Why Shouldn’t Lesbian Women Who Miscarry Receive Special Consideration?
A Viewpoint

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ABSTRACT. Over the past 20 years investigators have explored the incidence, experience, and extent of grieving following miscarriage for heterosexual partnered women and, to some degree, for men. Prior investigations confirm an increase in disturbed emotions following unexpected pregnancy loss and suggest a variety of predisposing social and obstetrical factors that lead to such responses. Little is known, however, about the ways in which lesbian women experience and respond to miscarriage. An argument is made that given the increased number of lesbian women attempting pregnancy through alternative methods of conception, research is warranted that explores their experiences and potentially unique caring needs following miscarriage. [Article copies available for a fee from the Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website: <http://www.HaworthPress.com> © 2006 by The Haworth Press, Inc. All rights reserved.]

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Miscarriage is an unexpected, unplanned pregnancy loss prior to the point of fetal viability (Hall, Beresford, & Quinones, 1987). Recent reports suggest that 12 to 31 percent of all pregnancies end spontaneously in miscarriage (Cramer & Wise, 2000; National Vital Statistics, 2001). Others argue that the true miscarriage rate may be closer to 50% since there is a high incidence of unreported and/or unrecognized pregnancy loss that occurs from two to four weeks after conception (Speroff, Glass, & Kaswe, 1999). According to Patterson and Redding (1996), between one and five million lesbian women in the United States are mothers through donor insemination, adoption, or short-lived heterosexual relationships. Yet, very little is known about how lesbian women experience and respond to miscarriage.

The aims of this article are to provide a succinct overview of literature pertaining to miscarriage and to present an argument for the need to understand the experience of miscarriage from the perspective of women who self-identify as lesbian. Ultimately, we argue that in order to develop caring-based interventions that are relevant to lesbian mothers who miscarry it is essential to take into account their potentially unique experiences of seeking and losing the role of expectant or new motherhood.

**LITERATURE OVERVIEW**

Revealed in the research, clinical, and lay literature is a pervasive assumption that unexpected pregnancy loss is an event solely affecting heterosexual couples. Computerized searches of Cochrane, MEDLINE, CINAHL, PsycInfo and Digital Dissertations databases produced only one investigation addressing miscarriage in lesbian women (Ferrara, Balet, & Grudzinskas, 2000). Findings from this comparative study showed that independent of a woman’s age, miscarriage rates subsequent to donor insemination were higher in heterosexual (n = 122) versus lesbian (n = 35) women (35% versus 15%, p < 0.05).

The miscarriage experience has been studied in depth with heterosexual, partnered women and, to a limited extent, with men. Qualitative inquiries have described the toll miscarriage can take on women’s lives including feelings of shock, grief, and lack of control, the need to be supported and listened to, disappointment in those responding to loss with indifference, and fears related to subsequent pregnancy outcomes (Bansen & Stevens, 1992; Harvey, Moyle, & Creedy, 2001; Swanson-Kauffman, 1986, 1988; Van and Meleis, 2003). Investigators also found
that women may experience a variety of emotions ranging from disappointment to fear and anxiety (Madden, 1994) and from relief to intense pain and grief (Swanson, 1999).

Qualitative researchers exploring males’ responses to miscarriage suggest that, similar to females, expectant fathers experience a range of complex feelings related to pregnancy loss of partners (Murphy, 1998; Puddifoot & Johnson, 1997). Moreover, Miron and Chapman (1994) suggest that despite their own sadness, men feel compelled to comfort and support their female mates through the grieving process but are oftentimes quite uncertain about just how to help.

Research conducted within the contemporary empiricist paradigm using controlled and prospective longitudinal designs has supported findings obtained using interpretive methodologies. The majority of descriptive investigations point to the presence of significant psychological distress and depressive symptoms in females lasting from weeks to months (Friedman & Gath, 1989; Prettyman, Cordle, & Cook, 1993; Thapar & Thapar, 1992) but generally subsiding by one year after loss (Janssen, Cuisinier, & Hoogduin et al., 1996; Neugebauer, Kline, O’Connor et al., 1992). A recent prospective study (Swanson, 2000) examined the intensity of women’s (n = 174) depressive symptoms at four months and one year post-miscarriage. Lazarus’ (1984) model of stress and coping guided the inquiry and accounted for 63 percent of variance in the women’s depressive symptoms at four months and 54 percent at one year after loss. Swanson’s (2000) findings demonstrated that women at highest risk for depressive symptoms were those with less emotional strength and who ascribed high personal significance to their miscarriage, lacked social support, felt less emotionally strong, had lower incomes, and did not conceive again or give birth by a year after loss.

Attempts made to examine the associations between obstetrical variables and women’s emotions after pregnancy loss produced less consistent results. Some investigators found no association between women’s responses to miscarriage and previous reproductive losses (Neugebauer, Kline, & Shrout et al., 1997; Turner, Flanneely, & Wingfield et al., 1991) while others (Swanson, Kieckhefer, & Henderson et al., 1991) found that women attributed greater meaning to miscarriage if they experienced previous reproductive losses.

Several attempts have been made to examine grief responses as well as factors that influence the course of women’s grieving. Findings of a longitudinal study of parameters of grief following miscarriage (Stirtzinger, Robinson, Stewart, & Ralevski, 1999) suggest that the se-
verity of grief is related to demographic and social variables. The degree of grief increased with women’s age, number of previous reproductive losses, and lower levels of support from family and social networks. Partner (Black, 1991, Conway, 1995; Swanson, Karmali & Powell et al., 2003) and social support (Ney, Fung, & Wickett et al., 1994; Rajan & Oakley, 1993) have consistently been shown to help women cope with pregnancy loss. Findings of other inquiries (Cuisiner, Jassen, & de Graauw et al., 1996; Lin & Lasker, 1996; Swanson, 2000) suggest a relationship between decreased intensity of miscarriage-related grief and subsequent pregnancy, putting into question the value of waiting to conceive again until after grief subsides.

Fewer studies have been conducted to identify effects of miscarriage on expectant fathers. While prospective investigations suggest that the majority of men respond to miscarriage in ways similar to their female mates (Beutel, Willner, & Deckardt et al., 1996; Puddifoot & Johnson, 1997), males’ grief and depressive symptoms tend to last for a shorter duration. Furthermore, the majority of males see themselves as comforters for their female partner during her time of grieving.

Little is known about what it is like for lesbian women who miscarry and even less is known about therapeutic ways to respond to lesbian mothers subsequent to miscarriage. While the biological uniqueness of women in itself creates grounds for universal research on women’s health, life experiences that shape sexual minority women’s mental, spiritual and social well-being deserve special consideration (McDonald, McIntyre, & Anderson, 2003). This article presents an argument that just as the issues faced by lesbian couples in the process of conceiving, gestating, and parenting are unique and deserve consideration (Baetens & Brewayes, 2001) their experiences and responses to unexpected pregnancy loss also warrant special exploration. Furthermore, we question the applicability and relevance of our own empirically derived heteronormative intervention strategies (Swanson, 1999) when caring for lesbian mothers after miscarriage.

**LESBIAN WOMEN’S REALITIES**

While the constitution of family is constantly shifting and reorganizing and societal tolerance for homosexual lifestyles seems to be growing, norms acquired through gender socialization continue to influence heterosexual societal assumptions about what constitutes normal in terms of both reproductive processes and family constellations. Biery
(1990) describes heterosexism as a form of oppression which elevates heterosexuality to a position of superiority that is enforced through ideology, theology, and other social institutions. Accordingly, the traditional heterosexist family model continues to occupy the position of privilege in the United States (Young, 1997). Lesbian and other non-traditional families encounter significant discrimination ranging from policies that prohibit same-sex marriage to preventing same-sex couples from equal access to family benefits that are readily available to heterosexuals (Shore, 1996). Because lesbian motherhood undermines the traditional notion of family and challenges the heterosexist monopoly of reproduction, lesbian women seeking to parent also experience prejudice and discrimination (Dunne, 2000).

In spite of these controversies, increasing numbers of women conceive and raise children within the context of a homosexual relationship thus presenting a radical challenge to the traditional heterosexist norms that govern societal rules (Philips, 1998). According to Englert (1994), lesbian couples are motivated to seek motherhood as an affirmation of their love and commitment. Yet, lesbians are expected to justify their decision since the very concept of a two-mother household unseats established social order and challenges commonly held ideologies and assumptions about families, their make-up, and roles. Parks (1998) suggests that societal pressure may lead lesbian couples to experience internalized homophobia that raises self-doubt as to whether it is all right to be lesbian and to mother. Parks claims that such doubting of personal entitlement to parent may create internalized pressures in lesbian women to perform better in their parenting role than other mothers. Another unique issue faced by lesbian couples regards parenting rights. Throughout the 20th century, developmental theorists have emphasized the importance of mother and father figures in a child’s life. Furthermore, societal assumptions are oftentimes made about the potential detrimental effects of parental homosexuality on child development. Although there is no empirical evidence to support claims of negative effects of lesbian mothering on child development or psychosocial well-being (Anderssen, Amlie, & Ytteroy, 2002; Brewayes & van Hall, 1997; Parks, 1998; Patterson, 1992), controversy about lesbian parenting persists in courts of law and society in general. Co-mothers (non-biological mothers) are particularly disadvantaged because they lack both biological and legal substantiation (Hequembourg & Farrel, 1999). Such legitimate concerns frequently lead lesbian couples to delay parenting plans until they arrive at a mutually held belief that they, as a
couple, can work through any unanticipated legal or parenting role issues (Baetens & Brewaeys, 2001).

Unlike the majority of heterosexual couples, lesbians establish single- or two-mother households through adoption, short-lived heterosexual relationships, or donor insemination. Hence, it behooves health care providers to consider issues that may be uniquely faced by lesbians as they conceive, bear children, give birth, or experience pregnancy-related losses (Ferrara et al., 2000). Because of the unique social realities, unanticipated obstacles, and biological challenges faced by lesbians seeking to become mothers, Baetens and Brewaeys (2001) refer to the pursuit of motherhood in lesbian households as engaging in a “child project.”

One unique issue faced by lesbian couples is that they cannot conceive through unprotected sexual intercourse with each other. Therefore, before pursuing their “child project” they must decide which partner will fill the role of biological mother. Baetens and Brewaeys (2001) suggest that the decision is usually influenced by the women’s age, reproductive health, and security of employment. They further describe how once the decision is made, the couples must engage in negotiating a method of conception that is both affordable and not offensive to their lesbian identities and couple relationship.

Although several methods of conception are possible, in recent years donor insemination in a clinical setting has become increasingly popular. It is considered safe, and the use of sperm from an anonymous donor is believed to protect the couple’s integrity and the position of co-mother (Gartrell, Banks, & Hamilton et al., 1996; Hequembourg & Farrel, 1999). However, financial burdens associated with sperm donation may prove problematic for lesbians with low incomes or who live in remote locations (Ferrara, Balet, & Grudzinskas, 2002). Moreover, since controversy exists amongst obstetrical and reproductive medical care providers as to whether or not lesbian women should be aided to conceive, availability of providers willing to inseminate a lesbian may also be a barrier (Baetens & Brewaeys, 2001). To avoid discrimination within the health care system, some lesbians pragmatically choose to hide their homosexuality and are subsequently destined to live with the burden of lying to conceive. Such deception may diminish the excitement of pregnancy and expectant parenthood and hinder a lesbian woman’s sense of entitlement to mother and to accept her child into a committed relationship with her loving partner. Ultimately, such forced deception will likely influence the unfolding relationship between both mothers and their expected child.
For these reasons, many lesbian couples select self-insemination since this allows preservation of lesbian identities and honors the intimacy of conceiving. Moreover, self-insemination provides an opportunity for utilizing a known donor which later enables lesbian mothers to answer their child’s questions about his or her origins (Jacob, Klock, & Maier, 1999) and to foster development of a potential relationship between the child and his/her biological father (Baetens & Brewaeys, 2001). On the other hand, the risk of the identified donor claiming paternal rights may prove quite anxiety-provoking to some lesbian couples. Especially threatened is the co-mother who lacks both legal rights and biological connection with the child (Brewayes, Devroey, & Helmerhorst, 1995). There are reports, however, that despite the risks faced by social mothers, their psychosocial experience of living through a partner’s gestation is similar to that of expectant fathers in terms of emotional investment, empathy, and partner attachment (Sandelowski & Black, 1994).

Some lesbian couples for various reasons choose to have a short-lived sexual relationship with a donor in order to conceive (Baetens & Brewaeys, 2001). In a study comparing lesbian and heterosexual women’s attitudes toward sexual intercourse with a donor, Wendland, Byrn, and Hill (1996) found that lesbians were far more likely to consider a sexual relationship with a donor (62%, p < 0.05) than heterosexual women who had been unable to conceive because of their husband’s infertility. This suggests that heterosexual women are less likely to act in opposition to established societal rules in the pursuit of motherhood. Nonetheless, findings of other research (Englert, 1994) imply that lesbian couples consider heterosexual intercourse as disrespectful to their lesbian identity and harmful to their couple relationship, and, therefore, this is unacceptable. Lastly, there is evidence that once pregnant, lesbians spend considerable energy to gain acceptance of their marginalized (lesbian, lesbian mother, social mother) and mainstream (biological mother) identities within their family and social networks. Based on in-depth interviews with nine lesbian mothers, Hequembourg and Farrel (1999) found that in their everyday experience participants sought acceptance for their marginal (lesbian/social mother) and mainstream (mother) identities through self-disclosure and negotiating in a range of social realms. As a result, while some continued to experience rejection and discrimination, the majority became well integrated within their social environment of predominantly heterosexual families, co-workers and friends.
CONCLUSIONS

In summary, the social realities of lesbians—both single and in a couple relationship and engaged in the process of conceiving, gestating, and mothering—are that they are marginalized. They disrupt established societal norms, experience prejudice, face discrimination, and must remain ever vigilant in navigating their marginalized maternal roles. Just as the social realities of lesbian motherhood are unique, so may be their experiences of miscarriage.

Likewise, if miscarriage is experienced differently by lesbians, questions may also be raised about the relevance of applying therapeutic interventions that are found effective with heterosexual women (Swanson, 1999). With increasing numbers of lesbians, both single and coupled, attempting pregnancy through alternative methods of conception, research exploring the experience of miscarriage from the perspective of lesbians is warranted.

The Human Experience of Miscarriage Model (Swanson-Kauffman, 1986; Swanson, 1999) may provide a useful starting point to consider and unravel the potentially unique ways lesbian mothers experience through early pregnancy loss. For example, Swanson’s (1999) model suggests that when heterosexual women (and men) miscarry, they: (1) go through a painful and confusing process of realizing they are losing their chance to bear this baby; (2) have to name for themselves just what they lost and gained through miscarrying; (3) must figure out how to disclose and let others know of their loss; (4) determine who is willing to share (recognize) their loss; (5) get through their experience; and ultimately (6) decide whether or not to try again (1999).

When lesbians face miscarriage one can speculate that each of these processes would be altered by their miscarriage having occurred in a heterosexist society that questions their entitlement to have even sought motherhood in the first place. Given the challenges lesbian mothers face in conceiving, gestating, and mothering, they may experience and respond to miscarriage differently than heterosexual couples. Since there is almost no research to date on this topic, we make the call for future research exploring the experiences of lesbian women who miscarry and for their potentially unique caring needs. In turn, this knowledge might provide a foundation for designing therapeutic interventions in which lesbian women will feel safe, understood and well supported.
REFERENCES


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