mother, explained that she and her partner ultimately chose an unknown donor, "because people–friends we asked–got weird; put different conditions on it: 'If it's a boy, they have to do this' . . . They wanted to be involved, but with strings attached. Finally we tried Ellie's brother but he had a low sperm count so he didn't work. So we had to move on . . . this was our last ditch effort at insemination. We thought it'd be weird and horrible but I really haven't thought about the donor much at all."

Thus, women's decisions about what type of donor to use were often quite complicated: often, their ultimate choice did not reflect their initial preference and occasionally women felt torn about what type of donor to use as they recognized the pros and cons of both known and unknown donors. Indeed, a number of women noted that initially they preferred a known donor but after talking with friends and lawyers decided against this option because of the legal risks. Likewise, some biological mothers would have preferred a known donor but because of their partners' concerns about feeling like an outsider or a third parent agreed to an unknown donor. As one biological mother said, "Lillian felt strongly about an unknown donor. I thought it was important to have a known donor in terms of the identity issues. But Lillian, as the nonbiological person, didn't want to feel pushed out like a third parent . . . It's more practical too, an unknown donor (though we had one friend who we had preliminary conversations about it with)."

Becoming Pregnant

The process of becoming pregnant was often difficult. Biological mothers reported a mean of 9 insemination attempts (median = 7) before finally conceiving (number of tries ranged from 1 to 33). Seventeen percent of the nonbiological mothers (5 women) had tried first: these women tried an average of 8 times (with number of tries ranging from 3 to 28). Correspondingly, many birth mothers rated the process of becoming pregnant as difficult (31%) or extremely difficult (24%). Seven percent (two women) felt neutral about the process; however, 31% of women did feel the process was easy, and 7% (2 women) rated the process as very easy. A similar number of nonbiological mothers felt that the process had been stressful: 18% of nonbiological mothers rated the process as very difficult, 43% rated it as difficult, 29% rated it as easy, and 10% (3 women) rated it as very easy. The average amount of money spent on getting pregnant was $5,750 (with cost ranging from $5.00 to $21,500). Indeed, a number of women commented on the financial strain of becoming a parent: as one biological mother noted, "We expended a lot of resources trying to get pregnant. It was very expensive."

Twenty-one percent of the sample (6 couples) experienced homophobia from health care providers during the course of becoming a parent. In two cases, women encountered doctors that elected not to inseminate, on the basis of their sexual orientation. "The first (obstetrician) we went to–she elected not to inseminate. It was a Catholic run clinic . . . they might have been concerned that they would have to go through legal stuff in order to approve us," recalled one biological mother. Likewise, in another couple, the biological mother-to-be's insurance company would not cover insemination costs for same-sex couples. In two cases, women encountered health care providers that "didn't know what to do with" the nonbiological partner. "She kept asking for Maggie's husband," Eileen, a nonbiological mother, recalled. Finally, one couple reported discomfort with what they referred to as "indirect homophobia"–namely, the fact that many providers, including their childbirth class instructor, seemed unwilling to adopt the term *partner*.

The process of giving birth was also unusually difficult for a large number of women. Indeed, 50% of biological mothers had their babies by caesarean-section. This is likely, at least in part, a function of these women's older age and, thus, their high risk pregnancy status.

Support

Family and Friends. At Time 1, women were asked whether anyone had been particularly unsupportive of their choice to have a child. Forty-one percent of biological mothers and 48% of nonbiological mothers reported that at least one person had been unsupportive of their choice to have a child. Of the biological mothers, 82% reported that the lack of support came from someone in their own families; 18% reported that the unsupportive person was someone in their partner's family. Interestingly, nonbiological mothers had somewhat different perceptions: 50% reported that the lack of support came from their own family members, and 50% reported that the lack of support came from their partner's families.

At both time points, women were asked about their perceptions of support from their own immediate family of origin, their extended family of origin, their partner's immediate family of origin, their partner's extended family of origin, and their friends. Table 1 presents means and standard deviations for biological mothers' and nonbiological mothers' perceptions of support at Time 1 and Time 2. In general, women perceived the highest levels of support from friends, and the lowest levels of support from their own and their partner's extended families. Interestingly, perceptions of support from family–one's immediate family of origin, one's extended family of origin, one's partner's family of origin, and one's partner's extended family of origin–all increased across the transition to parenthood. These data support the possibility that while families may not be completely accepting of their daughter's (or sister's, or niece's) sexual orientation (or their decision to raise a child with another woman), families typically wish to be involved once a child is born. Qualitative data is consistent with this notion: as one biological mother voiced during the interview, "My mom is very much involved with James–she loves to visit and is constantly showing off pictures to her friends. Her reaction was unexpected because until I had James she did not want her friends to know about my lifestyle." Similarly, another biological mother said, of her partner's family of origin, "They had reservations at the start of this, but now are fully supportive." Finally, perceptions of support from friends decreased slightly across the transition to parenthood. Qualitative data suggests that this was in part because of the fact that the majority of women's friends were lesbians, who did not have children. As Diane, a biological mother, stated, "Many [of our friends] don't have kids . . . so they have very different

TABLE 1. Support from Family and Friends for Biological Mothers (N = 29) and Nonbiological Mothers (N = 29): Means, Standard Deviations, and Ranges

	Own Family	Extended Family	Partner's Family	Partner's Extended Family	Friends
	M (SD), Range	M (SD), Range	M (SD), Range	M (SD), Range	M (SD), Range
T1 Biological Mother	4.2 (.87) 2-5	3.7 (1.01) 1-5	4.5 (1.06) 1-5	3.7 (.96) 1-5	4.9 (.36) 4-5
T2 Biological Mother	4.4 (.68) 1-5	4.1 (.99) 1-5	4.6 (.82) 1-5	4.4 (.72) 1-5	4.7 (.68) 4-5
T1 Nonbiological Mother	4.6 (.73) 2-5	4.0 (1.06) 1-5	4.0 (1.24) 1-5	3.7 (1.19) 3-5	4.7 (.36) 2-5
T2 Nonbiological Mother	4.7 (.44) 2-5	4.2 (.83) 3-5	4.2 (.69) 3-5	4.0 (.98) 1-5	4.2 (.42) 4-5

lives from ours and often in spite of their generosity I feel they are clueless about the demands on us taking care of twins."

A series of 2 × 2 Repeated Measures ANOVAs were conducted to examine the effects of Partner (biological/nonbiological mother) and Time (prenatal, postnatal) on social support. Several significant findings emerged. First, a partner effect emerged for support from one's own immediate family, with nonbiological mothers reporting significantly more support from their own families than biological mothers reported from their own families, $F(1, 28) = 10.92$, $p < .01$. A time effect emerged for support from one's own extended of family of origin: all mothers reported higher levels of support at Time 2 than at Time 1, $F(1, 25) = 4.12$, $p < .05$. Finally, a time effect emerged for support from one's partner's extended family of origin, with all women reporting higher levels of support at Time 2 than at Time 1, $F(1, 23) = 6.02$, $p < .05$.

Workplace. Domestic partnership benefits are a formal form of support that workplaces can offer lesbian and gay people with families: in this sample, 52% of biological mothers and 56% of nonbiological mothers reported that their workplaces offered domestic partnership benefits. However, it is important to note that these benefits are often only partial–for example, one's workplace might extend bereavement and family sick leave to the domestic partners of employees, but not offer

health benefits to domestic partners. Moreover, a number of women noted that they did not pay for these benefits because they were quite costly. Partner benefits are subject to state and federal income tax, unlike benefits for married couples. Thus, they can end up being quite expensive (Partners Task Force, 2003).

Most workplaces offered some type of leave benefits: specifically, 95% of biological mothers' workplaces and 96% of nonbiological mothers' workplaces offered parental leave benefits. Postnatally, women reported on the leave that they had taken. Forty-two percent of biological mothers took leave that was fully paid, 42% reported that their leave had been partially paid, and 16% reported that their leave had been unpaid. Seventy-one percent of nonbiological mothers reported that their leave had been fully paid, while 8% reported that their leave had been partially paid, and 21% reported that their leave had been unpaid.

Legal Safeguards. In many U.S. states, lesbian mothers who have not given birth to their children do not enjoy the same legal privileges as biological parents. That is, only some states have begun to grant coparent adoptions or second-parent adoptions which allow the nonbiological parent to essentially adopt their child without requiring the biological parent to give up her rights. In this sample, 55% of couples lived in a state that allowed coparent adoptions, and, in turn, planned to pursue this important legal safeguard upon their baby's birth. Eighteen percent reported that some lesbian parents had had success in pursuing coparent adoptions in their state/county, and intended to at least try to adopt. Twenty-six percent of the couples lived in areas that did not allow coparent adoptions, and, in turn, planned to pursue other legal safeguards such as wills, powers of attorney, and coparenting agreements. Thus, 76% of the sample intended to try to pursue a coparent adoption. At Time 2, 62% of the sample had already finished or were close to completing the second parent adoption procedure while 32% had not pursued a coparent adoption[4] and were not planning to (typically because it was not legal) in the near future. In addition, 3% (one couple) had not yet pursued a coparent adoption but were planning to in the near future, and 3% (1 couple) had planned to pursue a coparent adoption but were putting it off indefinitely because of financial reasons. For a number of nonbiological mothers, finalization of the coparent adoption seemed to alleviate certain insecurities and was viewed as an affirmation of their parental status. As Sari, a nonbiological mother, noted, "I'm glad the second parent adoption went through–*I have that paper.* The adoption went well . . . it was a big deal

and not a big deal at the same time." These feelings were echoed by Jackie, another nonbiological mother, who stated that "[the coparent adoption] went through in the second month. It was great. I didn't feel that it was a big deal–it was a formality. Even though, emotionally, I didn't feel like it mattered, it hit me, sitting in the courtroom. I started crying. It was kind of an overwhelming feeling. I felt even closer to him, that we were able to do this, where our foremothers didn't have that."

Participants were questioned about whether they had pursued other legal safeguards, as well. Prenatally, the majority of the sample already had wills and powers of attorney (79% and 82%, respectively).

Couples were also asked about their child's last name. In 44% of the couples, the biological mother's last name was used, in 26% of the couples the nonbiological mother's last name was used, and 19% of the couples shared a last name and, thus, this was the name their child was given. Seven percent (2 couples) chose a hyphenated last name for their child, and in one case, the child was given the last name of the nonbiological mother's grandmother. Those couples who chose to give their child the nonbiological mother's last name felt that this was one way of asserting and legitimizing the nonbiological mother's parental status.

DISCUSSION

First, it is useful to compare the women in this sample to women in other studies of lesbian couples with children. Like other studies of lesbian couples with young children, these participants were highly educated and were on average relatively affluent (Gartrell et al., 1996; Reimann, 1998). Clearly, this sample is not representative of the general population nor is it typical for the lesbian community nor even of lesbian mothers (Allen & Demo, 1995). However, many studies of lesbian baby-boom families show similar compositions (Patterson, 1995a, 1995b; Reimann, 1998). Reimann (1998) suggests that the high levels of education and income,[5] and the racial homogeneity that tend to characterize these samples, might be partly due to the very deliberate process of becoming a parent. Donor insemination[6] requires knowledge, money, and a willingness to expose oneself to and involve outside institutions. Also, as in other studies of lesbian couples, most of the women in this sample were in their thirties by the time they became parents (Gartrell et al., 1996). Like heterosexual middle-class women, many of

these women waited until they had established their careers and were financially stable before pursuing parenthood (Reimann, 1998).

In terms of commitment level, more couples in this sample have pursued a commitment ceremony than couples in other studies (Bryant & Demian, 1994; R. Oswald, personal communication, May 2003). For example, in one study of lesbian couples (some parents and some not) 19% of women reported having had a commitment ceremony (though 12% did report having some other ritual) (Bryant & Demian, 1994). It that a commitment ceremony is a means of symbolically consecrating one's relationship, it may be that this difference is explained by the fact that this sample is comprised of new parents; without the option of marriage, many of these women settle for the next best thing. Several women in the sample mentioned that they had "gotten hitched" over the past year or so, once they had decided to become parents.

Almost half of the couples in this study typically decided who would carry based on desire, or preference, i.e., one partner had a greater desire to be pregnant and give birth. Other reasons cited included fertility, health reasons, and age. These reasons are similar to those given by the women in Reimann's (1998) dissertation research. The process of deciding who would carry and bear the child was relatively straightforward for most couples, with the exception of those who made this decision based on fertility reasons. These data raise questions about the aftermath and implications of dealing with infertility for lesbians and lesbian couples; indeed, although some clinically oriented publications deal with this topic (Brown, 1991; Jacob, 1999), there is little empirical research on lesbians' experiences with infertility. What are these women's experiences with health care providers and fertility centers? Among those who seek out support groups, what are women's experiences with heterosexual women and couples who are struggling with infertility? How do couples who made the decision based on infertility experience the pregnancy, the birth, and the early months of parenting? To what extent do these nonbiological mothers, who initially wanted to carry the child but could not, struggle with feelings of jealousy or exclusion? And of course, of interest is whether biological motherhood–who is the biological mother and who is the nonbiological mother–has implications for parental roles and parent-child attachment. Collectively, research on lesbian mothers with older children suggests that more important than biological motherhood in determining parent-child bonding is the amount of time women spend with their children (Reimann, 1998; Gartrell et al., 1999, 2000). Findings from these data concerning the effects of biological motherhood early on also suggest

that, for the majority of couples, biology does not inevitably shape parental roles (Goldberg & Perry-Jenkins, under review). Specifically, these data indicate that many couples counteract potential inequity in parental roles by making sure that the biological mother is not disproportionately responsible for infant care. More research should certainly explore these issues.

In terms of what type of donor couples chose, this sample is quite similar to the Bay Areas Family Study sample (Patterson, 1995a, 1995b); specifically, in Patterson's sample which included 26 lesbian couples who were also parents 59% of couples chose an unknown donor compared to 46% of Patterson's sample. Likewise, 31% of this sample chose a known donor; 27% of Patterson's sample selected a known donor. Ten percent of this sample chose a Yes donor, whereas no couples in Patterson's sample chose this option. And, like the women in Patterson's study, and Gartrell et al.'s study, few women in this study expected or wanted the biological father to play a significant role in parenting or caretaking.

It is interesting that both biological and nonbiological mothers tend to perceive increased family support across the transition to parenthood from both their own and their partner's families. This is consistent with Gartrell's (1999) finding that 69% of women reported that having a child improved their relationship with their own parents. Indeed, the current findings suggest that not only biological mothers but also nonbiological mothers felt quite supported as parents. As Maria, a nonbiological mother, said with pride, "My family has provided a secure and welcoming place for all of us as a family. Max is treated as if he is my biological child." Of interest is whether perceived support from the nonbiological mother's family during this early period translates into consistent involvement in children's lives given that some previous research suggests that children of lesbian couples are more likely to have contact with the biological mother's extended family (Gartrell et al., 1999, 2000; Fulcher, Chan, Raboy, & Patterson, 2002). Importantly, Fulcher and colleagues found that children who were rated by their mothers as being in regular contact with grandparents were less likely to have behavior problems compared to children who lacked regular contact with grandparents. In that extended family involvement confers emotional, financial, and practical support (e.g., help with child care), it likely has positive effects on both parent and child outcomes.

Biological mothers and nonbiological mothers seem to have somewhat different perceptions of support. Interestingly, 82% of biological mothers who reported explicit lack of support surrounding their decision to have a child said this resistance came from their own families; only 50% of nonbiological mothers perceived this resistance as coming from biological mothers' families. Perhaps not all couples communicated with each other about indirect and direct expressions of resistance from their own families; this might explain why biological mothers were so much more likely to cite their own families as the source of resistance. Future research might build on the current study by gathering additional data on women's perceptions of support across the transition to parenthood and beyond. For example, in addition to simply asking about level of support, researchers might ask for information about types of support received (e.g., financial, emotional, practical), and for examples of support or nonsupport. Future research should also examine the effects of social support from various sources (friends, one's own family, and one's partner's family) on lesbians' mental health, adjustment, and relationship quality across the transition to parenthood. Indeed, some recent research examines how social support from family and friends affects lesbian couples' relationship quality during the transition to parenthood (Goldberg & Sayer, under review).

Given that the laws around second parent adoption are constantly changing, and have improved notably in a number of states over the past few years, the percentage of women pursuing a second parent adoption in this study is higher than those reported in comparable studies done just a few years ago (Reimann, 1998). The benefit of second-parent adoptions cannot be overemphasized: indeed, McClellan (2001) found that nonbiological mothers who adopted their children often reported that this helped them to establish a sense of "normalcy and stability" in their relationships with their children. These feelings are echoed in the narratives of women in the current study. The long-term positive impact of securing second parent adoptions is suggested by Gartrell et al.'s (1999) finding that those nonbiological mothers who had become legal adoptive parents of their children via second parent adoption felt that the adoption notably enhanced the legitimacy of their parenting role, and their (2000) finding that among couples who split up, having a coparent adoption increased the likelihood of shared custody. Moreover, Hequembourg and Farrell (1999) conducted in-depth interviews with lesbian mothers and found that second parent custody allowed nonbiological mothers to legitimate their parental position for those around them, particularly their families of origin. They concluded from these findings that "a national effort to legalize second-parent adoption and same-sex marriages would help lesbian mothers legitimate their marginal-mainstream identities" (p. 553). Indeed, widespread legaliza-

tion of second-parent adoptions would not only serve to protect the rights of nonbiological mothers but would also represent an institutionalized form of support and recognition of lesbian parents and their children. Such recognition has the capacity to strengthen and uphold the healthy development of lesbian families. As Schneider and O'Neill (1993) and others have noted, providing benefits to same-sex couples (such as the right to adopt one's own child) is advantageous to society in that such protections promote security, stability, and other idealized family values. The long-term impact of such legal supports on lesbian couples' relationship quality, mental health, and their children's psychological well-being is a topic very much worthy of future research.

In the current study, there was evidence of another arguably positive trend towards recognition of the nonbiological parent: in this sample, 26% of children were given the nonbiological mother's last name as a both a practical and symbolic means of legitimating their connection to the child (with 44% of children taking their biological mother's last name, 19% taking a shared last name, 2 children taking a hyphenated last name, and one child taking some other last name). This is in contrast to Gartrell et al.'s 1999 finding that in two-mother families, 43% of children carried both mothers' last names and the rest carried only the birthmother's with no child reportedly carried only the nonbiological mother's last name. The current movement towards greater symbolic and legal recognition of the nonbiological mother's relationship to the child is both reflected in and facilitated by these changes in naming practices.

Contributions, Limitations and Future Directions

There are several ways in which this study makes a contribution to the literature. First, it represents one of the first prospective studies of the transition to parenthood for lesbian couples. Second, it offers data on the decision-making process involved in becoming a lesbian parent via alternative insemination. Third, it provides some insight into lesbians' experience of support across the transition to parenthood from a variety of sources. Finally, the use of qualitative data raises questions that can and should be explored more fully in future research.

There are a number of limitations of this study. Most obviously, it is a small sample. Thus, all quantitative analyses should be viewed with caution. Additionally, this research was based on two time points only. Future studies should strive to include a larger number of participants, with more follow-up points. Third, this is a highly educated, mostly white, professional sample. These are limitations which characterize

most studies of lesbian couples (Laird, 1993; Gartrell et al., 1996, 1999, 2000; Patterson, 1992), although some scholars who have conducted research on gay and lesbian individuals (but not necessarily parents) have indeed had some success in recruiting more diverse samples (e.g., Carrington, 1999; Weston, 1991). Rothblum, Factor, and Aaron (2002) analyzed the recruitment methods of two studies that were successful in obtaining large, relatively diverse samples of lesbians and concluded that multiple sources of recruitment (e.g., lesbian publications, ethnic/multicultural groups, religious organizations, bookstores, events) are ideal in order to reach a diverse sample of lesbians. Indeed, it is also possible that the recruitment strategies utilized in the current study, e.g., relying heavily on advertising within lesbian publications, may have attracted couples who were necessarily more out in the community and thus failed to reach couples who are more closeted. Future research might also advertise in more general publications, such as newspapers.

Finally, the current study focuses only on lesbian couples that are becoming parents via donor insemination. Future research should address the unique experiences of single lesbians becoming parents for the first time as well as the experiences of lesbians and gay men who are pursuing parenthood through adoption. These are also areas that have received little attention from researchers. Indeed, lesbians who adopt internationally must present themselves as single women thus denying their partners and also their sexuality (Baetens & Brewaeys, 2001). Lesbians and gay men who choose to adopt domestically often find that the only children available to them are the children that are the most difficult to place and, often, the most disturbed (Baetens & Brewaeys, 2001; Parks, 1998). Thus, there are a multitude of ways that lesbians and gay men become parents each of which is accompanied by unique struggles and experiences. It is necessary to recognize and explore the diversity in the gay and lesbian parenthood experience, in order to effectively support gay and lesbian families–a new family form that appears to be here to stay.

NOTES

1. Frequencies for actual donor type used are not reported.
2. Previous research (e.g., Patterson, 1992) has commented on the challenges of obtaining an ethnically and racially diverse sample, as well as a sample that is diverse with respect to social class. Studies that rely on volunteerism are thus likely to get participants who are out about their sexual orientation, and, in addition, of higher education, and white.
3. All names of participants used here are pseudonyms.

4. The most common way in which same-sex couples adopt is that one partner already has legal custody of a child (either by birth or adoption) as a single parent. Then the second partner petitions the court to allow them to adopt their partner's child. This constitutes a second-parent, or coparent, adoption, and it allows a gay couple to adopt a child so that both parents can have equal parental rights; for example, the nonbiological mother can adopt the child born to her lesbian partner without terminating the nonparental rights of the biological mother (National Adoption Information Clearinghouse, 2002).

5. It is worth noting that men and women with same-gender partners often cannot share their employee benefits with them as married couples do, representing a significant reduction in the value of their earnings to them (Anastas, 2001). Indeed, a number of nonbiological mothers could not cover their partner or child under their insurance. Thus, in cases where their partners did not work or worked part-time and thus did not receive benefits from their own place of employment, these women had to buy private (expensive) insurance for themselves and their child(ren).

6. Gartrell et al. (1996) noted that donor insemination is less commonly chosen by African American lesbians than by white lesbians which may help explain the lack of diversity in this sample

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