

Lesbian couples requesting donor insemination: an update of the knowledge with regard to lesbian mother families

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Although a variety of ways exist of becoming a lesbian mother, an increasing number of lesbian couples have begun to visit fertility centres requesting donor insemination (DI). The practice of inseminating lesbian couples remains a controversial issue within the reproductive medicine world. Lesbian mothers offer their children a familial context, which differs on a number of important characteristics from the traditional heterosexual family. In lesbian families, a father has been absent right from the start, and the child is raised by two mothers. The present article reviews whether there is any theoretical and/or empirical evidence for the most common assumptions with regard to lesbian motherhood. It also reports on a number of studies in which the practice of counselling lesbian couples is discussed. Although many important research questions have yet to be addressed, none of the investigations carried out so far could identify an adverse effect of lesbian motherhood on child development. Counselling lesbian couples for DI should aim to provide information about the practical aspects of the treatment. The requests of lesbian couples, however, differ substantially from those of single mothers and heterosexual couples. Counsellors should respect these differences and focus upon the specific living conditions of lesbian families.

Key words: counselling/donor insemination/lesbian couples

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Introduction

Lesbian mothers have been an invisible minority for a long time, although the number who conceived in a heterosexual relationship is estimated at between 1 and 5 million in the United States alone (Patterson, 1992; Flaks *et al.*, 1995). Since the start of homosexual liberation movements in the 1960s, homosexuals have 'come out of the closet' (Hitchens, 1980; Patterson, 1997). The increasing number of women 'coming out' for their homosexuality has brought lesbian mothers to the attention of society. The majority of lesbian mothers conceived within the context of a heterosexual relationship. Often, lesbian mothers revealed their homosexuality after the children were born (Brewaey and Van Hall, 1997). During the 1980s the first

research on children raised by lesbian mothers was carried out because of adjudication in child-custody disputes.

An increasing number of lesbian women are having children within the context of a homosexual partner relationship, raising their children from infancy in a fatherless family. This evolution was even referred to as a 'Lesbian Baby Boom' (Patterson, 1994). In these cases, the partners will share the responsibility of parenting the child equally.

Donor insemination (DI) may provide an answer for lesbian couples who have a desire for a child, and doctors in reproductive medicine are challenged to deal with these 'special' requests (Englert, 1994). The use of DI treatment for lesbian couples is justified more on social than on medical grounds, since these requests are generated not by infertility but by the absence of a male partner. According to one author (Englert, 1994), the use of donor semen has never been a therapeutic treatment; rather, it allows infertile heterosexual couples to start a family in an alternative way when other medical treatments have failed. There is never a medical indication in the strict sense of the word and, therefore, lesbian couples should have the same right to DI. Nevertheless, others (Shenfield, 1994) considered DI as a palliative treatment of a heterosexual couple's infertility, whereas

the 'infertility' of a lesbian couple is not one that may be medically defined. Lesbian couples cannot provide both female and male gametes in order to conceive after regular unprotected intercourse over 1 to 2 years (Shenfield, 1994). This inability to conceive also holds true for heterosexual couples. DI is bypassing rather than treating the infertility of the male partner, providing a way to constitute a 'normal' family for the heterosexual couple (Brewaeys, 1996). Moreover, a family is a social construct, and to consider the family as an exclusively heterosexual phenomenon is primarily the product of laws based upon religious values and beliefs (Poverny and Finch, 1988). The latter authors plead, therefore, to expand the family based on bonds of intimacy, mutuality and interdependence, i.e. a domestic partnership.

The different opinions on the matter show the controversial nature of the requests of lesbian couples. The first ones to experience this controversy surrounding their wish for a child are the lesbian couples themselves. Accordingly, lesbians must therefore be reminded that they have reproductive rights, although some might deny these rights (Pies, 1989). Lesbians choose to parent for many of the same reasons as heterosexual women, but are expected to justify their decision (Pies, 1989). It has been stated (Englert, 1994) that lesbian couples explain their wish in a similar way to heterosexual couples: a common project of both partners desiring a child as an affirmation of their love. For this author, the concern of lesbian couples arises as 'déjà vu', referring to his opinion that the motivation for having children is not different for lesbian couples. According to others (Parks, 1998), this view fails to consider two issues that do not affect heterosexual mothers: (i) internalized homophobia; and (ii) a societal or religious attitude of 'compulsory childlessness'. Internalized homophobia refers to the right of lesbians to have children (i.e. Is it okay/not okay for lesbians to have children?). The second issue refers to religious or societal beliefs that consider lesbian women's desires for a child as not legitimate (i.e. that God created men and women to procreate, hence nature requires a female and male gamete to procreate). These concerns might provoke self-doubt, ambivalence and a sense that the lesbian mother should be better than an 'ordinary' mother (Parks, 1998). These concerns are in general the reason why lesbian couples often apply for DI after a long period of reflection, and after considering all possible consequences for the child to be raised in a lesbian family (Baetens *et al.*, 1996b,c).

Choices involved in the 'child project' of lesbian couples

Becoming a parent requires a considerable amount of planning and coordination for a lesbian couple. The start of this 'child project' involves making a choice, the available alternatives being: self-insemination with a known sperm donor or self-insemination with the spermatozoa of a man who wishes to have some paternal rights (i.e. shared parenthood); DI in a clinical setting with an anonymous donor or with an identity-release 'yes' donor; sexual intercourse with a man; and finally, adoption.

Sexual intercourse

Sexual intercourse, although often suggested as an easy way to become pregnant, is frequently an unacceptable solution for lesbian couples. The majority of couples consider this method of conception harmful to their relationship because it lacks respect

for the couple's identity. Moreover, suggesting intercourse with a man shows that lesbian couples are not respected in the same way as heterosexual couples because no one would suggest a heterosexual couple with a male infertility problem to consider this method of conception. In previous research (Englert, 1994), 12 couples opted for an anonymous donor because they refused to sleep with a man and/or break the couple's fidelity. Nevertheless, in subsequent investigations (Wendland *et al.*, 1996) lesbian women were significantly more likely to consider sexual intercourse with a man aware of the women's desire to achieve pregnancy (62%, $P < 0.05$) than were married women. Moreover, lesbian women were significantly more likely to attempt pregnancy in this way (31%, $P < 0.05$).

Adoption

In European countries, lesbian couples are not accepted as adoptive parents. In countries such as Belgium and France, the Civil Code considers only heterosexual couples and single women for adoption. Consequently, lesbians have to present themselves as a single woman denying their homosexuality and their partner relationship. Lying throughout the whole adoption procedure is considered to be a burden, and encumbers lesbian parenthood from the start. Moreover, often only 'difficult-to-place' children are available for lesbians who disclosed their homosexuality (Parks, 1998).

Self-insemination

Some lesbian couples will prefer self-insemination. As early as 1980, a feminist self-insemination group produced a pamphlet which explained the practicalities of this procedure. This group also set up a donor group. Donors were informed from the start that they would have no right to contact the child, or to have a relationship with the children born with their genetic material (Duelli Klein, 1984). Self-insemination involves no interference by medical staff or social workers, and therefore respects more the autonomy and the intimacy of the lesbian couple.

Another reason why lesbian couples prefer self-insemination nowadays is their preference for a known donor, or even a man who will father the child. Some lesbian couples believe their child has the right to know their genetic origin and choose therefore a known donor, even at the risk of the donor claiming paternal rights. In 1988, a court in the Netherlands sustained the request of a donor for visiting rights because of his weekly visits to a lesbian family (Holtrust, 1989). In appeal, the judge decided not to sustain the request of the donor because the visits were not frequent enough to meet the definition of family life: a continuous and personal bond between the donor and the child (Broekhuijsen-Molenaar, 1990). Lesbian women often consider a known donor because they intend to tell the child about the use of a donor, and they want to be able to answer the child's questions about the donor (Jacob *et al.*, 1999). In some cases, lesbian couples believe that their child has a right to have a father. In France, the Association des Parents Gay et Lesbiens (APGL) offers homosexual male and female couples and/or singles who wish to have a child and choose this form of shared parenthood the possibility to meet each other (APGL, 1998). In these cases, lesbian couples choose a 'biological' father who will also have some paternal rights such as a right to have contact with the child, the right to have an ongoing relationship with the child, and even

the right to recognize the child legally as theirs. In one study (Gartrell *et al.*, 1996), 45% of 84 lesbian families elected to have a known donor, and 51% of the group of lesbian mothers who chose a known donor were anticipating that the donor would be involved in parenting. In these cases, fertility centres are only confronted with the request of lesbian couples if conception fails after numerous subsequent cycles and the couple is suspected to have a 'medical' fertility problem.

DI in a clinical setting

Another alternative to become a mother is DI through a clinic. In some European countries, DI of lesbian couples is neither forbidden nor unavailable. Nevertheless, in the United Kingdom, where the Human Fertilisation and Embryology Act (HFEA, 1990) provides legislation governing the use of reproductive medicine, insemination of lesbian couples is discouraged by the importance attached to 'the child's need for a father' (Morgan and Lee, 1991). The ethical committee of the American Society for Reproductive Medicine (ASRM) has a more flexible attitude in that it resists any legal ban to 'medically assisted reproduction by non-traditional families because non-traditional arrangements can be compatible with a nurturing environment and hence compatible with the moral right to reproduce'. On the other hand, it is also stressed that 'the child's best interest is served when it is born and reared in the environment of a heterosexual couple in a stable marriage' (American Society for Reproductive Medicine, 1994). In Belgium, there is still no official regulation for the use of fertility treatment in lesbian families. In the Netherlands, the initial reluctance of most fertility centres to treat lesbian women has changed over the years. The majority of fertility centres in Belgium offer only insemination with an anonymous donor (Baetens *et al.*, 1996a). Nevertheless, the anonymity of the donor is not guaranteed by law. Belgian fertility centres can, therefore, accept a 'known' donor or a man who will also father the child in a situation of 'shared parenthood'. In the UK, non-identifying information on the donor is available (Blyth, 1998). The situation in the Netherlands will be changing as registration of donors will be enforced by law in the future, and DI children will have the right to know the identity of the donor. In the past, only one centre in the Netherlands (in Leiden) established a 'double track' system for anonymity of semen donors (De Bruyn *et al.*, 1996). In a double track model, donors have the option to enter the programme as an anonymous or as an identifiable donor. Consequently, recipients can choose between an anonymous or identifiable donor (Pennings, 1997).

The medical screening of the donors is an important reason for lesbian couples to opt for DI, which is considered to be a safe procedure. Furthermore, it is not possible in European countries to legalize the mother-child relationship between the non-biological mother and the child. The use of an anonymous donor is, therefore, often justified by the wish of the lesbian couple to protect the position of the partner. Another important reason is the protection of the partner relationship by avoiding the presence and the interference of a third party through the use of an anonymous donor (Englert, 1994; Baetens *et al.*, 1996b; Jacob, 1999). Lesbian couples are more likely to discuss custody of the DI child should the relationship end before the birth of the child (Wendland *et al.*, 1996).

The absence of a father in lesbian families has to be explained to the child. Children of lesbian couples ask about 'their father' shortly after starting school (Brewaeys *et al.*, 1993). Therefore, the option to keep the use of an anonymous donor secret from the child is more or less impossible in these families. Research shows that the majority of lesbian couples tend to be open towards their children (Brewaeys *et al.*, 1993, 1997; Leiblum *et al.*, 1995; Gartrell *et al.*, 1996; Wendland *et al.*, 1996). As a consequence of their openness, lesbian couples will be confronted with the influence of donor anonymity on the well-being of their children. Opponents of donor anonymity stress the importance of availability of information on the donor for the development of the child (Back and Snowden, 1988; Daniels and Taylor, 1993; Snowden, 1993). Donor anonymity might lead to an incomplete sense of identity of the young adult. This conclusion, however, is mainly theoretical, referring to research on adopted children (McWhinnie, 1986; Haimes, 1988). These authors claim that donor anonymity is protecting the practitioners, parents, and donors at the cost of the well-being of the donor offspring. Others (Pennings, 1997) promote, therefore, the double-track policy as long as there is no information on the effects of anonymity or identification as the best attempt to balance the rights of the donor, recipients and donor offspring.

Research on attitudes towards anonymity of parents of DI children shows that lesbian couples are significantly more likely to prefer donor registration, or to want access to more non-identifiable information on donors, than heterosexual couples (Brewaeys *et al.*, 1993; Wendland *et al.*, 1996). Interviews with lesbian mothers of toddlers show that some mothers even regret the use of an anonymous donor because they lost the opportunity for their children to know their donor (Gartrell, 1999). Nevertheless, lesbian couples interviewed before the start of DI were similar to heterosexual couples in what they themselves wanted to know about the donor: principally health variables and medical history (Jacob *et al.*, 1999). It seems that the use of an anonymous donor is convenient for lesbian women themselves. Nevertheless, openness towards the child motivates the lesbian parent's preference for removal from anonymity once the child is born. Disclosure towards the child means that parents are confronted with their children's questions and curiosity about the donor. Some lesbian couples might prefer, therefore, more an identity release (or 'yes') donor. Among the group of lesbian couples, more biological mothers than social mothers were in favour of donor registration (Brewaeys *et al.*, 1995), showing that donors might be regarded as threatening to the position of the non-biological mother.

Objections to lesbian parenthood

Many health practitioners ask questions about whether or not lesbian women should be allowed and/or aided to become mothers. Often these questions are primarily focused on the well-being of the children raised in lesbian families. Social objections to lesbian women being allowed to reproduce are based upon the following assumptions.

1. An important argument in cases of lesbian couples deciding to conceive within the context of their relationship is the right of each infant to have a father and a mother, as it was asserted in a European Convention (Englert, 1994). Although to assert the

presence of a preferably 'good' father for children seems an impracticable right, it probably emerged from the fundamental conviction in Western culture that a father is essential to the healthy psychological development of the child.

The importance of the father has been considered by various theories within developmental psychology. Psychoanalytical theorists have emphasized the need for a father figure in the child's identity development. The Oedipal phase necessitates the child's relinquishing of its incestuous attraction to the parent of the opposite sex by identifying with the parent of the same sex. From this perspective the absence of a father would entail disruption of a son's male identification process, opening up the possibility of less masculine behaviour in childhood and of later development towards homosexuality (Freud, 1905/1953; Bieber *et al.*, 1962).

More recently, the object-relation theorists have stressed that the father plays a crucial part in the child's separation-individuation process, which is indispensable for a healthy emotional development. This process, occurring during the pre-oedipal phase, refers to the psychological birth of the human infant as a separate and distinct individual. The father's presence is crucial to help the developing infant to differentiate out of the symbiotic bond with the mother (Chodorow, 1978; Abelin, 1971). It was also suggested (Abelin, 1971) that it is the father's maleness—his visible difference from the mother—that aids the development of a separate identity. It remains however, an open question whether or not the gender of the parent, other than the mother, is of crucial importance for this separation-individuation process.

Social learning psychologists, who place more emphasis on active learning processes, have stressed that the father provides a model for sons from which appropriate male gender-role behaviour could be learned, especially during the toddler and pre-school years (Block, 1976, 1983). Absence of the father is assumed to disrupt this learning process. However, contemporary social learning theorists have stressed the importance of other models such as peers and general gender stereotypes in the acquisition of gender roles (Carter, 1987).

Cognitive developmental theorists, on the other hand, do not necessarily consider the father to play a key role in the emotional and gender development of his children. According to this theory, children integrate information about sexual identity from their wider social environment, actively constructing for themselves what it means to be a boy or a girl (Kohlberg, 1966; Stagnor and Rubble, 1987).

2. A second assumption is that lesbian relationships would be less stable than heterosexual ones. Homosexual partnerships would have therefore little time for ongoing parent-child interactions (Patterson, 1997).

3. Moreover, lesbian women would possess less maternal skills in comparison with heterosexual mothers (Falk, 1989; Patterson, 1992). According to one author (Patterson, 1997), this assumption is often based upon the perception of homosexuality as a mental illness or disorder. Lesbian women would be, therefore, less maternal and not fit to be a parent.

4. Children of lesbian mothers are also believed to be more at risk of gender identity confusion and showing less conventional gender-role behaviour, resulting in a greater chance of become lesbian or gay themselves. Lesbian mothers are often assumed to

demonstrate atypical female gender-role behaviour and to be less concerned to discourage non-conventional gender-role behaviour in their children (Lewin, 1981; Hitchens and Kirkpatrick, 1985; Falk, 1989; Green, 1992; Patterson, 1992).

5. As a consequence of social intolerance, lesbian mother's offspring would be more at risk of emotional and social disturbances. Homophobia could push children to keep the sexual orientation of their mother secret because they wish to conform to the values of their peer group. This secrecy might have a detrimental effect on the identity formation and the self-concept of the adolescent child, and might increase the risk of social isolation (Tasker and Golombok, 1995).

Empirical research on children of lesbian mothers

Most of the assumptions mentioned above have not been supported by the empirical studies carried out among lesbian families. The majority of research on lesbian motherhood has been carried out as a reaction to a number of judicial and legislative decisions in which divorcing lesbian mothers were often denied custody of their children. Consequently, most of these studies compared divorced lesbian mothers with divorced heterosexual single mothers. Both groups had in common that the children spent at least some time with their biological father. Both groups differed only with regard to the sexual orientation of the mothers. The purpose of these studies was to examine the impact of the mothers' lesbianism on several aspects of child development.

The findings of these empirical studies were remarkably unanimous (for review, see Brewaeys and Van Hall, 1997). Lesbian mothers have not been found to differ from heterosexual mothers in their psychological health and in their approaches to child rearing. Maternal attitudes and the quality of the relationship with their children were at least as good as those of heterosexual mothers (Mucklow and Phelan, 1979; Miller *et al.*, 1981; Kveskin and Cook, 1982; Rand *et al.*, 1982; Golombok *et al.*, 1983; Ghazala, 1993). Children in lesbian mother families did not differ from children in heterosexual single families with respect to gender development (Green, 1978; Hoeffler, 1981; Kirkpatrick *et al.*, 1981; Hotvedt and Mandel, 1982; Golombok *et al.*, 1983; Green *et al.*, 1986), emotional/behavioural development (Kirkpatrick *et al.*, 1981; Golombok *et al.*, 1983; Puryear, 1983; Huggins, 1989; Tasker and Golombok, 1995) or quality of their social relationships (Green, 1978; Golombok *et al.*, 1983; Gottman, 1990).

There have been only a few studies investigating families with adolescent or adult children (Lewis, 1980; Gottman, 1990; Ghazala, 1993; Tasker and Golombok, 1995; Golombok and Tasker, 1996). In these studies, no differences have been found between adults raised in lesbian or heterosexual families with regard to their sexual orientation, the incidence of emotional problems or their social development. It was found that adults from lesbian family backgrounds were not more likely to remember peer group hostility than were those from heterosexual single parent homes (Tasker and Golombok, 1995). There was however, a trend for those from lesbian families being more likely to recall having been teased about being gay or lesbian themselves, and this appeared to be particularly so for boys. Especially when these children were younger, there had been a

need for secrecy towards their peers about the sexual orientation of their mothers. These findings suggest that having to cope with homophobic reactions in society may put an extra strain on both mothers and children.

When interpreting these results, one has to bear in mind that most of the children had spent their early years with their biological mother and father, and that they went through the divorce of their parents. As it is generally accepted that these childhood experiences have a great influence on children's later gender, emotional and social development, the findings emerging from these studies cannot be generalized to those children raised from birth in lesbian families.

More recently, investigations have been carried out among children who have been conceived by means of DI within a lesbian relationship (Patterson, 1994, 1995; Brewaeys *et al.*, 1995, 1997; Flaks *et al.*, 1995; Golombok *et al.*, 1997; Chan *et al.*, 1998; Gartrell, 1999). These newly created families differed from the families of the former investigations with respect to three crucial factors: (i) the children have been often conceived by means of an anonymous donor; (ii) they had been raised from birth by two lesbian mothers; and (iii) there had never been a father figure in the family. The results of these studies investigating family relationships and child development in this new family type were again remarkably unanimous. 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; Brewaeys *et al.*, 1997). Overall, lesbian mothers showed a higher quality of parent-child interaction compared with heterosexual two-headed families (Flaks *et al.*, 1995; Brewaeys *et al.*, 1997; Golombok *et al.*, 1997). Studies that compared the role of the non-biological mother in the lesbian families with the role of the father in the heterosexual families found that she was more involved in all childcare activities, including disciplinary issues (Flaks *et al.*, 1995; Brewaeys *et al.*, 1997). Moreover, childcare and professional activities were more equally divided between both lesbian mothers than between heterosexual fathers and mothers (Brewaeys *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). The psychological development of the children themselves was very similar to that of children raised in a two-parent heterosexual family. No differences were found with respect to their emotional/behavioural development (McCandlish, 1987; Steckel, 1987; Patterson, 1994; Flaks *et al.*, 1995; Brewaeys *et al.*, 1997; Golombok *et al.*, 1997; Chan *et al.*, 1998) or their gender role development (Patterson, 1994; Brewaeys *et al.*, 1997).

Literature on counselling lesbian couples seeking DI

Counselling lesbian couples is similar to counselling heterosexual couples as far as the treatment itself is concerned. Lesbian couples need to be informed by medical health workers about the procedure and the practical aspects of the treatment, the screening of the donors and the conditions under which the treatment is provided such as complete anonymity, availability of non-identifiable information and the availability of identity-release donors (double-track policy). In other aspects, lesbian couples

differ substantially from heterosexual couples, and counsellors should respect these differences. Few research data are available on the counselling of lesbian couples.

In one survey of 13 lesbian couples (Jacob *et al.*, 1994), presented at the 50th meeting of the American Fertility Society, the lesbian couples studied were unremarkable compared with two comparison groups of heterosexual couples and single women who applied for DI, except for two issues. Compared with heterosexual couples and single women, the lesbian couples were educated beyond the college degree. Moreover, lesbian women reported higher dyadic cohesion compared with married women. Lesbian couples approached the treatment with a greater sense of intimacy than married women. The findings of this study were confirmed in a paper reporting the results of 23 lesbian couples by the same authors (Jacob *et al.*, 1999). All couples were seen after mandatory pre-treatment counselling by a psychologist and were thus accepted for treatment. Couples could be rejected for the following reasons: if one partner was coercing the other; if an applicant was not competent to give informed consent; if a couple had strong objections against disclosure and they were not able to resolve this issue; if there was evidence of alcohol or drug abuse, psychiatric instability, or an unstable relationship; or if the safety of the future child was believed to be at risk. In a period of 6 years all lesbian couples were accepted for treatment.

In a report on 15 lesbian couples of which 14 were accepted for treatment (Englert, 1994), the treatment of one couple was postponed because of a long history of sexual abuse. The lesbian couples turned out to be 'fairly ordinary', with a clear division of roles and a long period of living together (mean 5.5 years). The couples were socially and professionally well integrated, and their families accepted them. They intended to be open to the child and had provided a paternal substitute for the child in the future.

Others (Leiblum *et al.*, 1995) presented results of 45 non-traditional mothers who completed at least one cycle of DI. Fourteen women were lesbian, and 10 lived with a partner. Compared with single heterosexual women, lesbian women were younger when applying for DI. Four major considerations influenced the decision of 70% of the women to initiate DI: (i) feeling secure in employment; (ii) the sense that time was running out; (iii) the sense that they had 'worked through' concerns or ambivalence about parenting; and (iv) the availability of social support. Single heterosexual mothers were more concerned that time was running out than were lesbians. Lesbians wished to share parenting with a female partner and were more concerned about finding sufficient social support. Singles were worried about having to handle the responsibility of raising a child alone, whereas lesbians were worried about the stigma their child might endure as a consequence of homophobia. All women, whether lesbian or single, worried about the absence of a father.

In another study (Wendland *et al.*, 1996), 13 women in a lesbian relationship were compared with 23 married women, six single women and five unmarried women involved in a heterosexual relationship. All women returned anonymous questionnaires while receiving DI (average of 5.4 cycles). The lesbian women were similar in age and education to the married women, while lesbian couples reported more relational stress during the treatment and were also more likely to tell the child and others about DI. In this research, couples received no psychological counselling before the start of the treatment. Some

81% of the recipients and 55% of their partners believed that psychological counselling should be available, but optional. Partners (and husbands in particular) were more likely to think that counselling of both partners should be mandatory before the start of the treatment.

One group (Baetens *et al.*, 1996b,c) counselled 52 Belgian lesbian couples who applied for DI between 1992 and 1995. All couples had a cohabiting relationship with a mean duration of almost 6 years. About 80% of the couples had discussed the wish for a child for more than 1 year. All couples were worried about the possible negative consequences for the child, if it was raised in their alternative family structure. Half of the couples (54%) were convinced that DI was the best solution; the other couples had been considering other alternatives than DI. Although partners shared the wish for a child, in 75% of the cases only one partner had the desire to be pregnant. Concerning the assignment of parental roles in this alternative family structure, 54% of the couples considered their family as a two-mother unit. These couples decided that their future children would call them by two synonyms for the word mother. The other couples thought that a child could only have one mother, the biological mother, whom the future child would call 'mother'. In these cases, the partner was considered to have a different role, but the responsibility for parenting was shared equally. All couples talked about 'our child'. Some 40% of the couples believed that the absence of a father could create problems for their child and that they should always be alert to detect whether or not this is the case. Consequently, 35% of the couples opted for the introduction of a 'godfather' who was willing to take more responsibility towards the future child than godfathers usually do, in order to compensate for the absence of a father. Other couples believed that their environment provided enough 'male role models'. All of the women accepted their homosexuality, although 14% of them referred to themselves as being bisexuals. When applying, 77% of the women and their partners were accepted by their parents and siblings. The family was informed about the desire for a child. Revealing themselves as homosexual did not cause major problems for most of the women. Consequently, 99% of the couples did not experience society as intolerant, although 60% felt they were perceived differently.

Discussion

As a result of an increasing tolerance towards homosexuality during the past 20 years, a growing number of lesbian women are living openly as lesbians and consequently, lesbian motherhood has attracted society's attention. Although the majority of lesbian mothers have conceived within the context of a heterosexual relationship, more and more lesbian couples nowadays are choosing to raise a child from birth in a two-mother family. DI may provide an answer for lesbian couples who wish to become pregnant. However, inseminating lesbian women remains a controversial issue within reproductive medicine. The bulk of the criticism is focused on the possible negative effects of lesbian motherhood on the well-being of the child. Nevertheless, there is a growing body of research showing that lesbian motherhood does not produce adverse effects on child development. Studies investigating a variety of aspects such as behavioural, emotional, gender-role and social development failed to find differences

between children of lesbian and children of heterosexual parents. Furthermore, a number of studies found that parent-child interactions between lesbian mothers and their children were of higher quality than parent-child interactions between heterosexual parents and their children.

When interpreting the results, one has to bear in mind that these studies have a number of methodological limitations. First of all, sample sizes remained relatively small in most studies, and this lowered the chance of finding significant differences between groups. Furthermore, most investigations used volunteer samples. The mothers in these study groups were predominantly white, middle class and well educated. A limitation of using such volunteer groups is that findings cannot be generalized to the population of lesbian mothers as a whole. It is also important to note that the children of these studies were relatively young. Their actual level of cognitive and social functioning at the time of the study makes it impossible to understand fully the implications of living in a lesbian family. One can expect that dealing with intolerant attitudes towards homosexuality among their peers will become a major challenge. Moreover, unanswered questions remain with regard to the use of anonymous donors. As soon as these children reach the cognitive stage of abstract thinking, they will realize that they are genetically linked to someone unknown. Especially in adolescence, where psychological development is characterized by the need to form a separate identity from the parents, children might want to know more about the donor. Further large-scale studies, involving adolescent and adult children are needed in order to provide answers to the above-mentioned questions.

The limited number of studies concerning the counselling of lesbian couples applying for DI reveals no major reasons to refuse these requests. Lesbian women were likely to be highly educated. Lesbian couples were involved in stable relationships. They applied for donor insemination after a period of reflection on the way their family should be created, after considering the possible consequences for their future child and after searching for strategies to cope with the potential risks for the child. They were very well aware that the absence of a father figure would raise questions from the children in an early developmental stage. In this regard, it is important to note that lesbian couples tended to be open about the use of donor spermatozoa. Moreover, the majority of lesbian couples were in favour of introducing male role models into the lives of their children.

Counselling lesbian couples is similar to counselling heterosexual couples as far as the practical and medical aspects of the treatment are concerned. For many lesbian couples the first visit is an introduction to the medical setting. Sometimes they tend to underestimate the impact of the treatment upon their everyday life. Especially if the lesbian couple has to travel in order to find a fertility centre willing to accept their request, the 'child project' involves a considerable amount of planning and organization.

In all other aspects the requests of lesbian couples are very different from those of single mothers and heterosexual couples, and counsellors and members of the clinic staff should respect these differences. Many lesbian couples have already been confronted with homophobic reactions to their relationship and their wish for a child. They need, therefore, to be reassured about the legitimacy of their wish. Moreover, a decision should be made about who is going to be pregnant and, if both women wish to be

pregnant, who is going to start with the treatment. Furthermore, there is no clear-cut family concept and parenting roles are not well defined. This gives a lesbian couple a certain freedom to construct their family structure, but it also introduces uncertainty about the way in which parenting roles should be assigned and about how the responsibility towards the upbringing of the child should be shared. Moreover, the partner's parenting role is not always recognized because of the lack of a biological tie. The need to integrate the child into the family and the social environment requires the homosexual nature of the relationship to be revealed to some extent. In particular, integration into the family who does not have a genetic tie with the child might be difficult. Couples should be informed about the consequences of donor anonymity for themselves as parents, and for the child. Couples need to be informed about other alternatives to fulfil their wish for a child if anonymity is not acceptable. Lesbian couples should be counselled about disclosure of issues such as homosexuality and the use of DI. They should also be informed about possible ways to tell their child about these issues. Moreover, the majority of lesbian couples fear stigmatization of their child because of homophobic reactions of the social environment, and search for ways to help their child deal with these reactions.

The majority of lesbian couples are very well aware of these issues. This results in a long period of reflection on the acceptability of raising a child in their family. Counsellors should address these issues specific to lesbian families, providing in this way the information and the psychological tools to help lesbian couples make the right decisions with regard to the planning of their future family.

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