

## Articles

# Counselling lesbian couples: requests for donor insemination on social grounds



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### Abstract

Fertility centres are increasingly involved in dealing with requests from lesbian couples for donor insemination (DI). Data were collected on 95 Belgian lesbian couples who applied for DI. The majority of couples were well integrated in a social environment (family, friends and work) that consisted mainly of heterosexuals. They tended to be open about their homosexuality and most couples considered the social environment to be tolerant towards their homosexual orientation. Couples who considered alternatives to DI would have liked to have had more information on the donor and were more inclined to introduce a 'godfather' who would take special interest in the child. Couples who considered DI to be the best solution considered the absence of a father to be less of a problem for the child and wished to have no information at all as regards the donor. Approximately half the couples considered their family a two-mother unit. For the other couples, the family unit consisted of a mother and her partner who shared parental responsibility for the child equally. The issues that are considered important to cope with and on which lesbian couples should be counselled are presented in the discussion.

**Keywords:** counselling, donor insemination, lesbian couples

### Introduction

Fertility centres are increasingly involved in dealing with requests from lesbian couples for donor insemination (DI). In 1981, the Centre for Reproductive Medicine of the Brussels Free University was the first centre in Belgium to provide DI to lesbian couples. The centre is of the opinion that each request should be evaluated in a fair manner without prejudice. Moreover, the desire for parenthood may be considered universal and legitimate and, consequently, the fact of being homosexual should not preclude having a child. This opinion, however, does not reflect the general attitude towards homosexual parenthood. Many fertility centres do not share this point of view and consequently refuse to help lesbian couples.

However, DI is only one possibility among others of helping lesbian women to become pregnant. In the United States the number of lesbian mothers is estimated at between 1 and  $5 \times 10^6$  (Patterson, 1992; Flaks *et al.*, 1995), the majority of whom conceived within a heterosexual partner relationship. Other

alternatives are self-insemination by a known donor or by a man who will also father the child (co-parenthood). In such cases, lesbian couples will come to a fertility centre only if subsequent cycles of self-insemination have failed and they suspect that they may also have a 'medical' fertility problem. Becoming a parent therefore involves a choice for lesbian couples. The use of DI is motivated by the wish to protect the partner relationship and the position of the non-biological mother by avoiding the presence of, and the interference from, a 'third party' (Englert, 1994; Baetens *et al.*, 1996b; Jacob *et al.*, 1999). Moreover, it is considered to be a safe procedure because of the screening of sperm donors. The majority of fertility centres in Belgium offer insemination by anonymous donor (Baetens *et al.*, 1996a). Opting for DI therefore means that the lesbian couple must cope with the consequences of donor anonymity on the well-being of their children (Baetens and Brewaeys, 2001).

The controversy surrounding homosexual parenthood focuses on the absence of a father and the homosexuality of the mothers. Both are considered risks to the well-being of the

children raised in lesbian families. Research on children raised in lesbian families has shown little or no empirical or theoretical evidence against helping lesbians to have children (Brewaeyns and van Hall, 1997; Baetens and Brewaeyns, 2001). In the 1980s, the first research was conducted in the United States as a result of actions denying homosexual mothers custody over the children. In such cases, the children had lived for at least some time in a heterosexual family, had experienced the divorce of their parents and had known their biological father. Recently, publications have appeared on lesbian couples raising children from birth in fatherless families. These children were conceived within the context of a homosexual relationship and both partners shared responsibility for the education of the children. The results of the studies were remarkably similar. Satisfaction with the couple relationship, the duration of that relationship, and the number of divorces after the birth of the child did not differ between lesbian mothers and heterosexual controls (Flaks *et al.*, 1995; Brewaeyns *et al.*, 1997). Lesbian mothers seem to be as competent as heterosexual mothers and lesbian mothers showed a higher quality of the mother-child interaction compared with heterosexual two-headed families (Flaks *et al.*, 1995; Brewaeyns *et al.*, 1997; Golombok *et al.*, 1997). Studies that compared the role of the non-biological mothers in lesbian families with the role of the father in heterosexual families found that social mothers were more involved in all child care activities, including disciplinary issues (Flaks *et al.*, 1995; Brewaeyns *et al.*, 1997; Golombok *et al.*, 2002). Moreover, childcare and professional activities were more equally divided between partners in lesbian families than between partners in heterosexual families (Brewaeyns *et al.*, 1997; Gartrell, 1999). One study investigating parental attachment found that children in lesbian families experienced greater warmth and were more securely attached than children in the heterosexual control group (Golombok *et al.*, 1997, 2002). Gender development was not influenced negatively during childhood (Patterson, 1994; Brewaeyns *et al.*, 1997). Moreover, the children showed no increased emotional or behavioural disturbances (McCandlish, 1987; Steckel, 1987; Patterson, 1994; Flaks *et al.*, 1995; Brewaeyns *et al.*, 1997; Golombok *et al.*, 1997; Chan *et al.*, 1998). Only a few studies were available as regards adolescents or adults raised in homosexual households (Lewis, 1980; Gottman, 1990; Ghazala, 1993; Tasker and Golombok, 1995; Golombok and Tasker, 1996). In these studies no differences were found with regard to the sexual orientation, the incidence of emotional problems or the social development of adults raised in homosexual families as compared with adults raised in heterosexual families, although adult children of lesbian mothers were more likely to remember peer group hostility.

Research cannot provide arguments for problems in the development of children raised in lesbian families. Nevertheless, different authors have pointed out that there are some shortcomings in the research into lesbian parenthood, such as small samples (the sample size varied between 7 and 84 households) and samples that are not representative for the entire group of lesbian mothers (most investigations used volunteer samples and mothers were therefore predominantly white, middle class and well educated) (Patterson, 1992; Brewaeyns and van Hall, 1997; Baetens and Brewaeyns, 2001). Some of the studies used DI children as subjects; however, these children are still young, since this treatment has only

recently been available to lesbian couples (Patterson, 1994, 1997; Flaks *et al.*, 1995; Brewaeyns *et al.*, 1997). Half of the studies used a control group of heterosexual families (Steckel, 1987; Flaks *et al.*, 1995; Brewaeyns *et al.*, 1997; Golombok *et al.*, 1997; Gartrell, 1999). Further large-scale studies of the children are needed because of the methodological shortcomings of some of the studies.

Less literature is available on counselling lesbian couples. The first article by Brewaeyns (Brewaeyns *et al.*, 1989) considered three issues in the counselling of lesbian couples: (1) the personal history of both partners, (2) the relational patterns and (3) the desire for parenthood. Jacob *et al.* (1999) consider issues such as the extent of coercion by one partner, the consent of both partners, the couple's identity and stability, disclosure, substance abuse and psychiatric stability.

Although little research is available on counselling lesbian couples, the profiles of the lesbian couples in these studies show similar characteristics (Brewaeyns *et al.*, 1989; Englert, 1994; Jacob *et al.*, 1999; Leiblum *et al.*, 1995; Baetens *et al.*, 1996a,b; Wendland *et al.*, 1996). The women were highly educated and involved in stable relationships. Couples were well integrated in their families and social environments. They were more likely to be open about the DI origin of the child. They applied for DI after a long period of reflection and after consideration of the possible consequences for their future child. These results reveal no major reasons for refusing requests by lesbian couples (Baetens and Brewaeyns, 2001).

## Materials and methods

Ninety-five Belgian lesbian couples asked to be considered for treatment with spermatozoa from anonymous donors between 1992 and 2000. The primary aim of the counselling was to inform and to support the lesbian couples and the current findings were obtained, therefore, through a semi-structured interview (3 h) of all Belgian couples on their first visit in the clinic without taping the interview. Counselling, in addition to helping lesbian couples to make a well-informed decision, provides interesting data on all biological mothers (i.e. the woman who wished to become pregnant) and their partners (i.e. social mothers) concerning the family of origin and the psychosexual development of both women. Furthermore, information on the present homosexual relationship, the social integration of the couple and their wish for a child was obtained. Questions were open-ended and started with the least sensitive material. The interview questions lent themselves to pre-coding and the categories could be checked off during the interview. The answers were therefore re-coded directly numerically for analysis. All couples were informed about the fact that the data would be used for research and had no objection if the confidential nature of the counselling was respected. Data on the number of treatment cycles and the outcome of the treatment was obtained from the general databank in this centre and the patient files.

Homosexual couples from other countries were excluded from the study. The majority of foreign lesbian couples (between 1992 and 1999 the number of requests of lesbian couples was 379) were French, because French legislation has restricted DI to heterosexual couples since 1994.

Homosexuality is not accepted in the same way in other countries and in this respect, a cultural bias might be introduced into the research. The social acceptance of homosexuality can interfere with the way in which the social environment is perceived by the couple and can therefore influence decisions by the couple as regards openness on the sexual nature of the relationship. Moreover, foreign lesbian couples are scheduled for a combined appointment with a psychologist, a gynaecologist and a nurse in order to reduce travelling time and expense for the couple. The appointment with the psychologist is limited in time and the psychological counselling therefore focuses on the specific situation of the couple.

## Results

### Demographic data

The women who wished to become pregnant (biological mothers) were on average 30.15 years old (SD 4.04) and ranged from 23 to 44 years old. The age of their partners (social mothers) was on average 31.43 years old (SD 5.77) and ranged between 22 and 49. In all, 95.8% of the biological mothers were working: 22.1% as skilled workers, 51.6% as clerical workers, 12.6% as members of executive staff and 9.5% self-employed. Of the partners, 92.6% were working: 28.4% as skilled workers, 46.3% as clerical workers, 7.4% as executive staff and 10.5% self-employed.

### Homosexual identity

In all, 76.8% of the biological mothers and 89.5% of the social mothers considered themselves exclusively homosexual. At this point in life, they accepted that they could have an emotional relationship only with a same-sex partner. They excluded having an intimate relationship with a man in the future if the current relationship would come to an end. A total of 14.7% of the biological mothers and 8.4% of the social mothers were convinced they could be involved in a relationship with a man and consequently considered themselves bisexual. A total of 8.4% of the biological mothers and 2.1% of their partners refused to label themselves as homosexual. In these cases they recognized the homosexual character of the relationship. These women loved a specific partner but did not feel attracted to other women. All biological mothers and 94.7% of the partners had a gender identity consistent with their sex. Although for five partners

the gender identity was not clearly female, they did not consider themselves transsexual.

As regards the labelling, social mothers considered themselves significantly more exclusively homosexual than biological mothers ( $\chi^2 = 5.41139$ ;  $df = 1$ ;  $P < 0.05$ ). Women (biological mothers and social mothers) who considered themselves exclusively homosexual were more likely to have a relationship with a woman who labelled herself similarly ( $\chi^2 = 8.52502$ ;  $df = 1$ ;  $P < 0.005$ ). **Table 1** provides details on recognition of first homosexual feelings and coming out.

Social mothers showed a significant tendency to recognize their homosexuality at an early age, i.e. before the age of 20, whereas biological mothers tended to be older ( $U = 3657.5$ ;  $P > 0.05$ ). Social mothers tended to inform others (friends and siblings) significantly sooner than biological mothers ( $U = 3695.5$ ;  $P < 0.05$ ). On the other hand, parents of biological and social mothers were informed about the homosexuality of their daughters in the same age period (often at the start of the first stable relationship or the present relationship). Although social mothers tended to know sooner that they were homosexual, they also tended to postpone the moment of telling their parents.

The announcement of their homosexuality in the family of origin of biological mothers caused severe problems that lasted more or less until the moment of the request in 22.8% of the cases. In these cases there had been no or very limited contact with the family of origin, at least for some time, and if contact was restored the biological mother had been seeing her parents alone (without her partner) for some time. In 40.2% of the families, the homosexuality of the biological mother was accepted from the beginning. In 37% of the families of the biological mothers, while coming out caused problems in the beginning, the couple was accepted later on. In more than half of these cases the homosexual nature of the relationship itself could be discussed with the parents of the woman who wished to become pregnant.

In all, 38% of the parents of the social mothers responded from the beginning in a very positive way to the homosexuality of their daughters. In 21.7% of the families of origin, coming out provoked serious problems between social mothers and their parents. Among parents of social mothers, 40.4% reacted negatively at first but accepted the couple afterwards. There was no significant difference in the way parents of biological

**Table 1.** Recognition of homosexual feelings and coming out. Values are expressed as percentages.

Age (years)	Recognition		Coming out to parents		Coming out to others	
	Biological mothers	Social mothers	Biological mothers	Social mothers	Biological mothers	Social mothers
<16	25.3	33.7	4.2	5.3	5.3	9.5
16–20	34.7	45.3	29.5	43.2	34.7	46.3
21–25	24.2	12.6	37.9	31.6	32.6	27.4
26–30	10.5	4.2	17.9	9.5	18.9	9.5
>30	5.3	4.2	8.4	6.3	8.4	7.4
Never informed			2.1	4.2		

mothers responded to the homosexuality of their daughters as compared with parents of the social mothers.

Previous partner relationships are detailed in **Table 2**. The few and/or short relationships with men were mainly during adolescence. Often these relationships were try-outs in the process of assuming their homosexuality and integrating it into their sexual identity. Biological mothers had had significantly more relationships with men ( $U = 3761.0$ ;  $P < 0.05$ ), while their partners had had significantly more relationships with other women ( $U = 3642.5$ ;  $P < 0.05$ ) before the present relationship.

### Current homosexual relationship

The mean duration of the current relationship was 5.45 years (SD 3.55) and ranged from 1 to 18 years. All couples were living together. In 22.1% of cases, other family members lived permanently or temporarily within the homosexual family: one couple had a foster child, one couple had an adopted child, and four couples had fostered a child of the extended family for a period of time. In 15 families, one or both partners had children from a former heterosexual relationship. In 12 families, at least one of the children was growing up with the mother and her partner. In three cases, the children were living independently or with the father. In five families, the children were from a former relationship of the biological mother and in nine cases, the children were from a previous relationship of the social mother. One couple had children from a previous relationship of both partners.

In the allocation of household work, 33.7% of the couples divided the tasks according to the personal preferences of the partners. In 36.7% of cases, these tasks were allocated to the partners who had more time to spend on such tasks. Often this partner was working part-time. Regarding household tasks, 23.2% of the couples had no strict allocation and did everything together. Only 6.3% of the couples had divided household tasks according to a male–female role model.

### Integration of the couple in the family of origin

The couple was recognized and accepted by 57.9% of the parents and 73.1% of the siblings of the biological mothers and by 57% of the parents and 69.6% of the siblings of the social mothers. In these cases, the homosexual nature of the relationship could be discussed and the relationship was regarded in the same way as the heterosexual relationships of siblings. Additionally, 25.3% of the parents and 11.8% of the siblings of the biological mother, 24.7% of the parents and 14.1% of the siblings of the social mother accepted the couple to the extent that the partners were always invited together. Partners were integrated in the family but the homosexual nature of the relationship was not recognized to such an extent that it could be discussed. Data revealed no significant differences in acceptance of the relationship by the family of the biological mother and social mother. Couples were in frequent contact (more than once a month) with at least one or both parents of the biological mother in 82.1% of the cases and with at least one or both parents of the social mother in 78.7% of the cases. Couples had the same degree of contact with the family of the biological mother and the family of the social

mother. In 35.8% of the cases, the DI child would be the first grandchild in the family of the biological mother. In 33.7% of the families of origin of the social mother, the child would be the first child that might be considered a grandchild.

### Social integration

Overall, 40% of the couples had mainly heterosexual friends, 42.1% had heterosexual and homosexual friends and 13.7% of the couples had mainly homosexual friends. In the majority of cases (92.6%), the couples were accepted and recognized in a predominantly heterosexual environment. Moreover, 75.8% of the couples had never been involved in any homosexual organization. Only 15.8% of the couples were currently active members of lesbian pressure groups.

With regard to living environment, 18.9% of the couples lived in a large city, 43.2% in a provincial town and 37.9% in a rural environment. In 87.3% of cases, the homosexual relationship caused no problems in the neighbourhood. Only one couple had problems with neighbours and 11.6% of the couples had no contact with neighbours.

In all, 77.9% of the biological mothers and 74.9% of the social mothers informed colleagues at work about their homosexual relationship and this caused no major problems. Data showed no significant difference in this respect between biological mothers and social mothers.

Coming out was important for 48.4% of the couples, to the extent that these couples informed others shortly after having met them for the first time, in order to have an honest friendship from the start. Half of the couples (50.5%) were more discreet about the homosexual relationship, to the extent that they first wanted a more regular social relationship with people before informing them of their homosexuality. Nevertheless, in both cases couples did not intend to hide their homosexuality and considered openness about the nature of the relationship indispensable in order to pursue social relationships. Only one couple tried to hide their homosexuality. Regarding acceptance by the community, 40% of the couples considered people in general to be tolerant towards homosexuality even to the extent that they did not feel treated differently by others. Another 58.9% of the couples considered people in general tolerant but felt them to be treated differently, mainly due to others' ignorance about homosexuality. The way in which couples perceived the

**Table 2.** Previous partner relationships. Values are expressed as percentages.

	<i>Biological mothers</i>		<i>Social mothers</i>	
	<i>Men</i>	<i>Women</i>	<i>Men</i>	<i>Women</i>
No relationships	27.4	45.3	42.1	26.3
Few and/or short relationships	38.9	20.0	33.7	26.3
Cohabiting and/or long-term relationships	33.7	34.7	24.2	47.4

attitude of the social environment did not influence their coming-out strategy.

## Desire for a child

The wish for a child arose for 54.7% of the biological mothers and 36.8% of the social mothers in adolescence. Nevertheless, 16.8% of the women who wished to be pregnant and 12.6% of the partners had excluded themselves from the idea of being a parent for some time because of their homosexuality. For 36.8% of the biological mothers and 60% of the social mothers, the wish for a child had started in, and was related to, the current partner relationship. The onset of the wish for a child differed significantly for biological mothers and social mothers. Biological mothers tended more to have had a wish for a child before the relationship, while social mothers' onset of the wish for a child was linked to the current relationship ( $U = 3414.5$ ;  $P < 0.005$ ). In 18.9% of cases, partners had talked for less than a year about realizing their wish for a child; 69.5% of the couples had discussed their wish from 1 to 4 years and 11.6% for more than 4 years.

In all, 55.8% of the couples did not consider an alternative to DI. Another 28.4% of the couples had thought for some time about insemination by a known donor and some had even asked someone to be the donor. Fear of complications such as interference from a third person in the couple and fear of a known donor's demanding paternal rights was the main reason behind a request for DI. All couples wished to raise a child together but in only 13.7% of the cases did both partners wish to become pregnant. In these cases it was always the elder partner who started with the treatment. In 74.7% of the couples, only one partner had a wish to be pregnant. In 11.6% of the couples, only one partner was able to become pregnant. In these cases the social mother had a fertility problem or was at risk of losing her job.

A total of 54.7% of the couples considered their family to be a two-mother unit: the two partners would both be considered mothers. Consequently, in 51.6% of the families, the children would learn to address both partners with a synonym for the word mother. In 43.2% of the couples, the family unit consisted of a mother who would be called mother and a partner who would have a parental responsibility equal to that of the biological mother but who would be called by her first name or a nickname derived from her first name. In two cases the child had a mother with a partner who had no parental role and less responsibility towards the future child. In these last two cases, the child was considered to be the child of the biological mother only, while all other couples talked about 'our' children.

Absence of a father might create problems according to 36.2% of the couples; 63.8% of the couples thought the absence of a father would not create major problems in the development of the child. The majority of these couples considered the fact that they were a two-parent family important to the child's well-being. The responsibility for the child's upbringing was to be shared by both partners. If one of the parents were to be less available or unavailable in the child's upbringing at some point, the other partner was to take over. For social development, and in order to protect the child from a symbiotic mother-child relationship, the presence of a second

parent was considered important. Nevertheless, all couples agreed that the presence of male friends and family was important for their children, while 70.2% of the couples believed that there were enough men present in their social environment to give their child the opportunity to develop frequent contact with a male role model. In 29.8% of cases, one particular man would be asked to be a kind of 'godfather'. This godfather was asked to take a special interest in the child so that the child could develop an emotional relationship with a man.

As regards the anonymity of the donor, almost 80% of the couples did not wish to have any information on the donor, 11.8% would have liked to have more information on the donor and 8.6% would have liked to know the identity of the donor.

It is possible to distinguish two different groups in the way couples perceive their wish for a child. The first group consists of couples who had considered other alternatives such as a known donor and tended significantly more to wish for at least some information on the donor ( $\chi^2 = 11.77259$ ;  $df = 1$ ;  $P < 0.005$ ). These couples tended significantly more to introduce a 'godfather' into the life of their child ( $\chi^2 = 4.61560$ ;  $df = 1$ ;  $P < 0.05$ ). The second group of couples considered DI the best solution from the start. They believed that enough male role models were present in their social environment. Moreover, these couples thought that, if enough men were present, the absence of a father was less of a problem for their child ( $\chi^2 = 8.10228$ ;  $df = 1$ ;  $P < 0.005$ ) and wished for no information on the donor at all ( $\chi^2 = 9.16751$ ;  $df = 1$ ;  $P < 0.005$ ).

## Outcome of the treatment

Of the 95 lesbian couples who asked to be treated with donor spermatozoa, six were not accepted for various reasons. These reasons were related to multiple traumatic life events for one or even both partners and had important consequences for the integration of the couple into their social environment. Twelve couples (12.6%) did not start the DI treatment: one couple had relational problems (the social mother was not ready to assume responsibility for the child that her partner wanted), three couples chose a known donor, one couple had financial problems and two couples started treatment in a fertility centre nearer to where they lived. No information is available on the remaining five couples. Four couples knew from the start that there was a fertility problem: in three cases oocyte donation and in one case IVF was proposed. Two couples started oocyte donation resulting in one twin pregnancy after oocyte donation (the donor was not the partner). The other couple started DI of the partner after two failed donor oocyte cycles (with the partner as donor).

In all, 73 women started DI. Forty-nine pregnancies ensued (three twins). In five cases, no information is available on the outcome of the treatment. There may have been a pregnancy, but the couple failed to inform the centre. Nineteen couples stopped treatment: three because of relational problems, 14 because of a fertility problem (after six cycles of DI), and two after recurrent miscarriage. In all, nine couples stopped definitively. Ten couples continued treatment: in seven cases, the same partner started an IVF procedure and in three cases the partner started DI leading to six more pregnancies [two

partners and four after IVF (one twin)]. One couple is currently being treated. In all, 56 women became pregnant (five twin pregnancies) and these pregnancies resulted in the births of 26 girls and 30 boys. Three women are currently pregnant for the first time and one couple failed to inform the clinic after the birth of their child. One couple had an abortion for chromosomal aberration (Turner syndrome).

Twenty-four couples started treatment for a second pregnancy: in 18 cases the same women wished to become pregnant and in six cases the partner started DI. In all, 22 women became pregnant (19 singletons and three twins) and this resulted in the births of 14 boys and eight girls. One couple failed to inform the clinic after the birth of the child and two women are currently pregnant for the second time. Two women (same biological mothers) came back for a third pregnancy, resulting in the birth of one girl. The other couple is currently pregnant.

In all, 51 Belgian lesbian families exist as a result of treatment in this centre: 27 with one child, 19 with two children and five with three children. In 15 families with more than one child (not twins) the children had the same biological mother. In five families, the children had a different biological mother.

## Discussion

Arguments against homosexual parenthood, in general, were based on ideas relating to 'the welfare of the child'. According to Pennings (1999), two different evaluation rules are used to assess whether the 'amount of welfare' is acceptable: the maximum welfare principle and the minimum threshold principle. The first evaluation rule implies that one should not knowingly and intentionally bring a child into the world in less than ideal circumstances, whereas the second rule condemns procreation only when the quality of life of the future child is below a minimum threshold. Neither 'the perfectly happy child' nor the 'minimal threshold for a life worth living' are very manageable goals in procreative decisions. Pennings (1999) proposes, therefore, 'the reasonable welfare principle', a principle that conforms more to the way in which procreation and parental responsibility are regarded in ordinary life. The degree of welfare of the child might be lower than the level that might be expected in ideal circumstances but sufficiently high to be considered a positive gift to the child. Even though a father is absent and both mothers are homosexual, follow-up research of children raised in lesbian families suggests that the degree of welfare of children of lesbian couples is sufficiently high. Moreover, if parents are aware that the circumstances are not ideal and they themselves look for and are informed about possible coping strategies for their specific parental situation, any problems will probably be less important than might be expected in general. In this respect, the follow-up research on the children born in lesbian families is also very important because it can provide the lesbian couples with the necessary information to cope with parenthood in this particular situation. Nevertheless, since the follow-up research is published in scientific journals, couples complain about a lack of information.

Psychological counselling should be an interactive process. Counselling should be a helpful and useful process: helpful and useful for the couple, for the child to be born and for the centre. It should provide the couple with the information to

cope with the particular circumstances in which they try to become parents. The usefulness of psychological counselling for the centre is often defined in terms of screening. Sometimes counselling reveals information on patients where one can sense that too many of the circumstances of a particular request do not favour 'the welfare of the child'. Psychologists should shoulder the responsibility to refuse a request if the risk of the 'the reasonable welfare principle' not being met is considered important. While this reasonable welfare principle might be a logical approach, defining objective psychological criteria to assess this principle for even one specific type of request, such as that by lesbian couples, is rather difficult. Although the profile of lesbian couples gives an idea of what can be expected in general, it is difficult to translate this profile into criteria fitting the specific life circumstances of each case. If counselling is considered an interactive process, the two aspects of counselling can fit one another: giving information on this particular form of parenthood does not exclude the assessment of the life circumstances at the same time. The expertise of the counsellor can be helpful to the lesbian couples in order to integrate the child within their specific life circumstances while protecting the best interests of the child.

Psychological counselling as an interactive process presupposes first that the lesbian couples should be informed regarding the medical procedure. The majority of lesbian couples have no experience of medical settings and they often underestimate the impact of the treatment on everyday life. The 'child project' demands a considerable amount of planning and organization, especially if couples have to travel from abroad. Moreover, their expectations regarding the treatment might be too high: often they expect to be pregnant from the first cycle because of the medical circumstances in which the attempt is made.

Secondly, lesbian couples should be counselled about the different alternatives in becoming a parent, in order to make a well-informed decision. This should be done even if the fertility centre provides only treatment with anonymous donors. Children of lesbian couples start asking about their fathers shortly after starting school (Brewaeys *et al.*, 1995). The option of keeping the use of an anonymous donor secret from the child is more or less impossible. Lesbian couples will be confronted with the consequences of donor anonymity on the development of their children. They have to be counselled on disclosure of issues such as homosexuality and the use of donor spermatozoa and they should be informed on ways of how to tell the child. Parents are advised to respond to the question 'who is my daddy?' with the truth, explaining that they were a couple of two women who had a joint wish for a child. Consequently, it should be explained to the child that he/she has no father. The anonymity of the donor should also be introduced at this moment. The donor should not be presented as a father, but as someone who made the birth of the child possible, a donor who gave 'the gift of life'. The research by Brewaeys *et al.* (1995) revealed that all lesbian parents wondered before the child's second birthday whether or not their child had inherited some characteristics from the donor. At the age that the children start to understand the concept of 'genetic origin' and the importance that is given to it in western culture, the children will have questions. Children can cope differently with the anonymity of the donor. Follow-up

research on 41 children (mean age years and 9 months, 22 boys and, 19 girls) born into lesbian families shows that 54% of the children preferred donor anonymity, while 46% of the children wanted to know more about the donor: 19% wanted non-identifying information and 27% would have preferred donor registration. Siblings growing up in the same family held different views on if and what they wanted to know about the donor, showing that the need for genealogical information may differ from one child to another even when they are raised in more or less the same circumstances. The views from the mothers and the children concerning the status of the donor differed, also showing that mothers and children do not approach the donor issue from the same angle (Vanfraussen *et al.*, 2001).

Referring to the research into adopted children, some authors claim that donor anonymity might lead to an incomplete sense of identity of the children (Haimes, 1988). In relation to adopted children, children of anonymous sperm donors have two advantages. Firstly only half of their genetic origin is unknown and for the other half they can refer to their biological mother. Most adopted children will primarily have questions about their biological mothers. Secondly, adopted children often wonder about who gave them up for adoption in order to know why. For children of anonymous donors, the question 'why' can be explained: their birth is related to the wish for a child of a couple. Moreover, donors are not motivated by the wish to be the father of the child but by the wish to help couples to fulfil their wish for a child. Presenting the situation in this way, the child of an anonymous donor will not feel rejected by a parent who did not wish to take responsibility for the child. Vanfraussen *et al.* (2001) found, however, a significant difference between children who did and who did not want to meet the donor. Significantly more boys than girls wanted to meet the donor, suggesting that boys in the lesbian families might cope less well with the absence of a father or a male role model. And this should also be stressed during counselling.

Moreover, lesbian parents should also be informed about the fact that their children in adolescence will probably have some questions about their own sexual preferences. In adolescence, children will wonder if they are homosexual just like their mother and if others will believe them to be homosexual. The latter might have consequences for peer relationships. Similar proportions of adults raised in lesbian and heterosexual single families identified themselves as homosexual but children from lesbian families were more likely to consider the possibility of a same-sex relationship (Tasker and Golombok, 1995). Lesbian couples preferred their children to be heterosexual because life would be easier on them but considered themselves more capable of guiding their child if she/he were to be homosexual. In the research by Tasker and Golombok (1995), especially adult sons of lesbian mothers recalled being teased about being gay, whereas in the review by Bisnovich Pennington (1987), adolescent daughters were more upset because they were believed to identify to a greater extent with their mothers than sons do. Lesbian parents should be aware that a homophobic climate among adolescent peers might create stress and uncertainty among their children and push them to secrecy about their mothers' life style. They should be aware of the need to avoid the risk of social isolation. Moreover, research has revealed that adolescent

children of lesbian mothers who perceived more stigma had lower self-esteem. Coping skills and especially that of decision-making coping were found to moderate the relationship between perceived stigma and self-esteem (Gershon *et al.*, 1999). Nevertheless, as regards the extent of relational stigmatization by heterosexual college students, the stigma was greater as regards the lesbian mothers than for their children. Between 80 and 100% of the students (18–23 years) were willing to be acquaintances, friends or best friends with children of lesbians (King and Black, 1999).

Assessing the specific situation of each couple is also considered important. Integration in the family and social environment presupposes openness about the homosexual nature of the relationship. Couples applying for DI were open about their homosexuality. Informing friends was considered less difficult by the majority of lesbian women than informing family and especially parents. Whereas the acceptance by friends was considered a condition *sine qua non* to continue the friendship, even at the risk of losing a friend, lesbian women feared possible rejection by their parents. This was also the main reason why parents were almost always the last to be informed. Often parents were informed when there was a stable partner relationship. Daughters wanted their parents to recognize their partner relationship as such and were therefore forced to reveal their homosexuality. This also explains why social mothers, although they had known earlier in life that they were homosexual, postponed the moment at which they informed their parents. Research revealed that, although the mean age of recognizing oneself as homosexual is falling as a result of societal tolerance, the mean age at which to be open about sexual orientation is constant (Deenen and van Naerssen, 1988). Moreover, revealing oneself as a homosexual is often the last step in assuming and integrating the homosexuality in one's identity. Sometimes the announcement is postponed because once everyone is informed, homosexuals will be pinned down because of it. Although homosexuality is often one characteristic among others, it marks social identity.

Having a wish for a child requires coming out. It is not the responsibility of the child but that of the parents to explain the family situation. Being open about homosexuality had a positive influence on the well-being of both mothers and children (Huggins, 1989; Gottman, 1990). Being open facilitates the integration of the child into the family of both partners. Social integration also benefits social interaction of the child with male models in the extended family. In her therapeutic work with children of lesbian mothers, Bisnovich Pennington (1987) stressed that the more open and secure the mothers are as regards their sexual orientation and their parental role, and the more they are supported by family and friends, the more accepting the child will be of the idea of having a lesbian mother. Moreover, Patterson (Patterson *et al.*, 1998) found in her exploratory study that children who had regular contact with their grandparents had fewer behavioural problems and children in regular contact with unrelated adults experienced a greater overall sense of well-being.

Coming out is also conducive to the recognition of the parental role of the non-biological mother. Pies (1989) considers the planning of the non-biological mother an even more complex task. Not only must she convey to her family, being parent to

a child, that her partner is giving birth, but the non-biological mother with her partner also has to persuade the genetically related extended family to accept her as a parent of the child. All non-biological mothers were aware that they were not protected legally, as it is not possible in Belgium to have two parents of the same sex or to adopt a child as a homosexual couple. In our culture, parenthood is still very much defined in terms of a biological and/or a genetic connection to the child. This might result in neglect of the non-biological mother and a lack of validation and recognition of her parental position. It might also become problematical if the relationship ends or if the biological mother dies. Most lesbians find that drawing up legal documents and spelling out the exact nature of their agreements helps to clarify the parenting arrangements. Moreover, attention should be paid to the willingness of the parents, brothers and sisters of the non-biological mother to identify as grandparents, uncles and aunts even though they are not genetically related to the child.

Vance and Green (1984) found two groups among lesbians. A first group consisted of lesbians engaged in same-sex relationships prior to the age of 17, sexually active at an earlier age and defining themselves as exclusively homosexual. The second group of women did not engage in same-sex sexual relationships before the age of 20, had more heterosexual relationships prior to defining themselves as lesbian and were more engaged in bisexual activities. In the research group, social mothers showed some resemblance to the women in the first group whereas the biological mothers fitted the second group more. This might explain some of the differences between the biological and the social mothers in the research group. In the majority of the 'Belgian' couples (75%) only one partner had a wish to be pregnant. The onset of the wish for a child also differed significantly between biological and social mothers. Nevertheless, all biological mothers waited for the 'right' partner in order to realize their wish for a child. For the French couples, the opposite is true: both partners had a wish to become pregnant and the elder started treatment. The differences in the Belgian group might therefore be coincidental.

Most couples discussed their wish for a long time, focusing on all the consequences there could be for their child to be raised by two 'mothers'. From the start it was clear that the wish for a child was a joint wish. All biological mothers came with their partners and both partners were to share the responsibility for the child's upbringing. Half of the couples chose to be a two-mother unit and this was reflected in the names they would teach their children to call them. Nevertheless, the other couples were convinced that a child could only have one mother and the partner had a parental role but was not the mother of the child. This choice probably reflects the influence of the language. In Dutch a considerable number of synonyms for the word 'mother' exist. The majority of French couples consider only the second family concept because in French only one word exists for the word 'mother' even if reference is made to the example of another 'two-mother situation', i.e. adoptive and biological mothers.

The majority of lesbian couples applying for DI showed no major reasons to be refused. The majority of couples assumed the homosexual nature of the relationship, were open about the nature of the relationship, had a stable relationship and were

accepted and well integrated in the family, social and professional environments. Nevertheless, lesbian couples with a wish for a child are not representative of all lesbian couples. The majority, for instance, were not interested in homosexual organizations. They recognized the importance of these organizations but they could not identify themselves with such a way of representing homosexuality. The majority of couples who applied for DI had a rather traditional way of life. Most couples considered counselling important because of the lack of information on this particular form of parenthood.

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