Acknowledgements

The Beginning: My partner and I were among the first handful of lesbian couples in Germany planning children in isolation of one another back in the early to mid 1990's. The two of us had countered all odds of a binational relationship, already conceived one beautiful child through donor insemination and were in the midst of a mother role switch. Only it didn't happen. Not like we expected it to anyway. Our second child kept us waiting...until we no longer believed it *would* happen. It was out of the despair over a 'lost' child who had not yet been conceived that the idea for *Unconventional Conceptions* was born. In the meantime, we got lucky...twice ☺...but the realization of this project has become even more important as our children age and we encounter more and more agencies of mainstream society that so desperately need information about our families.

The book you are about to read is a dissertation from the University of Basel, Switzerland supervised by Professor Dr. Udo Rauchfleisch and co-supervised by Professor Dr. Thomas Gehring. The realization of this manuscript has only been possible due to the help and support of many people. The obvious place to start is my life partner, Moni, who has encouraged me endlessly for eight years even though we never knew if this project "would lead anywhere" and our children, Lena, Dylan and Mia, who are both a complete distraction as well as *the* source of my passion to strive for change in the interests of children of LGBT parents. You are the loves of my life! I would also like to mention another essential ingredient in the working-mother-of-three-does-a-PhD. puzzle: Lotte (Oma) Herrmann who assisted us with seemingly endless childcare particularly in this past year of writing and Gerhard (Opa) Herrmann for putting up with it! I would also like to thank my mother, Christine (Grandma) Green, for producing so many elaborate and statistically intricate tables on which to base my results. I would like to thank my supervisor, Udo Rauchfleisch, for his openness to and interest in my work, also for the past eight years ☺, as well as, Thomas Gehring for being a supportive and constructive co-supervisor. I would also like to thank Suzanne Johnson & Elizabeth O'Connor, authors of *The Gay Baby Boom*, and Lynn Shelley-Sireci & Claudia Ciano-Boyce, authors of *Who's Mommy Tonight?*, for sharing the questionnaires they used in their research with me.

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Abstract

This study aimed to systematically describe the decision-making phase of family formation in German lesbians planning to parent via donor insemination, to assess the issues pertinent to each mother role and those involved in donor type choice using a retrospective, structured questionnaire. Data was collected from 105 self-identified lesbian women, 55 of whom were birthmothers and 50 of whom were social mothers.

The process of planning a lesbian-headed family created by donor insemination is, in many ways, unique to this family form. First of all, each woman has to successfully come-out and develop a positive self-identity as a lesbian and develop a committed lesbian relationship (in the case of planning a two-parent family). The decision-making phase of family building, which took 2 years on average, includes working through issues that are common to the decision of parenting shared by heterosexual couples as well as lesbian specific issues. The following lesbian specific aspects of family planning were identified in this study. Lesbian women must actively confront (internalized) societal taboos of lesbians and gays having children and develop strategies for handling homophobia. They must also develop a positive attitude towards a lesbian-headed family. In the absence of or outside of legally sanctioned relationships, women planning to parent in lesbian relationships consider the event of relationship dissolution or death of the birthmother for both the social mother and the child. The lesbian couple also decides what model of family they intend to build. In the absence of traditionally defined roles, the lesbian couple must negotiate and define the birth and social mother roles for their family. In the absence of terminology for the birth and social mothers, the lesbian couple must decide what they want the child to call them. Lesbian women must decide on the method by which they want to become parents. If a lesbian couple decides to become parents by conception, then they must negotiate which of the women will conceive (first). Another decision to be made regards that of donor type choice, i.e. how to get sperm and to what degree the male it stems from should be known to and involved in the life of the lesbian couple and child. Prospective lesbian parents must decide if, to what degree and in what way they intend to include men in their child's lives. In contrast to heterosexual family planning, lesbian prospective parents are choosing a non-normative path and, correspondingly, are faced with the issues of resources, challenges and eliciting support for their family decisions.

104 of the 105 participants planned a two-parent family with their lesbian partner. The allocation of mother role between the two women occurred via the decision over which

woman would bear the (first) child. The obvious difference between the mother roles lies in the biological fact that the birthmother goes through insemination and the physical work of pregnancy, childbirth and probably nursing where as her partner becomes a mother without it. The other major difference between the mother roles is that the birthmother role is culturally defined where as the social mother is culturally and legally (prior to stepparent adoption conclusion) non-existent. However, these differences do not impact the couple full force in the decision-making phase; they are anticipated and first strategies for handling upcoming difference is made, i.e. plans for equal parenting, and 'mother' terminology. In fact, during this phase, the roles seem more similar than different as the women make all the parenting decisions together.

The women in this study chose different donor types in planning DI: anonymous donors (n=42), identity-release donors (n=22), known donors (n=39) and unknown, fresh sperm donor (n=2) to conceive their first-born child. The decision as to which type of donor the couple wants may be conceptualized as a balance act between protecting the lesbian couple and LDI family unit boundaries in our social and legal context, on the one hand, and attitudes towards father related issues, on the other, such as, the degree to which the women think it is acceptable or damaging for a child not to know its biological father, and whether they felt the desire to know one's 'roots' is biologically determined or socially imposed. The attitudes of mothers who used identity-release and known donors conformed more with heteronormative attitudes while those of mothers via anonymous donors did not. Although different donor types were chosen, all women were able to identify positive and negative aspects of their donor choice attesting to the fact that there is no blanket solution for everybody, only solutions for individual couples.

Future research needs to assess the development of the LDI family by phase through all the stages of family formation in order to deepen our understanding of these families' transition to parenthood and passage through the life cycle. The information assessed in such studies would provide information future LDI mothers may need before they embark on motherhood as well as prove useful to professionals in a variety of disciplines who are educating and /or providing services for members of LDI families.

1.0 Introduction

Creating a family by bringing children into a loving couple relationship is no longer the domain solely of heterosexual couples or marriages. Increasingly, lesbian couples are joining the realms of those actively involved in the process of family building and parenting. Though lesbian families are often considered a recent phenomenon, the existence of lesbian mothers is not new. In fact, there have always been lesbian mothers throughout history (Epstein, 1993; Falk, 1989; Jacob, 1997). These children were primarily conceived in the context of (prior) heterosexual relationships, usually marriage. What is recent, however, is that more and more lesbians are choosing to parent in their lesbian relationships or alone. In fact, the dramatic increase of lesbians choosing to parent has lead several U.S. authors to speak of a "lesbian baby boom" (Patterson, 1994) or "gayby boom" (Pies, 1988). A similar trend has been observed in several European and other first-world countries around the globe, as is evidenced by the international nature of the research on planned lesbian families (see discussion of literature below).

Before we begin, it is necessary to clarify the assumptions that underlie this research and define the terminology used.

1.1 Perspective

This research is gay affirmative, that is, the underlying assumption of this researcher is that not one sexual orientation is inherently "better" than the other or that people with a particular sexual orientation are, due to their sexual identity, better suited to the tasks of parenting and child rearing than persons of other sexual orientations. As we will see below, psychosocial research supports this view, and, though it contrasts greatly with lay opinion, can therefore be considered a legitimate starting point for this research.

1.2 Terminology

Lesbian

For the purposes of this study *lesbian* will be defined simply as those women who self-identify as lesbian.

Family

What constitutes a family? "What family is or means depends on which historical epoch, social-cultural and individual life cycle focus one chooses…how family is defined, also determines what types of family one considers normal or deviant and which rights and obligations are recognized by legal or other social institutions. Societal recognition is therefore an important aspect for the constitution of family." (Schneewind, 1987, p.971). Schneewind (1987) distinguishes between three concepts of family: legal, genealogical and psychological concepts of family.

The Legal Concept of Family

Article 6 of the Federal Republic of Germany's constitution guarantees marriage and the family special protection under the law. The affiliation (dt. *Filiationsprinzip*) and custody principles (dt. *Sorgerechtsprinzip*) define family in its legal sense in Germany. Two generations that are connected by biological or legal parenthood are considered a family. The consequence of this definition for the lesbian DI family is that only the birth mother-child relationship is automatically recognized even if the birth mother and the social mother are life partners at the time of the child's birth. The only way for the social mother to achieve a legally recognized relationship to her child is through 'stepparent adoption', available to lesbian life partners only since January 1, 2005.

The Genealogical Concept of Family

The genealogical concept of family is oriented on the relatedness principle (dt. *Verwandtschaftsprinzip*) and encompasses a wider range of family living. The family is comprised of a group of people who are related, married or related by marriage irrespective of whether they live together or not and are alive or deceased. This concept of family may embrace the LDI family only if the birth and social mothers are life partners since the life partner is related by marriage (dt. *verschwägert*) to the birthmother's child.

The Psychological Concept of Family

The psychological concept of family is oriented on the principle of collaborative living (dt. *Prinzip des gemeinschaftlichen Lebensvollzugs*) which is characterized by privacy, closeness, longevity and high degree of involvement of the group members. This concept of family fully embraces the LDI family, even if the mothers are not life partners.

Rainbow Family

Rainbow family is an umbrella term referring to any family in which one or both (biological/legal) parents identify as lesbian or gay, irrespective of how the family was created.

Lesbian-headed Family

"Referring to a group of families, such as gay- and lesbian-headed families, as if they were a homogenous collection of families is misleading. Gay and lesbian families are a diverse group, not only in terms of the usual factors that differ among families, such as economic and racial backgrounds, religious affiliation, and residential area, but in ways that do not apply to families headed by heterosexual parents."(Johnson & O'Connor, 2002, p.54) The authors of *The Gay Baby Boom*, Suzanne Johnson and Elizabeth O'Connor, identified 2 subgroups of families with gay and lesbian parents in their U.S. National Study (2002): *lesbian/gay stepfamilies* and, what they coined, ***primary lesbian****/gay* ***families***.

Lesbian Stepfamily

Lesbian stepfamilies are lesbian-headed families in which one or both partners have a child who was conceived within the context of a previous heterosexual relationship, usually marriage (Johnson & O'Connor, 2002).

Primary or Planned Lesbian Family

Primary lesbian families are defined as those families that were begun within the context of a lesbian relationship (Johnson & O'Connor, 2002) either by adoption, foster-parenting, or by conception. Another term for these families is "planned lesbian family" (Flaks, Ficher, Masterpasqua & Joseph, 1995). The family defines its attachments based on love and commitment, not only biology.

Lesbian Mother

The term "lesbian mother"[1] is both ambiguous and used as an umbrella term to describe a woman in up to four different relational roles. First, it can be used to name the (birth-) mother of a child brought into a heterosexual relationship who later identifies as lesbian, also referred to in the literature as a *divorced lesbian mother*. Second, "lesbian mother" may also be used to denote the divorced lesbian mother's partner, who may occupy the role of *lesbian stepmother*. Third, the term may denote the *biological/legal mother* in a planned lesbian family. Fourth, it may be used to name the *social/non-legal mother* in a primary lesbian family.

Naming the mother roles in a primary lesbian family created by donor insemination

Common usage amongst the study population is to refer to the birthing mother of a child as the "**birthmother**" or "biological mother". [2]

The terminology used for the non-birthing mother is more diverse and somewhat controversial. "As we turn our attention to the nurturant, desirous women who is other than (M)other, we first struggle with the constraints of language as we attempt to represent her symbolically through language."(Muzio, 1993, p.225) Terms such as *co-parent* (Scheib, Riordan & Rubin, 2003; Scheib, Riordan & Shaver, 2000), *co-mother* (Muzio, 1993, Gartrell**,** Hamilton, Banks, Hamilton, Reed, Sparks, Bishop & Rodas, 1999; Wilson, 2000), *non-biological mother* (Pies, 1987, 1988; Patterson, 1996; Nelson, 1999), *social mother* (Brewaeys, Ponjaert, Van Hall & Golombok, 1997; Vanfraussen, Ponjaert-Kristoffersen & Brewaeys, 2001; Bos, van Balen & van den Boom, 2004), *psychological mother*, *nonlegal mother* (McClellan, 2001) and *other* mother (McClellan, 2001) have been used to distinguish this parenting role. Muzio (1993) considers these options, "....to be identified as non-biological is to be identified in and thru a sense of lack....The term co-parent seems on the surface is a somewhat friendlier, more benign term... Even on a more colloquial level, a co-parent is by definition either mother or father, a necessarily genderless being...We are left perhaps identifying as co-mother...It is perhaps more accurate than the other terms considered

[1] In the literature, it has been frequently commented that the terms *lesbian* and *mother* may, at first glance, seem mutually exclusive, an oxymoron (Dalton & Bielby, 2000).While the *lesbian* stereotype portrays a male-identified, yet man-hating woman who is "emotionally unstable and prone to psychiatric disorder" (Golombok & Tasker, 1995, p.205), that of *mother* is directly juxtaposed. However, women who are already mothers can and do attain lesbian identities and already-identified lesbians remain physiologically capable of conception, pregnancy and childbirth or may be partnered with a lesbian woman who intends to or has exercised this capability.

[2] This author is aware that, with the advances of reproductive medicine, the socio-biological role of "mother" can be broken down into three roles: genetic mother (producer of oocyte), gestational mother, and social mother (she who performs behavior of care-taking, child-raising, etc.). Since none of the women in this sample were oocyte donors, this more detailed derivation was refrained from.

here, as it is one that speaks to being with the mother." (p.226) *Co-mother* is actually a rather established term and, for example, used in the U.S. on birth certificates of children who have been second-parent-adopted by their lesbian parents.[3] In practice, however, this term is used ambiguously since it refers to any woman who is partnered with the lesbian biological mother irrespective of her definitional role in the family. This researcher holds the view that since the prefix "co-" means "with" that this term is better suited for designating a woman occupying the role of *lesbian stepmother*. It was important to this researcher to avoid defining the non-birthing mother role in a primary lesbian family in terms of "a lack of". It is this author's expressed intent to (1) clarify her role as a mother in a primary lesbian family, (2) signal the equality of this role to that of the biological mother and (3) define her in terms of what she *is*. The term ***social mother*** was preferred for these reasons.

Donor Insemination

The process of *donor insemination* refers to the mechanical introduction of sperm into the vaginal canal, cervix or uterus of a female for purposes of conception (Mohler & Frazer, 2002). It is a relatively non-invasive procedure frequently used in reproductive medicine primarily in cases of male factor infertility.[4]

Lesbian DI family

This term will be used out of convenience to refer to the more accurate, but long name for *planned lesbian-headed family created by donor insemination.*

Kinderwunsch

Directly translated *Kinderwunsch* (German) means "child wish" and entails the combined meaning of wishing to become a parent and wanting to have a child. This researcher would like to introduce this term into English language literature as it is a precise and efficient word which is cumbersome to translate, similar to *Gestalt* and *Zeitgeist*.

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[3] Anecdotal evidence acquired by the author when she asked what the most appropriate terminology used in the U.S. is via the listserv from Division 44 (Study of Lesbian, Gay, Bisexual and Transgender Psychology) of the American Psychological Association (APA). In general, responses to this inquiry were very emotionally and politically charged.

[4] Since ISCI, intracytoplasmic sperm injection, has become more readily available, many heterosexual couples who would have used DI are now choosing to use ISCI (first) (Scheib et al. 2000). ISCI offers them the opportunity for a biological connection between both the mother and the father and the child thereby avoiding the potential pitfall of asymmetric biological parenting inherent in DI. It is, however, a significantly more invasive procedure than DI for the woman as it entails overstimulation of the ovaries, egg retrevial and reimplantation.

Coming-out

The term coming-out has two meanings. First, it describes the *process* by which a person acquires lesbian or gay male sexual orientation and identity. Secondly, it describes the *act* of disclosing this personal information to others. (See section 4.1 Coming-out and, for a detailed discussion of this process, Rauchfleisch, 1994) This act of disclosure is necessary since lesbians and gay men are otherwise presumed to be and treated as if they were heterosexual (unless they fail to conform to gender role stereotypes, which is interpreted as evidence of a lesbian or gay sexual orientation, Greene, 1994).

(Internalized) Homophobia & Heterosexism

Homophobia and heterosexism are the sources of oppression for all non-heterosexuals and can be conceptualized as two sides of the same discriminatory coin.

Homophobia was coined by Weinberg (1973) to describe the "irrational fear, hatred and intolerance of homosexual men and women" by surrounding society (Slater, 1999, p.38). Homophobia varies is its expression from subtle, i.e. grimacing at the thought of two men kissing, avoiding physical contact with a known lesbian (as a woman), to extreme, ending in violence, hate crimes and death. Everybody socialized in our society suffers from varying degrees of homophobia. The internalization of negative societal attitudes and stereotypes of lesbians and gay men *by* lesbians and gay men is termed *internalized homophobia*.

Heterosexism refers to the assumption that heterosexuality is the only valid form of sexual identity or family life (Slater, 1999). Heterosexism is often evident in the omission of the homosexual reality, i.e. in books, movies, school materials, mass media, language and laws, etc., or in obvious privileging of the heterosexual lifestyle, i.e. laws such as Art. 6 of the German constitution, material benefits for heterosexually married couples, and increased social status.

Abbreviations:

LG (lesbian, gay)

DI (donor insemination)

LDI (lesbian donor insemination) family/child

2.0 Early Research on Lesbian Mothers

Initial research on lesbian mothers has predominantly been done in the U.S. since the 1970's and has involved lesbian mothers who conceived their children in the context of heterosexual relationships. Historically, custody suits brought attention to this population, as the (new) homosexual orientation of the mother was often cited as the reason to grant custody of joint children to the father (Baetens & Brewaeys, 2001). To this day, attorneys are more likely to suggest a father sue for single custody of the couple's child (-ren) if the mother identifies as lesbian (Muir, 1999). Prejudiced ideas regarding the (lesbian) mothers included assumptions that they were prone to psychological disorder and were not maternal (Brewaeys et. al. 1997a; Baetens & Brewaeys, 2001; Jacob, 1995; Kershaw, 2000). As for their children, homophobic fears, that may even persist today, included ideas that, due to their mother's lesbian identity, they will grow up confused about their gender identity, not display "appropriate" gender role behavior and be more likely to become gay themselves (Ibid)[5]. Finally, due to the social stigma attached to homosexuality, the children would be teased and ostracized by peers thereby compromising their ability to make friends which in turn would negatively impact their social and emotional development (Brewaeys et. al. 1997a; Baetens & Brewaeys 2001; Kershaw 2000)[6]. The research was therefore motivated by an attempt to assess the validity of these (mis-) assumptions regarding the ability of a mother who is lesbian to be a good mother and to raise happy, healthy and well-adjusted children. Psychological research thus focused on the adjustment and development of children raised by lesbian mothers as compared to children raised by heterosexual mothers, as well as, the psychological adjustment of the lesbian mothers themselves, and their parenting abilities.

The results of this body of literature have led to the general conclusion that the children of lesbian mothers do indeed develop normally and that lesbian mothers are 'fit' mothers. In fact, sexual orientation of the parent does not seem to be a pertinent factor in determining parenting ability at all, rather the strength of the desire to parent (Golombok, 1999; Mooney-Somers & Golombok, 2000; Kirkpatrick 1996). Also, a child's adjustment is enhanced when

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[5] It is interesting to note that this stance fails to acknowledge that the „appropriateness" of behavior for a particular gender is dependent on (1)time in history and (2) place, i.e. culture since "notions of 'good parenting' [are]...culturally specific and variable" (Kershaw, 2000, p.367). Additionally, this discussion revolves around the presumed catastrophic consequences of deviation from the heterosexual nuclear family model although his family form in itself is relatively new and only emerged after World War II as the dominant model of family (Jiles, 1999). Finally, to date, most people with a homosexual orientation were raised by heterosexual parents.

[6] Steffens and Thompson (2003) point out the irrationality of this cognition with their analogy, "overweight people should not be allowed to have children because obesity is rejected in our society and the children could be teased because of the obesity of their parents" (p.102). Pies (1988) and Gershon, Tschann & Jemerin (1999) also stress that potential discrimination of the child should not be a deterrent to parenthood but that the source of oppression should be fought.

the lesbian mother lives with her partner, when the lesbianism is acknowledged before the child reaches adolescence, and when the child has contact with peers from other lesbian families (Patterson, 1992).

This research typically compared heterosexually divorced single women with heterosexually divorced lesbian women, irrespective of their lesbian partnered status, and their children on certain measures. It was thought that these results may not be generalizable to children who, from birth, have been raised by lesbian parents. Also, the focus on "single mother" in the legal sense caused the "oversight" of the lesbian partner by the researchers. This poses limitations on the results since Kirkpatrick et al. (1981), for example, noticed benefits to children if the lesbian mother had a live-in partner, such as, more diversified social life, less distress over daily burdens, higher income and mothers were more available to children. Also, using divorced mothers inherently entailed the confounding factors of martial discord, divorce, and separation from the child's other parent, the child's father. To avoid these methodological pitfalls, another body of research has used newly emerging planned lesbian families, primarily LDI families, as its base to study the effects the mothers' lesbianism on child development and lesbian family functioning in a purer form.

3.0 Literature on Planned Lesbian Families

Societal climate regarding the subject of homosexuality has changed in the USA and northern European nations. Since the riot at the Stonewall Inn in New York City in 1969, marking the beginning of the second gay and lesbian emancipation movement (Cruikshank, 1992), gays and lesbians today enjoy greater societal tolerance. This does not mean that homophobia and heterosexism are issues of the past, but, in some countries, gays and lesbians have increased protection by law (anti-discrimination legislation) and rights ('gay marriage' or civil unions). Paralleling these developments has been an increased (a) access of single and lesbian women to reproductive medicine and (b) interest in self-insemination which as led to the emergence of what has been labeled the "Lesbian Baby Boom" (Patterson, 1992) in North American and northern European nations since the early 1990's.

Lesbian couples have begun creating families in increasing numbers over the last 20 years via adoption, foster parenting and, most commonly, by conception. Lesbians becoming parents by conception may inseminate sperm obtained from a sperm bank or a male friend. A small subgroup opts for conception via heterosexual sexual relations with a man. The child or children are thus born into a family of origin with a mother or mothers who identify as lesbian

from the start and may or may not have additional parents, such as, a social mother and/or known (biological) father. These planned lesbian families are therefore characterized by a lesbian identity of the mother(s), a high intentionality to parent (Golombok et al.,1996), and, in some cases, biological father absence.[7]

Only a small subset of the literature on lesbian mothers has focused on these families, though these are more international in nature. The early studies discussed above have well established support for maternal ability of lesbian mothers as well as the psychological well-being and normal development of their children. Some of the research conducted on primary lesbian families, usually created by donor insemination, has continued to investigate the effects of the family's structure on family functioning and child outcome. Other research has focused on uncovering the uniqueness of planned lesbian family functioning and experience.

Generalizing the results presented below is limited mostly due to sampling. The research relies largely on convenience and volunteer samples recruited through snowball techniques or through LG parent organizations, press, etc. It can not be eliminated that families that are 'closeted' may function differently or that families with low functioning may decline to participate in research. Also, ALL studies of LDI families obtained samples of predominantly white, well-educated lesbian women with a high socioeconomic status. This feature of lesbian DI samples is consistent in all research irrespective of country, New Zealand, United States, Canada, Belgium, Holland, UK, so that there may be a class aspect to the method of donor insemination (Patterson, 1994). However, Brewaeys et al. (1997) and Chan, Raboy & Patterson (1998) obtained their samples through a fertility clinic to avoid volunteer bias and Golombok, Perry, Burston, Murray, Mooney-Somers & Stevens (2003) achieved a nearly representative lesbian parent sample from a community sample that also shared these characteristics. This author finds it more likely that societal and institutional privileging of heterosexual parents and their children may have a gateway function so that only those lesbian couples with a very strong desire to become parents and who have sufficient emotional, financial and social status resources may 'dare' to become (out and open) lesbian families. Surprisingly, this possibility has not been discussed in the literature to the author's knowledge. If this were to be the case, then the reservations concerning the representativeness of samples in existing planned lesbian family research could be put aside and generalized, at

[7] Brewaeys et al. (1997) address the issue of father absence in their review. They discuss that the prevailing conviction that a father is essential to the healthy psychological development of a child is supported by psychoanalytic and social learning theory. Only cognitive developmental theory does not predict a negative outcome for children due to father absence since, according to this theory, children integrate information about sexual identity from their wider social environment. They conclude that empirical research did not find any generalizable differences between children brought up with and without a father and could not lend support to the theories predicting negative outcomes.

least to middle class planned lesbian families. And then the more pertinent issue relevant to family functioning would be strength of desire to parent and class as opposed to family structure.

3.1 Parents

3.1.1 Psychological Adjustment

Primary lesbian parents have also been found to be psychologically well-adjusted (Golombok et al., 2003). They have healthy levels of maternal self-esteem and adjustment (Patterson, 1996) and did not differ from heterosexual DI parents on measures of parenting stress, life stress, depressive symptoms or self-esteem (Chan et al.,1998).

3.1.2 Aspects of Lesbian Parenting

Aspects of planned lesbian parenting have been repeatedly studied, often as part of assessments of general family functioning. Overall, planned lesbian parents consistently do not differ from heterosexual natural conception/DI parents on parenting measures, i.e. parental burden or parental competence (Bos, van Balen & van den Boom, 2004), parenting stress (Chan et al., 1998; Shelley-Sireci & Ciano-Boyce, 1999) quality of parent-child interaction (Brewaeys et al., 1997; Golombok et al., 2003) or on ratings of child-rearing goal of 'autonomy' (Bos et al., 2004). Nonetheless, some differences between the lesbian and heterosexual parents have been found. Lesbian parents were found to smack their children less (Golombok et al.,2003), to have superior parenting skills (Flaks et al.,1995) and to find the child-rearing goal of 'conformity' to be less important than heterosexual parents (Bos et al., 2004). Further, lesbian parents have been found to possess appropriate responses to emergency situations, have an affectionate expressive communicative response to affect, resolve problems by working through conflicts, have appropriate affective involvement in children's lives and value open, direct communication in their families (Steeno, 1997). Also, they are very enthusiastic about participating in their child's growth and reported loving the child deeply (Gartrell, Banks, Reed, Hamilton, Rodas & Deck, 2000). Ciano-Boyce & Shelley-Sireci (2002) reported similar patterns of parent-child-interactions in lesbian birth (i.e. DI and natural conception), lesbian adoptive and heterosexual adoptive families. Children tended to seek out one parent for nurturance, i.e. when tired, sick, hungry, etc., and the other for activity, i.e. rough-and-tumble play, reading, watching TV, etc. They also found that the parent who was sought out for nurturance was less likely to be sought out for activity and vice versa, though this was reported not to cause conflict, except in the case of lesbian adoptive

parents. Some competitiveness between biological and social mothers parenting roles has been reported, but primarily in connection with bonding and breast-feeding infants (Gartrell et al., 1999). In general, LDI biological and social mothers do not differ from each other on parent-child interaction (Brewaeys et al.,1997; Golombok et al., 2003).

3.1.3 Lesbian Couple Relationship

The lesbian parents' couple relationship has also been a subject of research interest. Dyadic adjustment of lesbian parents is consistently reported to be good (Patterson, 1995, 1996), and not to differ compared to heterosexual parents (Flaks et al., 1995; Brewaeys et al., 1997; Chan et al., 1998; Shelley-Sireci & Ciano-Boyce, 1999), or lesbian couples without children (Krüger-Lebus & Rauchfleisch, 1999). Bos et al. (2004) reported a difference between heterosexual parents and lesbian parents with respect to relationship satisfaction: While both lesbian parents were satisfied with their relationship and their partner as a co-parent, heterosexual fathers were less satisfied with their couple relationship and the heterosexual mothers were less satisfied with their husbands as a co-parent. Relationship satisfaction in lesbian couples is consistently reported higher in egalitarian households, primarily in which *child care* is evenly distributed between birth and social mothers (Bos et al., 2004; Jacob, 1997; Krüger-Lebus & Rauchfleisch, 1999; Patterson, 1995, 1996). Lesbian couples with children differed from those without children only in the areas in which conflict most often arose (child rearing vs. sexuality) and the amount of perceived stress they had, with this amount increasing with the number of children in the household (Krüger-Lebus & Rauchfleisch, 1999).

The ground-breaking documentation of LDI family existence and functioning by McCandlish (1987) aimed to develop a "theoretical model of normal lesbian mother family structure which would lead to appropriate clinical services for these families and future research" (p.31). She found the following changes in the transition from dyad to triad: Strong attachments were formed between parents and children, the children made the normal developmental shift from primary mother –child attachment to an equal attachment to both lesbian parents, and sexual intimacy between the lesbian parents decreases or ceases and is not resumed in the first 5 years.[8]

[8] Reports of lesbian sexual behavior are difficult to interpret. There is some discussion that reports of low sexual frequency may be biased by male standards of sexual desire (Loulan, 1984). Lesbian sexual behavior has been reported to include more nongential contact than other couples and sexual satisfaction is less likely to be linked to sexual frequency (Slater, 1999).

As for the unique aspects of lesbian parents' couple relationships, friendship is an important part of lesbian relationships (Mercier, 1999; Krüger-Lebus & Rauchfleisch, 1999). In a dissertation by Mercier (1999), lesbian DI parents stressed the importance of equal status and shared interest in family. They also considered complementary characteristics in partners to be a source of strength and persevering through times of hardship to deepen their commitment. The transition to parenthood, however, impacts the couple relationship in that it leaves too little couple time, increases conflict and reduces sexual intimacy (Curry, 1999; Gartrell, Hamilton, Banks, Mosbacher, Reed, Sparks & Bishop 1996; Gartrell et al., 1999; McCandlish, 1987; Mercier, 1999; Pies, 1990). Nonetheless, planned lesbian parents describe parenthood as "the best thing that ever happened to them", yet it was both "much better" and "much harder" than they expected (Gartrell et al., 1999). In a longitudinal study of planned lesbian families by Gartrell et al. (2000), one third of original lesbian couples had experienced lesbian divorce by the time the index child was 5 years old. The best predictor of relationship dissolution was relationship duration prior to becoming parents, with shorter durations being more liable to divorce. However, 2/3 of divorced lesbian parents shared custody and, in the rest, the birthmother had sole custody. The likelihood for shared custody was greater for divorced social mothers who had second-parent-adopted their child. The non-divorced or continuous couples felt that by 5 yrs. the child was equally bonded to both mothers and therefore feelings of jealousy had declined. Though the couples still reported decreased sexual frequency, they felt that having a child strengthened their relationship.

3.1.4 Division of Labor

The division of labor or the allocation of work/family time and duties in planned lesbian mother families is also of interest due to the non-existence of traditional roles or allocation based on gender as in heterosexual couples. A unanimous result in the literature is that lesbian couples are more egalitarian than heterosexual couples (Brewaeys et al., 1997, Shelley-Sireci & Ciano-Boyce, 1999; Ciano-Boyce & Shelley-Sireci, 2002; Bos et al., 2004). However, there has been some evidence that while lesbian couples are egalitarian in their household and decision-making aspects of family life, there is some specialization towards the birthmother doing slightly more child care while the social mother spends slightly more time in paid employment (Patterson, 1995, 1996; Ciano-Boyce & Shelley-Sireci, 2002, Bos et al., 2004). Nonetheless, social mothers are more involved in child care than are heterosexual fathers (Patterson, 1996; Brewaeys et al., 1997; Bos et al., 2004) while lesbian birthmothers spend more time in paid employment than heterosexual mothers (Brewaeys et al., 1997).

LDI families have creative strategies for balancing work and family (Mercier, 1999) that usually involved reducing overall work hours and alternating work schedules so that both can be involved in child care (Gartrell et al., 1999). In the longitudinal National Lesbian Family Study by Gartrell et al. (1996, 1999, 2000), when the children were 2 years old, mothers often identified the birthmother as the primary parent even though both mothers considered themselves equal co-parents. By the time the children were 5 years old, 2/3 of continuous couples were sharing child rearing equally and only in 1/3 of families, was the birth mother still doing more. This is important since lesbian relationship satisfaction has been found to be higher when child care is divided more evenly (as above) which in turn has been found to be related to better adjustment in children (Patterson, 1995). McCandlish (1987) also reported shifting patterns of care-taking over time.

3.1.5 The Social Mother

Salient themes in a discussion of the social mother role are (a lack of) language (Muzio, 1993; McClellan, 2001), invisibility (Wilson, 2000), lack of legal recognition (Epstein, 1993; McClellan 2001; Nelson, 1999; Wilson, 2000), the benefits of second parent adoption (Gartrell et al.,1999; Gartrell et al., 2000; McClellan 2001) and role definition (Wilson, 2000; Morton, 1998).

The role of social mother struggles with language. On the one hand, ambiguous terms abound (McClellan, 2001) yet on the other, the role suffers from a lack of adequate language both reflective of and causing social mother invisibility (Muzio, 1993) (see discussion above in section 1.2 Terminology). While LDI families almost always title the birth mother ‘mother’, they put a great deal of thought into what the child should call the social mother (Wilson, 2000). Terminology chosen by LDI parents to denote the social mother is often reflective of her status as an equal parent or not in the individual family. In the literature, LDI families are often reported with having the social mother named a word meaning ‘mother’ and, less often, her first or nickname (see discussion below in section 4.3.2.3.8 Lesbian Family Concept).

Though their position within the family is clear, social mothers almost unanimously struggle with invisibility in interactions with the outside world. Social constructs of ‘family’ are based on patriarchal and heteronormative assumptions that there is one (biological) mother and one (biological) father (Rohrbaugh, 1988; Leiblum et al., 1995). Denial of the social mother’s role is even incurred by her own family. Nelson (1999) found that while parents and siblings immediately recognize the birth mother as ‘mother’, only the social

mother's siblings tend to see her as 'mother' to her child. McCandlish (1987) reported the same finding 10 years earlier. This may be a factor explaining findings that LDI children have more contact to relatives of the birth mother than the social mother (Patterson et al.,1998; Fulcher, Chan, , Raboy & Patterson, 2002). However, for some social mothers, having children normalized their relationships to their parents because parenthood was something they could relate to (Wilson, 2000). Also, while her lesbianism is denied, birthmothers experienced feelings of being welcomed into the "mommy's club" or culture of motherhood due to the experience of pregnancy and giving birth, while social mother's felt denied that access (Nelson, 1999). These experiences impact the social mother's initial relationship to her child; they worry that the child will also not legitimize them as mothers and are surprised to discover that they feel an immediate and intense attachment to their baby (Gartrell et al., 1996; McCandlish, 1987).

Many social and nonlegal mothers feel negatively impacted by the corresponding lack of social recognition inherent in not having a legally recognized parenting role. Feelings of insecurity (Epstein, 1993), 'emotional jeopardy' (McClellan, 2001) and ambivalence in social mothers feelings of legitimacy in claiming the title of 'mother' even though they identify as such and fulfill the role in practice in their families (McClellan, 2001) have been reported. The tenuousness in their parent-child relationship stems from the knowledge that, in cases of lesbian divorce or death of the birthmother, they are not guaranteed continued contact with their child. Despite frequent efforts on the part of couples to take as much legal action as possible, in the end, the birthmother controls continued parenting in the event of relationship dissolution and a judge decides over custody in the case of death. Currently, this can only be alleviated by second parent adoption.[9]

Second parent adoption by the social mother has been found to have a positive effect. Social mothers desire for second parent adoption is motivated by the protection is affords the child which include health and life insurance coverage, survivor and inheritance rights, timely emergency decisions, a guaranteed legal connection to the other mother[10], and a sense of legitimacy (McClellan, 2001). Social mothers, who have successfully adopted their children, agreed that the adoption provided both internal and external validation in their parental role

[9] Second parent adoption allows the social mother to adopt her child while the biological mother retains her rights as mother. However, it is only offered in some states, in certain counties of some states, or on a case by case or judge by judge basis in the United States. Other states have constitutional bans on lesbian and gay adoption (McClellan, 2001). In Germany, stepparent adoption is open to registered life partners with biological children since January 1, 2005 and can be expected to have a similar positive impact on German social mothers.

[10] This aspect is not applicable to German social mothers as they can more directly attain this goal by entering a registered life partnership. In the United States, however, a second parent adoption of a joint child is the only legal avenue of creating a legal bond between partners (McClellan, 2001) with the exception of *civil unions* in Vermont and marriage in Massachusetts.

(Gartrell et al., 1999; Gartrell et al., 2000; McClellan, 2001). Having adopted the child was also found to be associated with a higher likelihood of shared custody of the joint child with the birth mother in the event of relationship dissolution (Gartrell et al., 2000).

"The mother has historically been considered the primary caregiver. In the lesbian family with two mothers, the unique task facing the women is to define their roles when each sees herself as "mother". Difficult enough in itself, this task must be accomplished within a larger cultural milieu that seeks to make one of the women invisible (Crawford, 1987), and insists on asking "Who's the real mommy?" (Morton, 1998, p.416-417). The parenting role of the social mother has been compared to both that of lesbian biological mothers and heterosexual fathers in the literature. Generally, it can be said that social mothers are highly invested in their families (Wilson, 2000). The literature reports equal division of labor between birth and social mothers or a trend towards specialization of the birthmother doing more child care and the social mother spending more time in paid employment (see discussion above), whereby this trend may shift as the child matures (McCandlish, 1987). In comparison to heterosexual fathers, lesbian social mothers only differed in the following respects: they felt they had to justify their parenting role more (Bos et al., 2004), the social mother demonstrated greater interaction with the child (Brewaeys et al., 1997) and they smacked their children less than heterosexual fathers (Golombok et al., 2003). Lesbian social mothers were as warm and involved in parenting as heterosexual fathers and reported similar or higher amounts of play (Golombok et al., 2003). A frequent finding for social mothers is feelings of jealousy surrounding the exclusiveness of the birthmother-child breast-feeding relationship and bonding (Epstein 1993; Gartrell et al., 1999; Wilson, 2000) though equal bonding is reported for older children (Gartrell et al., 2000).

3.2 Children of Planned Lesbian Parents

Most studies on children in primary lesbian families has attempted to assess the effect of family structure, i.e. the lesbian orientation of the mothers, having two female parents and father absence, on children's development in a purer form than achieved in studies of children of divorced lesbians (see above). Other research has sought to assess unique aspects of lesbian family functioning with regards to the children.

3.2.1 Socio-emotional Development and Behavioral Adjustment

Children in primary lesbian families have consistently been reported not to differ from children with heterosexual parents on measures of child stress (Shelley-Sireci & Ciano-

Boyce, 2002), behavioral adjustment (Brewaeys et al.,1997; Chan et al.1998; Flaks et al., 1995; Golombok et al.2003; Patterson 1994, 1996), cognitive functioning (Flaks et al., 1995) self-concept (Patterson, 1994) and peer relations (Gartrell et al., 2000; Golombok et al., 2003). Steckel (1987) also found predominantly similarities in the two groups of children but also reported provocative suggestive differences. Children of heterosexual parents were reported as seeing themselves as more aggressive and were perceived by parents and teachers more negatively. Children of lesbian parents, by contrast, saw themselves as more lovable and were perceived by parents and teachers as more affectionate, more responsive, and more protective towards younger children. Patterson (1994) was not able to replicate the above result. Instead, she found that children of lesbians reported greater stress reactions, i.e. felt angry, upset scared, but also a greater overall sense of well-being, i.e. felt joyful, comfortable with themselves. It is unclear whether this result is attributable to real higher levels of experienced stress or due to an ability to discuss emotions openly. Research has failed to identify any adverse effects of the lesbian *family structure* on child outcomes. Interestingly, some research has identified relationships between *parental* measures of *adjustment* and *children's well-being* (family process). Patterson (1995) found that more equal division of childcare between the mothers was associated with greater couple satisfaction and better child adjustment. Also, Chan et al. (1998) found that children's behavioral adjustment was negatively related to parental distress and conflict while positively related to parent's relationship satisfaction and love.

One study addressed how societal attitudes, i.e. social stigma, as opposed to family structure/process impacts self-esteem in adolescent children of lesbian families (Gershon et al., 1999). Only one third of the children were LDI children, the remainder were conceived in the context of a heterosexual relationship. High perceived stigma was related to low self-esteem on 7 of 9 subscales, but unrelated to scholastic and athletic competence. Decision-making coping, but not effective social support coping, was able to moderate low self-esteem in the face of high perceived stigma. Disclosure coping positively affected self-esteem in the area of close friendship in the face of high perceived homophobia. Conversely, lower perceived stigma was associated with higher self-esteem. The authors caution though that "the impact on a child because of societal attitudes about lesbianism should not be confused with the impact of the woman's lesbianism on her child" (p.442) "This [would be] similar to stating that African Americans should not have children because the children will experience racism. In both situations, the focus must be placed on fighting racism and homophobia rather than preventing such families from raising children" (p.444).

3.2.2 Psychosexual Development

Sexual identity is composed of gender identity, gender roles and sexual orientation (Lähnemann, 1997). *Gender identity* is defined as the subjective sense that one is male or female (Steckel, 1987). *Gender roles* consist of behaviors that are culturally ascribed to either females or males (Steckel, 1987). *Sexual orientation* refers to a person's attraction to and choice of sexual partner (Kershaw, 2000).

Children born to lesbian parents displayed gender role behavior considered normative for the age groups studied (Dundas & Kaufmann, 2000; McCandlish, 1987; Patterson 1994, 1996) and no differences were found to children of heterosexual parents in this regard (Brewaeys et al.,1997; Golombok et al., 2003). Golombok et al. (2003) conclude that "maternal sexual orientation is not a major influence on children's gender development because boys and girls in lesbian-mother families were not found to differ in gender-typed behavior from their counterparts from heterosexual homes. This finding was obtained from a representative sample of children with lesbian parents using a measure that was specifically designed to assess within-sex variation in gender role behavior." (p.31)

3.2.3 Children's Contact to Grandparents and Other Adults

Children of lesbian parents do not differ from children with heterosexual parents with regards to regular contact with grandparents, other relatives, and adult non-relatives outside their immediate households (Fulcher et al., 2002; Patterson et al., 1998). Both children of lesbian and heterosexual parents had more frequent contact with grandparents on the biological maternal side than with grandparents on the paternal or social maternal side (Fulcher et al., 2002; Gartrell et al., 1999; Patterson et al.,1998). Although children of lesbian parents rarely had contact to biological fathers or sperm donors, even if known, they had regular contact with men (Patterson et al.,1998). Close friends are often incorporated into the extended lesbian family network as aunts and uncles (Gartrell et al., 1999). Unrelated female adults are often former partners of one of the mothers (Patterson et al., 1998). Also, children of lesbian-headed families spend more time in other non-traditional families than children of heterosexual adoptive families (Shelley-Sireci & Ciano-Boyce, 1999).

"The fact that children born to lesbian mothers showed normal development and adjustment represents a challenge to developmental theories that emphasize the importance of structural aspects of home environments....[The children in the sample of the above research grew up with two female parents.] The psychological health of these children suggests that

structural properties of family environments such as father presence versus absence and parental sexual orientation can not be crucial for successful outcomes to occur." (Patterson, 1994, p.171)

3.3 Social Support and Extended Family Networks

Lesbian families' social support network is, in part, made of extended family networks that consist of both relatives and *families of choice* (Jiles, 1999). Families of choice are composed of close gay and straight friends who are included in the family as aunts and uncles (Gartrell et al., 1999; Jiles, 1999); Unrelated women are often former partners of one of the mothers (Patterson et al.,1998). Occasionally, a known donor is included in the family's network (Jiles, 1999), but if he is not or is unknown, then parents ask a close male friend to be a "godfather" (Baetens et al., 2002). Generally, lesbian parents describe enhanced relationships to their parents with increased contact due to becoming a parent although a common finding is that children have more contact to grandparents from their biological mother than with those from their social mother (Fulcher et al., 2002; Gartrell et al., 1999; Patterson et al., 1998). However, this finding was the same for children of heterosexual parents (Fulcher et al., 2002). Gartrell et al. (2000) reported that, although 63% of grandparents had "outed" themselves as grandparents of their lesbian daughter's child by the time their grandchild was 5 years old, one quarter (equal parts parents of birth and social mothers) was still not relating to the child as a fully fledged grandchild.

Lesbian parents experienced shifts in their friendship circles after the onset of parenthood. They had less contact with lesbians without children and more contact to other families with same and opposite sex parents (Curry, 1999; Gartrell et al., 1999) and most family social activities involved other gay and lesbian-headed families (Gartrell et al., 2000). Lesbian families were involved in the lesbian community (Jiles, 1999) and, by the time the child was five, half of the sample from The National Lesbian Family Study participated in a religious or spiritual community chosen based on its willingness to accept lesbian families (Gartrell et al., 2000). LDI parents and heterosexual parents reported similar usage of informal support, i.e. friends, family, and formal support (Bos et al., 2004). More and more lesbians are joining together to form parenting groups which eventually become play groups and remain a major resource network for the LDI family (Gartrell et al., 1996; Pies, 1988).

3.4 Concerns of Lesbian Parents and Coping Strategies

The most commonly mentioned concern of lesbian parents involves fears of the child being negatively impacted by societal homophobia (Dundas & Kaufmann, 2000; Gartrell et.al, 1996, 1999, 2000; Jiles, 1999; Steeno, 1997). In her sample of lesbian mothers, Jiles (1999) identified the coping mechanisms of (1) conscious, informed parenting, i.e. being active in the child's school environment (Mercier, 1999; Steeno, 1997), preparing the child to respond to homophobic comments through role-playing (Curry, 1999; Gartrell et al., 2000), choosing accepting school environments (Gartrell et al., 1999) and (2) building self-esteem in children by modeling pride, honesty about self, and maintaining open communication with their child (Gartrell et al., 1996).

Another concern for lesbian parents is the child's safety at school (Mercier, 1999). They cope by (1) choosing LG friendly schools, ideally, with LG staff and other children of LG families with an emphasis on multiculturalism, and by (2) actively participating in their children's schools to increase their visibility and contact with teachers and peers (Mercier, 1999).

Lesbian parents also worry that their child may have a problem with its DI origins (Gartrell et al., 1996, 1999). They plan for this in (1) choice of donor type to begin with and (2) by disclosing the child's DI origins to him/her at an early age. Research with adoptive children supports disclosure at an early age (Golombok, 1999). They plan to be open about their use of DI and to explain it to their children in an age appropriate manner while emphasizing the 'wantedness' of the child. (See section 4.3.2.3.5 Disclosure of DI Origins to Child)

Additionally, Gartrell et al. (1996) reported lesbian mother's concerns about raising a child in a non-traditional family, i.e. father absence, as well as the impact of multiple oppressions on non-white or non-Christian children. One third of the sample planned to raise their child in the Jewish faith and one tenth were raising children of color. Coping strategies to ward off potential negative impacts included planning to include men in the children's lives so that they would have a male role model, educating children about prejudice, and making a strong commitment to diversity.

Another concern for lesbian parents is non-acceptance of children in the lesbian community and the exclusion of sons at all-women events (Gartrell et al. 1999). Finally, some lesbian mothers described feeling distressed when their child witnessed heterosexism (Gartrell et al., 1996, 2000), i.e. questions such as "Does your son resemble his father?"

One topic is repeatedly NOT a concern for lesbian parents but for society at large – the sexual orientation of their children. Lesbian mothers typically express support of the child regardless of its future sexual orientation (Gartrell et al., 1999; Gartrell et al., 2000; Jiles, 1999).

4.0 Family Formation in LDI families

Normative family building for heterosexual couples, for example, can be adequately exemplified by the rhymes elementary school aged children chanted in the schoolyard when the researcher was a child (in the U.S.) "First comes love, then comes marriage, then comes [name] in the baby carriage!" German elementary school children today have adapted this rhyme to accommodate the high divorce rates and lower birth rates of the day, "verliebt, verlobt, verheiratet, geschieden."

Family life cycle models, such as that from Duvall (1977) postulate a series of steps characteristic of family building that begin with family formation and continue through the life span of the family until it is dissolved (Schneewind, 1987). Duvall's 8-step-model of the family life cycles begins with the married, childless couple whose developmental task is the establishment of a satisfactory married life, preparation for parenthood, and adjustment to pregnancy. The second step is marked by the birth of the first child and the adjustment from a dyadic to triadic system as well as establishment of individual parental roles.

Duvall's model provides a beginning point for constructing a model which reflects the changes adults experience as they move through the stages from individual to partnership to (possibly) family. It reflects a normative expectation of the family life cycle that is not necessarily experienced by a large percent of our modern society. Even for heterosexual relationships, it does not adequately reflect the numerous cases in which either the couple is not married, a child is not planned or wanted, the pregnancy occurs before any relationship commitment between the parents has been established, or cases in which there is only one parent, etc. to name a few possibilities. It is not surprising, then, that life cycle models do not adequately portray the lesbian experience of family building (Slater, 1999).

Mohler & Frazer (2002) break the journey to LDI parenthood down into three distinct stages: (1) making the decision to parent, (2) implementing inseminations to achieve conception, and (3) pregnancy, childbirth and child rearing. This author further differentiates the family formation phases and conceptualizes the process of family building for lesbians chronologically:

- *Coming-out
- Committed Lesbian Relationship
- *Kinderwunsch-planning
- *Kinderwunsch-Insemination
- Pregnancy & birth
- Transition to Parenthood
- Children in *Kindergarten* (5x half or whole day, ages 3-6/7)
- Children in elementary school (grades 1-4, ages 6/7-9/10), adolescence
- Children in secondary schools (grades 5-9/10/12 depending on school level), puberty

The uniqueness of LDI family formation in comparison to normative family building for heterosexual couples lies in the coming-out, conscious and active decision-making phase and the insemination phase in order to achieve a 'normal' pregnancy. In contrast, heterosexuals do not generally need to pass through a phase of heterosexual sexual identity development as this is the norm. Though heterosexual couples may also make active and conscious family planning efforts, due to biology, these are (1) voluntary and (2) usually characterized by hindering conception. Finally, heterosexual couples only enter an insemination phase if they have fertility or hereditary disease issues. Once pregnancy is achieved, the lesbian couple is absorbed by the same unfolding of events dictated by biology and subsequent development of their children as are heterosexual parents. However, the phases of pregnancy & childbirth, transition to parenthood, children in kindergarten and school, and puberty pose additional challenges for lesbian parents and their children navigating the heterosexual world arising from heterosexism and homophobia. Lesbian parents re-engage in the unique phases of decision-making and insemination for sibling children which may include a role switch between partners, so that the social mother of the firstborn may become the birthmother to the sibling child.

Some of the research on LDI families discussed in previous sections has addressed lesbian specific parenting issues and experiences. However, with the exception of the longitudinal study by Gartrell et al. (1996, 1999, 2000), these are not addressed according to phase of family formation. Additional research should definitely be undertaken to deepen our understanding of unique aspects of LDI family life by phase. This information would be useful to educators and providers working with members of LDI families, and for LDI

families themselves as well as lesbian couples considering parenthood. Of particular interest would be the study of the consequences of donor type choice and donor involvement on the family during family formation phases and in the long term.

The present study focuses on the initial phases of the LDI family building process: coming-out, committed lesbian relationship and the *Kinderwunsch*-decision-making phases. The following sections address the literature on these aspects of family formation.

4.1 Coming-out/Lesbian Identity Acquisition

The prerequisite of lesbian parenting is the acquisition of a lesbian identity, also known as coming-out. There are several models which seek to describe this process. Brown (1995) categorizes lesbian identity development into biological models, traditional psychodynamic models, feminist psychodynamic models, and stage models. Biological models seek to determine genetic or endocrinological differences between lesbian and heterosexual women in order to account for lesbian identity acquisition. This approach inherently pathologizes homosexuality and is problematic because it assumes a fixed sexual orientation of the person. However, definition of 'who is lesbian?' is difficult since sexual behavior, sexual orientation and sexual identity can be at variance as well as fluid. Traditional psychodynamic models assume a patholigized psychosexual development in the acquisition of a lesbian identity. However, they recognize sexual identity as fluid, yet modifiable in response to interpersonal and social/contextual experiences. Feminist psychodynamic models, in contrast, "address lesbian identity development within a broader framework of women's sexual identity processes, thus framing a lesbian outcome as one of several normative possibilities for women" (Brown, 1995, p.15). "Such models, with their emphasis on the quality of relationships, place lesbian identity within the broader question about how women come to love and bond with other women, and ask the more subversive question as to why some women *fail* to develop primary and affectional bonds to women, rather than seeing the development of such bonds as representing a separate, relatively infrequently taken, and possible deviant pathway." (Brown, 1995, p.16).

"Stage" models, derived from Atkinson, Morten, & Sue's (1979) model of minority identity development, seek to explain the coming-out process as a passage through various stages of identity assumption (Brown, 1995; Jiles, 1999) which require dislodging negative self-images created by external homophobia and replacing these with positive images (often requires connection with other lesbians and separation from the oppressive, dominant culture) before reintegrating themselves into the mainstream environment (Slater, 1999). The most

commonly cited stage model is from Vivian Cass (1979), who identified the stages of identity confusion, identity comparison, identity tolerance, identity acceptance, identity pride, and identity synthesis (Slater, 1999). A smooth transition through stages is complicated by the presence of negative societal attitudes and stereotypes about gay men and lesbians (Greene, 1994). Stages models do not assume that all succeed in passing through all stages. Arrested lesbian identity development, termed "identity foreclosure" by Cass, is primarily due to the affects of internalized homophobia and can occur at any stage. In such a case, the person may adopt strategies enabling them to avoid labeling themselves as 'lesbian' or rationalizing their current lesbian sexual behavior or attractions (Slater, 1999).

4.2 Committed Lesbian Relationship

Clunis & Green (1988) describe six stages of lesbian relationship development. The Prerelationship stage (1) is the "getting to know you" phase and is followed by the Romance stage (2), characterized by merger, fusion and increased intimacy. In the Conflict stage (3), the partners discover negative aspects of the other partner and each partner is little disillusioned, but, out of the struggles, comes the establishment of the ground rules, communication patterns and goals for the relationship. The Acceptance stage (4) is marked by a sense of stability, contentment and deep affection as well as acceptance of each other's short-comings. The Commitment stage (5) is described by the authors as meaning "...choice. It implies an expectation about the future, but does not guarantee future outcome." (Clunis & Green, 1988, p.25) Collaboration (6) is the stage where the couple has made a commitment and is relatively secure in the relationship so that energy is left over for a joint project that is bigger than the two of them to share with the world.

Slater (1999) proposed a model of the *lesbian* family life cycle which does not include children so as to leave it applicable to all lesbians and not to introduce the idea that lesbians *should*, by imperative, include children in their lives. Stage 1, Formation of the Couple, assumes that some lesbian identity acquisition has occurred though not necessarily fully achieved. Lesbians find romantic partners in different ways, often after a close friendship has evolved: lesbian friends become lovers, committed lesbians have an affair, female heterosexual friends become lovers, and a heterosexual woman and lesbian become lovers. The tasks of this phase for the couple include building a sense of themselves as a unit, developing a healthy management of conflict, replacing idealized impressions of the partner with realistic ones, and building trust. In stage 2, Ongoing Couplehood, the initial passion needs to be integrated into everyday live. The tasks of this stage include needs for more

commitment, may involve moving in together, and the difficult balancing of fusion, distance, differentness and healthy resolution of conflicts. The Middle Years, or stage 3, involve accepting that the partner and relationship is not perfect and that outside sources, i.e. friends or family, be used to fulfill additional needs. Partners often demonstrate increased commitment by buying a home, having children, wearing a wedding ring, etc. Stage 4, Generativity, includes the awareness that partners are mortal, and a feeling of "What next?" Stage 5, Lesbians over 65, is characterized by more time available in case of retirement and a corresponding redefinition of relational roles, financial and physical interdependence and culminates in widowhood.

Slater (1999) also identifies persistent stressors in lesbian couple's lives throughout the life cycle: (1)homophobia, heterosexism and internalized homophobia, (2) the double bind of stress caused by invisibility as a couple or stress caused by visibility as a lesbian couple, (3) managing private identity as a lesbian and public identity outside their home, i.e. passing or outing, (4) areas of difference between the partner's, (5) establishing relational roles , (6) sexism and (7) racism.

4.3 *Kinderwunsch*-planning

The beginning of the planning phase is probably vague, marked by loose discussions of topics related to children and parenting. It ends with the beginning of the insemination phase. If conception proves difficult or the couple is not satisfied with their procedure or the insemination phase is disrupted in some other way, they may return to the decision-making phase, before proceeding with inseminations.

4.3.1 Choosing Children

When a lesbian couple is deciding to whether or not to have children, they must come to terms with the same issues faced by all prospective parents who consciously choose parenthood: They analyze their life plans, life style, carrier plans, work and financial situation (Pies, 1988) as well as the timing of pregnancy, planning for child care, coping with the psychological challenges involved in expanding the couple/family, and restructuring relationships with the extended family (Rohrbaugh, 1988). However, there are several aspects which are unique to the lesbian parenting situation which will be discussed here.

4.3.1.1 Desire to Become a Parent

Lesbians have been socialized in a culture which perpetuates myths about the inappropriateness of lesbian parenthood. Lesbian women may lack the feeling of legitimacy in their desire for parenthood in a non-traditional family as most images of parenting are imbedded in the heterosexual nuclear family (Leiblum et al., 1995; Gartrell et al., 1996). When a lesbian considers parenting she may discover that she has internalized some of these myths herself and will have to work through them and develop new images of parenting appropriate to lesbians. If not, the lesbian parenting couple may find themselves trying to replicate as many elements of the nuclear family as they can, i.e. providing a 'father', vying over primary/secondary care taker roles, which create strains on the relationship (Pies, 1988; Rohrbaugh, 1988). In addition, when she begins discussing plans to parents with others, she may again be confronted with homophobic prejudice against lesbian parenting. This can be hurtful especially when coming from parents since heterosexual couples can expect their parents to welcome grandchildren. In essence, the positive choice to become a parent is the result of a process. This is reflected in the literature which reports long periods of reflection and deliberation before beginning the first cycle of insemination ranging from several months to several years (Baetens et al., 2002; Jacob, 1997; Jacob et al., 1999; Wendland, Byrn & Hill, 1996).

In a large sample of lesbian women, Johnson et al. (1987) found that 2/3 of lesbian and bisexual women had considered having children. Lesbian women's motivation to become a parent is similar to that of heterosexual women (Jacob, 1997; Siegenthaler & Bigner, 2000). However, sometimes a woman's coming out temporarily interrupts her *Kinderwunsch* (Chabot, 1998). Desire was the most commonly reported motivation: personal desire or the desire was linked to the current relationship, i.e. "next step" or partner's desire (Curry, 1999; Dalton & Bielby, 2000; McCandlish, 1987). Baetens et al. (2002) found that lesbian DI parents and heterosexual natural conception parents had similar hierarchies of parenthood motives rating the motives happiness (expected happiness and affection with children) and parenthood (expectation that parenthood provides fulfillment) highest. Lesbian birth and social mothers spent significantly more time thinking about their reasons for wanting to have children than heterosexual parents and the strength of desire to parent was correspondingly higher. The strength of desire to parent has been linked to the parent-child relationship.

4. 3.1.2 Cultural Perceptions of Motherhood

Another psychological issue of lesbian parenting surfaces in the allocation of mother roles. "In our culture nurturance is viewed as central to femininity; therefore mothering,

domesticity, and social planning are often crucial to a woman's self-definition and sense of self-esteem" (Rohrbaugh, 1988, p.54). This may figure strongly in lesbian parent's commitment to equal parenting by reconfiguring the two-parent family to include two active mothers: "The construction of a two-parent family consisting of women, both of whom seek to perform parenting in gender appropriate ways...means that the traditionally single role of mother is divided between the women." (Dalton & Bielby, 2000, p.51). Lesbian couples often discuss plans for childcare in advance with most preferring an even split or a temporary period in which the birthmother does more but rarely a plan for traditional male-female parenting roles (Baetens et al., 2002; Gartrell et al., 1996; Wendland et al., 1996).

4. 3.1.3 Asymmetry

The fact that there is only one *legal* mother reinforces the cultural tendency to perceive only one *real* mother (Rohrbaugh, 2000). To counter this, many lesbian parents share a strong commitment to establishing the social mother as a mother in her own right. Strategies include sharing of care giving tasks for newborns, equal parenting (Dalton & Bielby, 2000), introducing the social mother first in new situations and taking turns in taking children to day care, doctor's appointments and other child-oriented facilities (Rohrbaugh, 2000) as well as taking turns being the birthmother. This equality model is reflected in the terminology used for parenting roles: two mothers or first name/first name. Couples in which the birth mother is 'mother' and the partner is called by her first name or nickname signal that they subscribe to cultural perceptions of the lesbian family in which only the birth mother is perceived as a primary parent and the partner is seen as a supportive, but less central parent (Rohrbaugh, 1988). Only one early study with a small sample size, McCandlish (1987), and two Belgian studies, Brewaeys et al.(1993) and Baetens et al. (2002), reported relatively large portions of LDI parent samples using this latter approach.

The asymmetrical legal relationship between the lesbian parents and their child makes it necessary to discuss plans for custody should the relationship ever dissolve or in the event of the birth mother's death. Even if there are options such as second-parent-adoption available to the couple, there is a time lag where the social mother-child relationship lacks legal protection. This distinguishes lesbian and heterosexual couples. Wendland et al. (1996) found that only 12% of married couples discussed custody after possible divorce in the planning stage whereas 97% of lesbian couples in their sample did and a third of these had drawn up a legal document documenting their intentions. In contrast, McCandlish (1987) and Dundas & Kaufmann (2000) report only oral agreements. Plans for custody typically are either (a)

shared custody or (b) custody for the biological parent and visitation rights for the social mother (Curry, 1999; McCandlish, 1987). In the event of the death of the birth mother, the plan is for the social mother to gain custody of the child (Curry, 1999). However, none of these agreements are legally binding and not many courts have granted social mothers even visiting rights after relationship dissolution if she has not second parent adopted the child. This vulnerability of the social mother consolidates itself in an asymmetry of power in the couple and parenting relationship.

4.3.2 Choosing DI

The literature discussed below reports lesbian usage of DI in a medical setting since the studies are often carried out by reproductive centers wishing to advance knowledge about the effects of DI and donor anonymity on the family. This has not been sufficiently possible using heterosexual DI families because they are generally unwilling to participate in research and do not disclose DI origins to the child. Clinical DI implies the usage of unknown donors: anonymous donors, with/ without non-identifying information and/or identity-release donors. By contrast, self-insemination, usually with a known donor, skirts medical intervention and is therefore generally not reported in the literature. The usage of known donors surfaces only in exploratory studies of LDI families' descriptions of children's contact to donors (see below).

4.3.2.1 Choosing The Method by Which to Become Parents

A major issue for lesbian couples who wish to become parents is the choice of method by which they want to achieve this goal. Lesbian couples may theoretically choose between adoption (but not as a couple), foster parenting or conception using a sperm donor (known/unknown) or heterosexual intercourse with a man (aware/unaware of plans to conceive). Preference for DI over adoption has been reported to be due to the desire to experience pregnancy and childbirth (Daniels, 1994; Wendland et al., 1996), to have control of the child's genetic background and prenatal care (Wendland et al., 1996), a lack of adoptive alternatives and desire to raise a new born (Harvey, Carr & Bernheine, 1989), but not due to worries over being rejected as prospective adoptive parents (ibid). Some lesbian DI couples choose not to pursue the parenting option of foreign adoption due to concerns over multiple oppressions (Chabot, 1998). Lesbians opting for DI over heterosexual contact do so because heterosexual sex with a man is not considered desirable and violates the couples' sexual orientation and fidelity as well as moral reluctance to sleep with a man for conception without his knowledge and consent (Jacob, 1995). Lesbians wishing to become parents make

a positive decision for (clinical) DI since it is (1) safer than other conception options, i.e. protection from HIV and other STD's, (2) they wish to have a child, (3) the anonymity provides safety from 3rd party claims to the child, i.e. known donors or birth parents, in the case of adoption, and (4) they desire to experience pregnancy and childbirth (Harvey et al., 1989; Jacob, 1995; Jacob et al., 1999).

4.3.2.2 Deciding Who Will Get Pregnant (First)

Another major lesbian specific issue for lesbian couples choosing to become parents by conception is the issue of who will bear the child (first). It is this decision which allocates each woman her parenting role and the corresponding ramifications of either physical trials and joys of insemination, pregnancy, childbirth, breast-feeding as well as social and legal recognition of status as a birthmother or the joy of becoming a parent without the physical tribulations yet social and legal invisibility beyond the lesbian family unit as a social mother.

Although it may be expected that this decision is difficult to make, for most couples it is reported to be made quite easily. Often, one partner is the obvious choice due to stronger desire to experience pregnancy and childbirth (Baetens et al., 2002; Chabot, 1998; Martin 1993; Mohler & Frazer, 2002; Pies, 1990; Wendland et al., 1996). Prospective social mothers often are interested in becoming a parent but not interested in experiencing pregnancy (Chabot, 1998) or, in some cases, plan to give birth to a sibling child (Wendland et al., 1996). In the few cases where both women want to give birth, usually the older partner goes first (Baetens et al., 2002) or they try simultaneously (Martin, 1993; Pies, 1990). The allocation of parenting roles also entails discussions of terminology to be used to name each parent. (See section 1.2 Terminology and 4.3.2.3.8 for a discussion of LDI family concept)

4.3.2.3 The Issue of Donor Anonymity and Donor Type Choice

Traditional donor options for lesbians include using an **unknown donor**, i.e. *anonymous donor* or an *identity-release donor* from a sperm bank, or having a *go-between* organize a donor-recipient fresh sperm transaction or using a **known donor**, i.e. male friend or relative of social mother. Since fresh sperm inseminations skirt medical intervention, the effects of this choice on the family are not documented in the scientific literature. The literature on DI usage discussed below, however, has focused on DI as a medical intervention and therefore considers only aspects of frozen sperm unknown donor use.

4.3.2.3.1 Controversy over Donor Anonymity

There is much controversy over the anonymity of frozen sperm donors regarding the effects on couples and consequences for the child (Brewaeys et al., 1993). Historically, three stances vie with each other: (a) complete anonymity, (b) anonymity with non-identifying information, (c) registration of donor identity.

Complete anonymity is achieved with anonymous or "no-donors" and holds that "the donor's role must be minimal and complete distance between donors and recipients must be guaranteed" (Brewaeys et al., 1993, p24). This stance parallels early attitudes supporting closed adoption. Also, it can be derived from the function DI was initially developed for, namely to help heterosexual couples achieve pregnancy and become a "normal family" (Brewaeys et al., 1993, p.21). The use of a donor is conflicting for heterosexual couples as it raises the issue of fidelity for them and fears on the part of the mother that the (social) father may reject the child (Thorn, 1994). For proponents of complete anonymity, the issue of the child not knowing its (biological) father is rationalized since (a) heterosexual couples rarely disclose use of DI to their children (Brewaeys et al., 1993; Brewaeys et al., 1995; Scheib et al. 2003) and (b) the child is raised with a (social) father, satisfying the male role model or identification figure "requirement" of positive child development.

Registration of donor identity is a consequence of the stance holding that a child has a right to know who (s)he is descended from and is achieved with "identity-release" or "yes-donors". The documentation of adopted children in closed adoptions 'searching for their roots' has been used to support the need for registration of more donor information (Golombok, 1999). Those supporting donor registration place more emphasis on the importance of genealogical awareness in identity development (Brewaeys et al., 1995). However, the necessity of donor registration presumes knowledge of one's DI origins, and, for it to aid the DI child's identity development, donor identity must be available to a child during those developmental periods, i.e. puberty. It does not, however, address the issue or consequences of knowing the donor's identity, i.e. possible subsequent recipient – donor – DI child contact.

Anonymity with access to non-identifying information of donor may be considered a middle of the road stance and is included in some "anonymous" or "no-donor" programs. This stance achieves maximum distance as desired by donor anonymity, yet allows for some knowledge of the donor for the DI child, thought to facilitate disclosure of DI origins to children (Scheib et al., 2003).

The arguments revolving around donor anonymity stances are often emotional and not based on empirical evidence (Brewaeys et al., 1993). There has been little research on the

long-term effects of donor anonymity due to the overwhelming cloud of secrecy imposed by heterosexual DI recipients couples (see section 4.3.2.3.5 Disclosure of DI) and their corresponding reluctance to participate in research. The consequence is that there is no scientific knowledge regarding the effects of donor anonymity on child development for the lesbian couple choosing parenthood to base their donor type choice on, only personal and heterosexually biased public opinion.

4.3.2.3.2 LDI Parents' Attitudes towards Donor Anonymity

Some LDI research has documented DI recipient couples attitudes towards donor anonymity.

Purdie et.al (1992) reported that 70% of donors at a New Zealand reproductive clinic were willing to have their identity made available to offspring. Leiblum et al. (1995) concludes that while the practice of anonymity and secrecy was justified by wanting to ensure the donor's privacy and protect him from paternal responsibility, research such as Purdie's suggests that sperm donors may be more willing to provide identifying and background information than previously assumed. It must be noted that the clinic in Purdie's study made identity registration optional and donors were able to consider each future request for identity release on a case by case basis. Nonetheless, particularly lesbian couples and single women are more likely to support having at least some information made available about the donor (Wendland et al. 1996).

In a comparison of heterosexual and homosexual DI recipient couples at a Belgian reproductive center which offers only anonymous donors, Brewaeys et al. (1993) found that most heterosexual DI recipient couples favored complete donor anonymity (76%). Those favoring registering of donor identity (20%) preferred it solely for medical reasons. In contrast, lesbian DI recipient couples were more divided. 40% preferred complete donor anonymity, 20% would have wanted non-identifying information so they could provide a sketch of the donor for the child, and 40% favored donor registration. All of the lesbian mothers expected the child to have questions about the donor and 48% thought that donor anonymity may pose a problem for the child during certain developmental periods in the future.

In a follow-up study of 50 lesbian DI recipients couples using anonymous donors at a Belgian reproductive medical center, Brewaeys et al. (1995) again assessed attitudes towards donor anonymity. A change in attitude since insemination begin (t1) and the child being 1-2 years old (t2) was documented. Only half of those who initially favored donor anonymity still

did when the child was 1-2 years old. In contrast, by the time the child was 1-2 years old, half of the sample favored donor identity registration. Few couples preferred the option of non-identifying information. The subjects that preferred donor registration at t2 initially choose an anonymous donor to exclude a third party in the family. With the child's arrival, they became more pre-occupied with the fact that the child may want to know the donor's identity and felt having this information would be helpful for the child. In contrast, the subjects who continued to favor donor anonymity felt that, although they also expected the child to have questions about the donor, having knowledge of the donor's identity would not solve problems for them. In 1/4 of couples, the biological mother favored donor registration while the social mother did not. This result was interpreted as reflecting the social mother's more vulnerable position in the lesbian DI family unit.

In a Belgian study of 47 LDI children (aged 7-17 years), Vanfraussen et al. (2001) compared children's and mother's attitudes towards donor anonymity. 19% of children and one social mother would have been interested in non-identifying information about the donor. The children supporting this option were primarily curious about the donor's appearance and whether or not he looked like them. 27% of children and only 11% of mothers would have wanted to know the donor's identity. Although girls and boys did not differ overall on their need for more information about their donor, more of the children wishing for *identifying* information were boys. The majority of children (54%) and mothers (74%), however, were content with absolute donor anonymity. It was concluded that mothers and children had significantly different attitudes towards donor anonymity, namely that children more often wanted information about the donor to be available than mothers. Also, since siblings differed in attitudes, the needs of one child for information may be different from those of another, even if they live in the same household.

Leiblum et al. (1995) compared lesbian couple, heterosexual couple and single women's use of DI in an U.S. anonymous donor program. The majority of the sample responded that *they* would not want to personally meet their sperm donor. Those women, who would like to, would have preferred to meet him before beginning inseminations (52%) or upon child discretion (39%). In contrast, the majority of women responded that they would like for their *child* to be able to meet their sperm donor.

Scheib et al. (2003) reported the attitudes towards up-coming identity-releases in a sample of U.S. lesbian and heterosexual DI families with children 12-17 years. All parents who had disclosed DI origins to their child anticipated children exercising the request for donor identity and attempting to contact the donor. However, parents did not feel their child

was looking for a father in the donor. Children reported looking forward to the meetings. Their top three questions were: "What is he like?", "Is he like me?", "Can I meet him?". Parents also reported feeling positive about up-coming identity-releases although they had some concerns about how the process would unfold, whether the donor would be alive and whether he would be willing to meet the child, how such a meeting might go and, if so, will he be nice and able to live up to their child's expectations. They also worried whether the donor would be homophobic and what the consequences would be for sibling children who either have the same donor yet denied the choice in obtaining identity because their sibling had decided for them or a different donor and possibly not the same access to donor identity.

In sum, these studies of LDI mothers who conceived using anonymous donors show that mothers and adolescent children are managing donor anonymity quite well. It does appear that attitudes towards anonymity may fluctuate over time and vary from person to person, even among members of the same family. Needs for information about the donor, therefore, are individual and changeable. In cases where accessing donor identity is assured, the desire for information about the donor is more clearly expressed. Generally, lesbian mothers are open to the idea of donor information but want it more for their children's sake than their own and children are more likely to want identifying information than their mothers.

4. 3.2.3.3 Donor Selection

Some studies have assessed which characteristics of donors influence DI recipient couples' donor selection.[11] Leiblum et al. (1995) reported that the majority of the lesbian and heterosexual DI sample using anonymous donors indicated that education, ethnicity, height, weight, hair and eye color were major considerations in selecting a donor. Scheib et al. (2000) analyzed the donor selection of lesbian couples and heterosexual couples at The Sperm Bank of California, which offers very detailed donor descriptions including self-descriptions, message to offspring and motivation to donate. Subjects indicated using a "positive impression" of the donor, derived from the self-descriptions, and identity-release as well as physical and personality characteristics in making their donor selection.

A major issue in donor selection is **matching**, i.e. picking a donor with similar physical and personality characteristics as the partner. Scheib et al. (2000) found that lesbian and heterosexual couples were equally likely to match their donor to their partner. In contrast, Wendland et al. (1996) reported that matching was the most major issue for heterosexual

[11] Discussion of recipient couple thought processes in personally selecting a donor has only occurred in U.S. studies and appears independent of whether the clinic/sperm bank offers only anonymous donors or a choice between identity-release and anonymous donors.

couples in donor selection but not for lesbian couples. Matching is common practice for heterosexual DI couples so as to best 'hide' the DI origins that are usually not intended to be disclosed. Matching may also fulfill the functions of allowing the child to resemble the social parent thus facilitating everyday interaction without the parental status being questioned, to increase the partner's involvement in DI, pregnancy and commitment to the child, and may increase social parent-child affinity (Scheib et al., 2000).

The biggest issue regarding donor selection is whether to choose an anonymous or identity-release donor from a sperm bank or a known donor that may or may not be active in the child's live.

Lesbian parents who choose an **anonymous donor** attempt to secure the right to be a two-parent family in that they circumscribe the contribution of the male and thereby eliminate the role of father from the family equation (Dalton & Bielby, 2000). This eliminates the possibility that the birth father could displace the social mother within the family by claiming that he is the child's legal parent (Baetens et al., 2002; Chabot, 1998; Dalton & Bielby, 2000; Gartrell et al.1996). This does not mean lesbian mothers are unaware or insensitive to the cultural importance placed on male role models for children (Dalton & Bielby, 2000; see men in children's lives). Many couples who eventually choose an anonymous donor seriously considered a known donor but decided against it for fear of "complicated parenting" with a third party or because they did not know a man willing to be a donor/father (Chabot, 1998; Gartrell et al., 1996).

Identity-release donors provide the non-third party involvement of anonymous donors but eventual access to donor's identity (Chabot, 1998; Dalton & Bielby, 2000). Scheib et al. (2003) reported that parents who chose identity-release donors did so in order to give their children the option of getting more information about the donor, learning his identity and possibly meeting him one day, and because they felt it was the right thing to do. In contrast, DI recipient couples who choose an anonymous donor explained that other priorities were more important, i.e. matching, availability of samples, etc., and that they wanted to minimize the donor's role in their life (Scheib et al., 2000). The author finds the studies at The Sperm Bank of California particularly interesting since recipients have the exceptional situation of a true choice between donor anonymity and identity registration. We see that both options are chosen for different reasons, lending further support to the discussion above, that needs for access to donor information are very individual. Legislation prescribing one kind of donor may not be the best method of meeting DI recipients' needs.

A **known donor** may be any male other than the birthmother's first degree biological relative whose involvement with the child is determined on an individual basis based on the needs and wishes of all parties involved. Gartrell et al. (1996) reported that only half of the known donors in her sample were involved in offspring's lives. Half of those involved were acting as parents while the other half was not. (See discussion of known donor's involvement in section 4.3.2.3.7 Men in Children's Lives). Parents feel they have an answer to the question "Who is my daddy?" (Chabot, 1998) and there is the option of donor involvement as a male role model for the child with this donor type. The challenge of known donors lies in the balance between maintaining the lesbian-headed two-parent family while allowing the sperm donor to be involved. Sometimes the solution is to redefine the biological father from 'father' to "sperm donor", "uncle", or "close family friend" so that the social mother can fulfill the social role of second parent (Dalton & Bielby, 2000). Difficulties may arise from the triangulation of the couple in cases where the donor takes an active parenting role in which all decisions must take his opinions, etc. into account, aside from the obvious potential threat of the donor suing for paternal rights or custody.

Finally, the choice of donor involves a choice between fresh and frozen sperm. The use of fresh ejaculate is associated with higher fecundity rates than frozen sperm (Subak et al., 1992 in Carroll & Palmer, 2001). For fertile women, pregnancy rates with frozen sperm were found to be about 14% per cycle if inseminated intrauterine (IUI) versus only 9% (2 insemination per cycle)/ 5% (1 insemination per cycle) if inseminated intracervically (ICI) (Carroll & Palmer, 2001; Ferrara, Balet &Grudzinskas, 2000). The cumulative pregnancy rate for IUI in lesbians was found to be 70% after 8 cycles, whereby 87% of pregnancies occurred within the first 6 cycles (Ferrara et al., 2000). This would suggest that, when using frozen sperm, IUI would be the method of choice.

Due to the risks[12] imposed by IUI, Carroll & Palmer (2001) investigated whether its use was justified in fertile, i.e. lesbian, women. They came to the conclusion that, due to the significantly higher fecundity rates using IUI versus ICI, fertile women wishing to achieve pregnancy with frozen sperm should use IUI rather than the less invasive ICI. IUI, however, can only be conducted by medical personnel since sperm is "washed", i.e. prepared in the laboratory to eliminate exposure to seminal plasma, and inseminated using a catheter inserted directly into the uterus whereas intravaginal and intracervical insemination can be done using self-insemination (at home).

[12] The method of IUI carries the risk of endometritis, cramping, bleeding and, rarely, anaphylaxis (Peters et al.. 1993 in Carroll & Palmer, 2001)

It is probable that lesbian couples planning their use of DI are unaware of fundicity rates of methods of insemination. For the insemination experience of these couples, it does predict that (a) not everyone will get pregnant, (b)pregnancy is most likely occur within the first 6 cycles (for IUI), (c) those couples self-inseminating with frozen sperm are less likely to achieve pregnancy than couples using a medical insemination (usually IUI). However, medical insemination also brings with it a possibility of more extensive treatment, such as, follicle stimulation and ovulation induction, as well as the issue of finding a physician or clinic willing to "treat" lesbian women.[13]

4.3.2.3.4 Regulation of DI by Country

The types of donors available in reproductive centers are dependent on country and point of time in history. Legislation regulating DI is continually changing and very variable amongst countries. Also, fertility clinics may vary in their policies regarding donor anonymity even within a nation. Lesbian couple and single woman access to reproductive medicine is generally limited and clinic specific. In the U.S., Scheib et al. (2000) reported that only two fertility centers in entire North America offered the choice between anonymous and identity-release donor programs. Interestingly, these institutions were also of few that accepted lesbian couples' requests for DI. By 2003, Scheib et al. loosened this claim to include more fertility centers offering donor registration programs although it is definitely not the norm. The norm is anonymous donors with non-identifying information that typically includes health information, blood type, physical appearance, but sometimes also self-descriptions of donor's character, motivation to donate and a message to offspring. Identity-release occurs after age 18 years to avoid complications of paternal rights and responsibilities of donor and associated risks for the recipient couple. Identity-release programs elsewhere developed after the UN Convention on the Rights of the Child (1989, Part I, Article 8) endowed formal recognition of the rights of children to their genetic origins (Scheib et al., 2003). Sweden, Austria, Switzerland, Australian state of Victoria and The Netherlands[14] have mandatory donor identity registration at the time of this writing (ibid). Belgium (Vanfraussen et al., 2001), Norway (Purdie et al., 1992) and Germany have strictly anonymous sperm donors. Baetens et

[13] In a retrospective analysis of IUI treatment outcome in 35 lesbian couples, only 34% of the lesbian subjects were inseminated following spontaneous ovulation (Ferrara et al., 2000).

[14] This shift in Dutch policy occurred late 1990's. The sample studied here was partially affected by this change in policy since it caused a sharp decrease in donor sperm availability that forced several clinics to shut down (anecdotal evidence from participants who were contacted by their clinic, i.e. due to donor reservation for sibling children, or new plans for donor registration, etc.). Almost all Dutch clinics offer DI and IVF (in-vitro fertilization) to unmarried women including lesbians (Bos et al., 2003) and many German woman traveled there for sperm from anonymous and identity-release donors. Since the above change in policy, German women no longer have access to Dutch sperm banks.

al. (2002) reported high usage of Belgian DI programs by French women because legislation has restricted DI use to heterosexual couples since 1994. UK management of DI is based on the Warnock Report which leaves it to the discretion of the clinics whether they provide services for lesbian couples and provides for non-identifying information about the donor (Tasker, 2002; Vanfraussen et al., 2001). Currently, the UK is considering switching over to (mandatory) donor identity registration (Boden & Williams, 2004). Purdie et al. (1992) reported that New Zealand clinics have anonymous donors with non-identifying information available. However, Scheib et al. (2003) report that, although New Zealand does not have mandatory donor identity registration, most programs only offer this alternative. Generally, it can be concluded that the starting point for DI regulation is complete donor anonymity with a progression to more liberal attitudes including more donor information over time (paralleling the handling of adoption). From the literature, it is not clear what motivates the changes in policy since there is little to no research on the consequences of donor anonymity on the DI family on which to base such decisions.

4.3.2.3.5 Disclosure: Telling children of DI origins

The issue of donor anonymity, discussed above, is closely related to the issue of disclosure of DI use and DI origins to the child. It is currently difficult to judge the long-term effects of donor anonymity on the DI child since research has shown that heterosexual couples opt for non-disclosure (Brewaeys et al., 1993; Scheib et al., 2003) and are very reluctant to participate in research efforts as is evidenced in the frequently reported low participation rates of heterosexual couples as compared to the exceptionally high participation rates of lesbian couples (Bos et al., 2003; Brewaeys et al., 1993; Brewaeys et al., 1997; Jacob et al., 1999; Scheib et al., 2000; Scheib et al., 2003; Vanfraussen et al., 2001; Wendland et al., 1996). Generally, in contrast to heterosexual DI recipient couples, lesbian couples unanimously opt for disclosure of DI use and DI origins at an early age (Brewaeys et al., 1993; Brewaeys et al., 1995; Dundas & Kaufmann, 2000; Gartrell et al., 1996; Jacob et al.,1999; McCandlish, 1987; Mitchell, 1998; Scheib et al., 2003; Vanfraussen et al., 2001).

This difference in openness to disclosure reflects the function DI has for the couple in forming a family. Heterosexual couples utilize DI as a means of creating a ‘normal’ family (Brewaeys et al., 1993). It is a ‘treatment’ of the couple’s infertility (usually male factor). Non-disclosure of DI usage is motivated by attempting to keep the husband’s infertility a secret (Brewaeys et al., 1993; Brewaeys et al., 1995), avoiding subjection to negative societal attitudes towards reproductive medicine (Brewaeys et al., 1993), as well as fears that the child

would be upset by the knowledge of its DI origins (Brewaeys et al., 1993; Brewaeys et al., 1995; Wendland et al., 1996), and fears that the (social) father-child relationship would be negatively impacted (Brewaeys et al., 1993; Brewaeys et al., 1995; Wendland et al., 1996). However, non-disclosure carries the risk of the negative impact of secret-keeping on family relationships or the child finding out under difficult circumstances, i.e. death or medical emergency (Golombok, 1999). By contrast, lesbian couples 'consolidate their differentness' by opting as lesbians to become parents and then again by using reproductive medicine (Brewaeys et al., 1993). Using DI is not connected with the pain and shame of infertility for lesbian couples. Rather they approach it as presumably fertile women who simply need access to sperm to create their 'own' family with their female partner without compromising their couple fidelity (Jacob 1995). They also must explain the child's conception in the face of father absence (Brewaeys et al., 1993). The presumed positive effects of lesbian couples' choice to disclose DI origins to the child at an early age is supported by conclusions drawn from adoption research (Brewaeys et al., 1993; Vanfraussen et al., 2001). [15] [16]

Lesbian parents have been found to initially explain DI origins to their children in connection with their family structure rather than due to their child's curiosity about reproduction (Brewaeys et al., 1993; Vanfraussen et al., 2001) and because they don't want a secret and want to be honest with their children (Jacob, 1999). Mothers' stories involved the mothers' desire for a child, intervention of a hospital or sperm bank, having the 'seeds' put in the birthmother's belly (Brewaeys et al., 1993; Brewaeys et al., 1995; Gartrell et al., 1996; Mitchell, 1998; Vanfraussen et al., 2001) and that there are different types of families: families with mother/father, two mommies, or one mommy (Leiblum et al., 1995). Generally, disclosure of DI origins occurred spontaneously and explanations were age appropriate and

[15] Two studies have, however, reported higher rates of disclosure in non-representative samples of heterosexual couples in connection with availability of information about the donor. Purdie et al. (1992) reported that 84% of heterosexual couples initiating DI in a New Zealand reproductive center planned to tell their child of its DI origins. However, this group of subjects had visited a voluntary counseling session introducing them to the issues of telling the child about its DI origins and they were aware that non-identifying information about the donor would be available once pregnancy was confirmed. Also, Scheib et al. (2003) reported 70% of heterosexual DI couples disclosing to their child. However, all subjects in the study had in common that they specifically chose identity-release donors from one of two clinics in North America offering this option and this sub-sample was extremely small (n=10 children).

[16] DI is often considered similar to adoption since children lack a biological connection to one or both parents, respectively. However, there are some important distinctions. DI children are a result of a visible pregnancy (Scheib et al., 2003), biologically related to one of their parents, their conception occurred after a positive decision for a child within the context of the recipient's relationship, and they have no history of abandonment or being given up as do adoptive children (Golombok, 1999; Purdie et al., 1992; Scheib et al., 2003; Vanfraussen et al., 2001). Also, DI children know their biological mother and it is this information most commonly sought by adoptive children (Baetens et al., 2002). The differences between adoption and DI also affect disclosure of origins to the child. In disclosing DI, there are no generally accepted stories to tell, one has to explain reproduction, yet have little or no information to tell about the donor (in case of anonymous donors) and discuss a father's infertility (in case of heterosexual couple) (Golombok, 1999).

gradually included more detailed information as capacity for understanding grew (Vanfraussen et al., 2001). Baetens et al. (2002) suggest that disclosures to children should include the following aspects: (a) both women wanted a child, (b) there is no father, (c) anonymous donor should not be presented as a father, but as someone who made the birth of the child possible, who gave the "gift of life".

Scheib et al. (2003) reported the impact of disclosure on LDI children of identity-release donors aged 12-17 years. Most children had been told by age 6. Their initial reactions were either neutral or they showed no response. During their teenage years, the DI children reported at least a neutral to positive attitude towards their conception. For them, DI origin was just a part of their life and certainly not a focus and they did not know any differently. Also, the children were happy and would not want to give up their social mother even though they did wish their family was less different. The parent-child relationships were also neutrally to positively impacted by disclosure since it created trust that the parents would always be honest with the child and the child felt 'wanted'.

In sum, LDI parents are open with their children regarding their DI origins. Disclosure is a process that occurs gradually and spontaneously with parents being guided by the child's questions and age as well as capacity for understanding. Generally, explaining family structure, i.e. two mothers and father absence, rather than an interest in reproduction triggers first discussions that usually occur between ages 3-6 years. Knowledge of DI origins is not as spectacular for the children themselves as it is for the world around them. Small children simply accept the information whereas the parent-child relationship in older children is more obviously positively impacted by the increased sense of trust and feeling 'wanted'.

4.3.2.3.6 Concept of Donor

Some research has assessed the DI recipients' concept or attitude towards the donor as well as thoughts about meeting him.

Brewaeys et al. (1993) found that discussions about the donor were a source of tension for heterosexual couples. In contrast, lesbian couples had a very positive image of the donor, attributed him mainly positive features and those characteristics found in the child but not seen in the biological mother, and felt a sense of gratitude towards him. All had talked or thought about him.

Brewaeys et al. (1995) concluded ambivalence in their Belgian lesbian mother samples' concept of donor. The donor was interpreted as being excluded from the lesbian family by being reduced to an anonymous sperm cell, on the one hand, while being personified by

visualizing him with features observed in their child and preferring him for sibling children, on the other.

Dundas and Kaufmann (2000) conducted The Toronto Lesbian Study in Canada. LDI mothers in their sample described neutral attitudes towards their donor. Their image of him was that he was a nice person who made it possible for their child to be in the world and/or was based on attributes seen in the child. The DI children (all under 5 yrs.) stated they had no father or named another important male as their father.

Scheib et al. (2003) reported the concept of donor in U.S. lesbian and heterosexual DI families using identity-release donors. The donor was conceptualized differently from a father; when talking about him most families referred to him as "the donor" or "biological /birth father" but not "father" or "dad". Also, the donor was not mentioned when children were asked to name important people in their lives. However, parents and children were predominantly positive and curious about their donor. Parents felt a sense of gratitude toward the donor.

Vanfraussen et al. (2001) assessed the donor concept in Belgian LDI families with children aged 7-17 years conceived using anonymous donors. The majority of the children (63%) described the donor as "seeds" whereas a minority discussed him as a distant person ("unknown father" 20%, "unknown man" 17%). The majority of children (63%) also reported no need for conversations with their mothers about the donor. Some children (37%) had joked, speculated about donor's personality or appearance or discussed the use of an anonymous donor. Three children (of n=41) had asked for their donor's identity. The majority of mothers (54%) also reported hardly talking or thinking about the donor and saw no difference between donating blood or sperm. For the remainder (43%), characteristics seen in the child had led to remarks or joking around about the donor or health problems in the child had led to wondering about the donor's medical history. Some parents wished they could thank the donor.

In sum, the donor is not conceived of as a "father" by LDI families but more as a distant bearer of characteristics seen in the child. This is not only the case for families who conceived using an anonymous donor but also in families where the child may meet the donor due to identity-release. The author interprets this data as supporting the idea that distancing the donor is not (solely) a mechanism to cope with donor anonymity but may reflect the 'completeness' of the LDI family concept of two mothers and children in these families. The general tenor towards the donor in cases where he may be met is curiosity. Overall, families are very positive about their donor and parents feel a sense of gratitude towards him.

4.3.2.3.7 Men in Children's lives

This section covers known donor and other male involvement in LDI families, LDI parent's attitudes regarding the effect of father absence on their child's development and the importance placed on men being incorporated in their children's lives.

In Patterson (1996) sample of planned lesbian families, only children conceived using known donors or conceived by heterosexual intercourse (n=10, 27%) had contact to their donors. However, in the majority of cases, the donor had no special role in the family unit (60%). Occasionally, he had the role of 'family friend' (39%). Only in two cases did the donor occupy the social role of 'father'.

In the longitudinal National Lesbian Family Study, Gartrell et al. (1999) reported that 75% of the LDI children had no father in their lives whereas 20% had known donors. The known donors (a) actively parented in half the cases or (b) were involved in the children's lives, but not parenting in the other half when the children were toddlers. By the time the children were 5 years old, 29% saw their donor/father regularly where as the majority (71%) interacted with him only occasionally (Gartrell et al., 2000).

Brewaeys et. al. (1995) found that only 1/5 of their lesbian mother sample using anonymous donors were concerned about father absence and expected it to cause problems in their child's life. Importantly, it was these mothers who had initially preferred a known donor. In contrast, the remaining 4/5 felt that parenting qualities were more important than their gender and were not expecting difficulties as a result of father absence.

Baetens et al. (2002) reported that 2/3 of their LDI sample did not expect father absence to cause problems, where as 1/3 thought it might. Instead, the majority of LDI mothers felt a two-parent family and the presence of male friends or relatives were important for their children. Approximately one third of mothers, who were more likely to have considered a known donor, planned to ask a special man to become 'godfather'. The remainder felt there were enough men in their social environment for children to choose from.

Despite choices of unknown donors and low known donor-child interaction, a common finding in research on LDI families is the importance placed by the parents on including men in children's lives. LDI mothers adhere to public opinion and find it important for their children to have male role models and often plan for/chose a man to play a special role in their child's life, i.e. godfather (Brewaeys et al., 1995; Gartrell et al., 1996, 1999). A good male role model was described as a man who demonstrated sensitivity, empathy, thoughtfulness, and morality - all non-gender specific traits (Gartrell et al., 1996). Except in the case of known donors, the male role model is a non-related person. A non-related male

role model poses no threat to the LDI family since he has no legal or social claim to father status (Dalton & Bielby, 2000). Gartrell et al. (2000) reported that, although 88% of LDI mothers planned to include a loving male in their toddler's life, only 53% of mothers felt they had been successful in this by the time the child was 5 years old.

In sum, lesbian parents, who are content with unknown donors, do not expect their child to suffer from father absence. Parents, who would have preferred a known donor, worry more. Also, known donors have limited contact with their offspring. Nonetheless, lesbian parents value the potentially different influence a male role model may have on a developing child and find it important to incorporate men in their children's lives, though not all are as successful at this as they would like to be.

4.3.2.3.8 Lesbian Family Concept & Terminology

Generally, the concept of the LDI families included two mothers, a child/or children, but no father (Brewaeys et al., 1993; Brewaeys et al., 1995; Dundas & Kaufmann, 2000; Gartrell et al., 1999; Nelson, 1999; Vanfraussen et al., 2001).

Brewaeys et al.(1993) reports that the children also demonstrated a clear two-mother family unit concept although they were very aware that other families had a father and they often included a 'father' in their fantasy play. Brewaeys et al. (1995) found that 40% of couples consider the birthmother and social mother roles to be equal, while 60% of the couples felt the birthmother was the 'mother' and the social mother had a different role, but educational responsibilities were shared and equal. Nonetheless, 60% of couples chose terminology reflecting equal mothering (mammy/mummy) and the remaining 40% titled the birthmother 'mother' and the social mother was called by her first or nickname. A similar division in stance was reported by Baetens et al. (2002). By contrast, Dundas & Kaufmann (2000) reported that all children old enough to answer defined their family as two moms and themselves and children under 5 years were not able to name any differences between their family and their friends' families. The exception: One child said his house was cleaner than his friends' houses.

4.3.2.3.9 Disclosure: Telling Children of Parental Lesbian Identity

Brewaeys et al.(1993) and Brewaeys et al. (1995) report that the majority of their sample identified as lesbian and planned to reveal this to their child. A minority had ambivalences using the *word* lesbian to describe their relationship due to negative connotations. Participants in the study by Dundas & Kaufmann (2000) reported mothers

wanted to tell their children because otherwise the child would think the parent's were doing something wrong and because they feel secrets are unhealthy for families. None of the other studies discussed here addressed this aspect of disclosure. Presumably it is too self-evident and as superfluous as it would be for heterosexual parents to feel the need to disclose their heterosexual identity to their children. It is more likely that lesbian parents need only to explain that the label 'lesbian' describes their identity and relationship.

4.3.2.3.10 Disclosure: Telling the World

When interacting with the social environment, LDI parents face the dual challenge of having to combat invisibility as a two-mom family caused by heterosexist social constructs of family and acknowledge the use of DI to clarify child origins that otherwise might lead to speculation.

Brewaeys et al. (1993) and Brewaeys et al. (1995) reported that all parents and friends of the lesbian mothers in their sample knew of DI use and shared parenthood and that half were open in a broader social network. In contrast, only ¾ of parents and friends knew of the lesbian relationship, while the rest avoided the label. It was concluded that the lesbian DI mothers talked far more openly about DI usage than their lesbian relationship.

Wendland et al. (1996) reported that all lesbian couples and single mothers had disclosed use of DI to at least one person. In contrast, only 3/5 of heterosexual couples had confided in anyone. Those who told had perceived supportive reactions independent of relationship status. The people most likely to be disclosed to were the recipient's mother, siblings or close friends whereas fathers were the least likely to be told.

Scheib et al. (2003) also found differing patterns of disclosure between lesbian and heterosexual birthmothers and co-parents. Birthmothers did not differ in disclosure to friends, but lesbians were more likely to disclose to family. Co-parents did not differ in disclosure to family, but lesbian co-parents were more likely to disclose to friends. Generally, reactions to disclosures were considered neutral to positive. However, reactions from lesbian and heterosexual co-parents' families were the least positive.

5.0 Legal situation

The legal situation in a particular country also shape the creation of LDI families and impact them profoundly by determining whether or not legal options are available to secure the couple, legal parenthood for social parents, and by controlling their access to reproductive

medicine. This section first discusses the legal institutions for LG unions in Europe and then Germany, in particular. Finally, German lesbian access to sperm banks and reproductive medicine is discussed.

5.1 Legal Institutions for Lesbian and Gay Couple Relationships

5.1.2 Europe

Table 1: Legal Institutions for Lesbian and Gay Couple Relationships in Europe (Braun, 2006)

I. Marriage	**II. Marriage minus adoption**	**III. Registered Life partnerships**	**IV. Domestic Partnership**
The Netherlands, 2001	Denmark, 1989	France, 1999	Hungary, 1996
Belgium, 2003	Norway, 1993	Germany, 2001	Portugal, 2001
Spain, 2005	Sweden, 1994	Luxemburg, 2004	Croatia, 2003
	Iceland, 1996	Czech Republic, 2005	Slovenia, 2005
	Greenland, 1996	Switzerland, will take effect 2007	
	Finland , 2002		
	England, Scotland, Wales, North Ireland, 2005		

In 1989, Denmark surprised the world by being the first country to offer LG couples a state sanctified legal institution for their relationships analogous to marriage. Since then, 18 European countries and 12 of the 15 "old" European Community countries have followed suit. In general, the institutions offered to the LG community fall into four categories ranging from the opening of heterosexual marriage to include lesbians and gays to very weak forms of protection (Braun, 2006).

I. Marriage

Four countries in the world have opened the institution of **marriage** to their lesbian and gay community: The Netherlands (2001), Belgium (2003), followed by Canada and Spain (2005). Married LG couples enjoy all of the same rights as heterosexually married couples in these countries.

II. Marriage minus adoption

Seven European nations have created a special legal institution for lesbian and gay couples similar to marriage. In 1989, Denmark created the *Registreret Partnerskab* that

included all the rights of heterosexual marriage without the right to (joint) adoption of children. The other Scandinavian countries adopted the Danish model. In 2005, the UK created *Civil Partnerships* that also includes almost all rights of heterosexual marriage. Even though adoption is excluded, it is allowed based on another law.

III. Registered Life partnership

The countries in this category developed an alternative legal institution for lesbian and gay couples with reduced rights compared to heterosexual marriage.

In 1999, France instituted the *Pacte Civil de Solidarité (PaCS)* which is open to both heterosexual and homosexual couples. Luxemburg instituted an institution similar to the French model *Loi Relative aus Effet Légaux de Certains Partenariats* also open to both LG and straight couples in 2004.

In 2001, Germany created *Eingetragene Lebenspartnerschaften* for same sex couples only, which was expanded in January 2005 to include more rights (see discussion below). In 2005, Switzerland held a national referendum in which the public voted on whether or not registered life partnerships for gay and lesbian couples should be created. It passed with an overall 58% vote of "yes" (Gesellschaft für Sozialforschung [GfS], Bern, 06/2005*)* and will take effect 2007. The Czech Republic passed their law in 2005.

IV. Domestic Partnerships

This institution is also open to heterosexual couples and offers very minimal rights and protection to cohabitating couples.

5.1.2 The World

Australia and New Zealand also have legal institutions for lesbian and gay couples while Canada has opened marriage to them. By contrast, the issue is hotly debated in the U.S. and the courts are very involved in whether or not it is constitutional to restrict *marriage* to heterosexual couples. Each of the 50 states has the sovereignty to decide for itself. As it stands today, lesbians and gays may marry in Massachusetts and, in Vermont, they may enter a *civil union,* which grants couples the same rights as marriage for state laws but not federal laws (i.e. immigration, federal tax, social security benefits) and enjoy only limited recognition outside of state boarders. Several other states have changed their marriage laws to specifically define marriage as "between a man and a woman" in order to block further attempts for lesbian and gay couples to protect their relationships. U.S. President Bush even attempted to

write discrimination into the U.S. Constitution with the "Defense of Marriage Act" which, had it been passed, would have defined marriage explicitly as "between a man and a woman" for the whole country.

5.2 The Legal Situation in Germany

5.2.1 *Lebenspartnerschaftgesetz (LPartG)*

In August 2001, the coalition government of the SPD & Bündnis90/DieGrüne parties under Chancellor Schröder instituted "registered life partnerships" for lesbian and gay couples in Germany. This success was due to a tactical decision to include only those aspects of heterosexual marriage law that would only require the passing of the bill in the *Bundestag* to become law and could circumvent deliberation in the *Bundesrat,* in which the coalition parties no longer held a majority after spring 1999. All rights and responsibilities are delineated from the LPartG individually due to this tactic (Ladnar, 2001).

The life partnership law (*Lebenspartnerschaftsgesetz (LPartG))* thus began in 2001 as a compromise and offered minimal rights and required all of the responsibilities of marriage to those who choose it. It offered the LG couple a first degree relationships status (important in case of, for example, hospitalization, death) and the opportunity of the life partners to be on each other's medical insurance and carry one of the two people's last names. Critique focused on the financial disadvantage the LPartG imposed on the couple since their income was considered combined as regards social law (*Sozialrecht*) but separate for tax purposes (*Steuerrecht*), not giving them access to the tax breaks heterosexually married couples enjoy, even though the life partners are financially responsible for each other. Often this distinction was justified by the *fact* that married couples have children and need special treatment to help them with this financial burden while homosexual couples are not procreative (Siegfried, 2001).

In January 2005, the life partnership law was extended (*Lebenspartnerschafts-ergänzungsgesetz (LPartGErgG*)) to include equal access to social security benefits, extension of name changes to biological children and stepparent adoption (analogous second parent adoption in the U.S.) of biological children of the life partner if the other biological parent relinquishes his/her rights or is not known. As it currently stands, the LPartGErgG entitles LG couples to all the rights of legal marriage with the exception of all tax related laws (*Steuerrecht*) and the right to jointly adopt children (*Adoptionsrecht*).

5.2.2 The Implications of the LPartG on LDI Families/Couples[17]

Prior to the institution of the LPartG or for couples who have not entered a life partnership, the legal situation is the following:

The lesbian couple is treated as two, independent, non-related persons or "biological strangers" in all legal or state related matters. A non-German partner can not gain a resident permit through her relationship to her German partner. For LDI parents, this means that the birthmother to the child is the only legal parent: Only her name appears on the birth certificate. The child is on her insurance, has her nationality, her last name. Only she has access to extended maternity leave and she has sole custody. The social mother remains a non-relative and, legally speaking, a non-parent.[18] In the event of death of the birthmother or relationship dissolution, the social mother has no security regarding gaining custody or continued contact to the child. In the event of the social mother's death, her partner and child do not inherit from her unless stated in a will. A birthmother with low income, however, may qualify for some federal benefits, i.e. maternity leave benefits, giving the couple a financial advantage over life partners in this respect. In this legal situation, the LDI family is at its most vulnerable though slightly less financially disadvantaged compared to LDI families with life partners.

For LDI families in which the parents were life partners according to the LPartG, the legal situation was the following[19]:

The LDI family attained some degree of protection since the lesbian couple had first degree relative status. The social mother became an "in-law" to her (partner's biological) child(-ren).[20] The biological mother to LDI children remained the sole custodian, name and nationality giver and only her name appeared on the birth certificate. The social mother attained the so-called "small custody" (*kleine Sorgerecht*) which enabled her to carry out aspects of everyday life with and for the children. In the case of separation, the social mother

[17] All German lesbian couples considering parenthood before the government under Chancellor Schröder took office made their parenting choices under the expectation that "gay marriage" and adoption of social children was a hope for the future that they and their children may or may not ever experience. Couples considering parenthood after the LPartG was instituted also made choices under the assumption that stepparent adoption would be a thing of the future if at all. It came rather suddenly and quietly – its inclusion in the LPartGErgG was only announced in November 2004!

[18] This rendered LDI parents unequal before the law and may cause a power imbalance in the parenting relationship further exacerbated by unequal biological connection to the child. (See section 3.1.5 for a discussion of the social mother role)

[19] See Siegfried (2001) in *LSVD Familienbuch* for a detailed legal discussion of the impact of the LPartG 2001 on life partners who were parents. This discussion, however, does not specifically address LDI children.

[20] Access for the social mother to extended maternity leave, by which heterosexual couples, for example, may take turns by year, was not regulated by the LPartG but by legislation regulating maternity leave, at that time, also in reform.

would have visitation rights. Joint adoption and stepparent adoption were excluded from this version of the law as was the opportunity for children to take on the (new last) name of their biological mother. A non-German partner could gain access to residence permits through her German partner, however.

The financial disadvantage increased for LDI families since, on the one hand, they were still taxed as individuals as opposed to a family even though, as life partners, they are financially responsible for each other but, on the other hand, the combined income was considered when applying, for example, for maternity leave or unemployment benefits. Also, the social mother could not access tax breaks for parents and families even though she often carries a large part of the financial burden in the first years of parenthood due to extended maternity leave practices in Germany.[21] The LG couple was also left unprotected in the event of death, since the surviving life partner would not have access to widow benefits. Finally, although the inheritance line was established, the taxing of the inheritance would not be that of a married partner but of a "biological stranger" – the highest tax category. This aspect can have severe consequences for a family in the event of jointly owned homes, for example. In this legal situation, the LDI family was minimally better protected but more financially disadvantaged than if the parents were not life partners.

Since January 1, 2005:

LPartGErgG is, at this writing, with the exception of the remaining financial disadvantages resulting from the exemption of all tax related laws of marriage (*Steuerrecht*) and joint adoption (*Adoptionsrecht*), relatively LDI family friendly. LDI social mothers may now apply to adopt their (life partner's biological) child so that the child(-ren) then have two equal mothers before the law. Children born after the birthmother and social mother have become life partners, however, must also be adopted. Once adopted, the child is issued a new birth certificate with both mothers' names on it. Also, for couples who became life partners after the child(-ren) was/were born, it is now possible to pass on the life partnership last name, if one is chosen, to children in order for family members to have same or partially same last names. In the event of death, the surviving life partner and children, would receive widow/orphan benefits. Once the children are adopted, the LDI family attains equal status

[21] Extended maternity leave or *Elternzeit* allows for (biological) mothers of newborns to take a leave of absence from their job for up to 3 years with a guarantee of an equivalent job upon return. During this time the women are protected by law from being fired (also during pregnancy) and may work part-time with their employer's permission. While on extended maternity leave, the woman may apply for maternity leave benefits such as *Erziehungsgeld* and she and her child enjoy free medical insurance coverage. Recently, life partners to new mothers may also exercise maternity leave. However, this option was not available to the participants in this study.

under the law as heterosexual families. The severe financial disadvantages compared to heterosexual family due to exemption of marriage tax laws in the LPartGErgG remain, however.

5.2.3 Access to Reproductive Medicine

DI has been accepted as a medical treatment in Germany only since 1973. Since that time, it has been estimated that 50,000 children have been born as a result of DI in Germany (Schilling, 1999 in Thorn, 2003). The Embryo Protection Act (*Embryonenschutzgesetz* - ESchG) of 1991 does not regulate access to assisted conception services. However, guidelines for medical professionals (Ärtzekammer), which reserve DI for married heterosexual couples only, do (Thorn, 2003).[22] It is therefore not illegal *per se* for physicians to inseminate lesbian women, but by doing so, they would be in violation of their professional guidelines. German lesbians must, therefore, look internationally to obtain DI services or self-inseminate with a known donor. (See section 4.3.2.3.4 Regulation of DI by Country)

6.0 Statement of Purpose

In recent years, lesbians in Germany have begun starting families. The existence of lesbian-headed families in Germany is not at all well-documented in the psychosocial literature and there is a corresponding lack of information on them. Generally, these families are not legally or socially recognized despite the fact that the phenomenon of gays and lesbians parenting does not even pertain to a small number of individuals (Patterson 1996.In.Savin-Williams & Cohen). There are an estimated two million lesbians residing in Germany and approximately 650 000 of them are lesbian mothers (Krüger-Lebus & Rauchfleisch, 1999). According to the *Statistisches Bundesamt,* children are being raised in every eighth same sex relationship (Statistsches Bundesamt, In Dworek & Ferchau, 2006). The majority of these children were conceived in the context of heterosexual relationships (Berger et al., 2000). It is estimated, however, that, based on the Swedish experience of a baby boom after legal reforms for homosexuals, children who were born (or adopted into)

[22] Interestingly, the treatment of DI for single or lesbian women is entangled with the unclarified contradiction in German DI usage. On one the hand, a court decision in 1994 upheld a child's right to knowledge of its decent, yet only anonymous donors are used in DI treatment. It is argued, however, that a heterosexual couple better fulfills the child's right to knowledge of its paternity because it offers the child a (social) father whereby the single or lesbian woman does not (Berger et al., 2000). However, in the lesbian parent community it is speculated that, with the option of stepparent adoption in the LPartGErgG, German physicians may be more willing to provide lesbian women DI services.

into primary lesbian families in Germany may increase rapidly in up-coming years (Berger et al., 2000). Knowledge of this family form would be useful for all members of society that regularly interact with LDI families, parents and/or children. In particular, it would be especially advantageous for the families themselves if others had knowledge of them in order to respond to them appropriately.

Little is known about the early stages of lesbian family formation or the factors that influence LG couples inclinations to make parenthood part of their lives (Patterson, 1996, In Savin). This study endeavors to contribute to the knowledge about (1) the process by which German lesbian couples become parents through donor insemination by systematically describing the early family formation phases for these families. It aims (2) to explore the roles of biological and social mother in the initial family planning stages and (3) the cognitions and processes that result in their donor choice. The information assessed in the present study is intended to provide the information LDI mothers would have liked to have had before they embarked on motherhood. It is also intended to be useful to professionals in a variety of disciplines who are educating and /or providing services for members of LDI families.

7.0 Methods

7.1 Sample

A non-random, convenience or volunteer sample was used for this study. A total of **105 lesbian DI mothers** took part in this study of whom 55 were birthmothers and of whom 50 were social mothers. The average age of the participants in this study was **38 years**.

60% of women had used frozen sperm from a sperm bank while 40% of women had used fresh sperm to conceive their first DI child.

The women in this study chose different donor types in planning DI: **anonymous donors** (42%), **identity-release donors** (18%), **known donors** (38%) and unknown, fresh sperm donor (2%) to conceive their first-born child.[23]

The participants in this study were in different current phases of family formation: **insemination** of self or partner **/pregnant** (n= 20), first born DI **child was 0-3 years** (n=32), first born DI **child was 3-6 years** (kindergarten age; n=35), first born DI **child 6 years +** (school aged; n=18).

The subject sample of 105 women had produced a total of **47 first-born children** conceived via DI. 43% of the children were female and 57% were male. These children were **0-13 years** of age (M(s) = 4.2 (2.0) years) and born between the years 1991 and 2005. There were also a total of 16 sibling children. Sibling children were 0-7 years old and born between the years 1997 and 2005. Approximately half of the sibling children were born to the birthmother and the other half were born to the social mother of the index child. One sibling child was a foster child. Table 2 shows the increase in DI births to the lesbian mother sample.

Table 2: Births of DI children born to the lesbian mother sample between 1991 and January 2005

	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
∑	**1**	**1**	**0**	**2**	**2**	**1**	**7**	**5**	**6**	**7**	**7**	**5**	**5**	**13**	**2**
%	2%	2%	0%	3%	3%	2%	11%	8%	10%	11%	11%	8%	8%	21%	3%

60% of had the official family status ‘single’ while 38% had entered same-sex registered life partnerships (*Eingetragene Lebenspartnerschaft*) since its institution August 1, 2001. Two women had experienced heterosexual divorce and 7% women had experienced lesbian divorce. None of the participants were currently heterosexually married.

[23] The analysis of this donor type as a separate entity was abstained from due to the low number of participants who chose it and to preserve anonymity of these participants. The responses from these two women were considered for totals for all women and users of fresh sperm donors. See section 7.3.4: Data Analysis.

The vast majority of subjects were German citizens. The non-German mothers were all from 'western' countries, i.e. European nations, the United States or Israel.[24] The 'foreign' mothers had lived at least half of their adult lives in Germany (mean 23.6 years, range 10-38 years). Three mothers moved to Germany in order to be with their partner, whereby six mothers moved to Germany independently of their lesbian relationship.

Though only a minority of participants in the study were non-German nationals, 1 /5 of families considered their family to be bicultural. In all but one household German was spoken in the home. In some households, a second language was spoken, reflecting the bicultural nature of these families. English was the most common second language spoken in these families.

Almost all participants in this study are from the 'old states' of Baden-Württemberg, Bayern, Nordrhein-Westfallen and Berlin. Subjects from the 'new states' and remaining western states are underrepresented in this study. [25]

Most participants in this study lived in urban or semi-urban communities (68%, 100 000 – 500 000 inhabitants). However, of those living in more rural areas (36%), half lived in communities with up to 100 000 inhabitants, which, in several cases, were university towns.

Overall, the respondents consisted of a highly educated group of women. All of the women had completed secondary education (83% *Abitur*, 14% *Realschulabschluss*, 3% *Hauptschulabschluss*). The majority of respondents (64%) had also completed master's level university education as compared to the national average of 16% completing such high levels of education (Statistisches Bundesamt, 2004).

Most mothers had a gainful employment status (86% of whom 56% *Angestellte*, 4% *Beamte*, 26% self-employed status) and worked a mean number of 30.6 hours/week. Social mothers (34.5 hrs/wk) spent significantly more time in paid employment than birthmothers (26.3 hrs/wk; $p < .05$). Birthmothers with children 0-3 years of age were more likely to be on maternity leave than social mothers. Social mothers on maternity leave were on leave as birthmothers to sibling children aged 0-3 years.

There appears to be variation in work patterns due to phase of family building. Women without children in their daily lives, that is, in the insemination or pregnancy phase, more often work full-time and have longer mean work hours/week. (Birth-) Mothers with children

[24] This is pertinent because being from a 'western' nation positively influences these women's social status as a 'foreigner' in Germany and access to resources, i.e. education level and resident permit status which in turns influences employment opportunities, etc..

[25] 'West Germany' refers to the social democratic nation of the Federal Republic of Germany while 'East Germany' refers to the now obsolete communist regime of the German Democratic Republic. Since the reunification of Germany in 1990, the prior West German states are referred to as 'old' states while prior East German states are referred to as 'new' states to avoid prejudicial connotations inherent in 'east' and 'west'.

0-3 years are more likely to not be gainfully employed. This time frame coincides with German maternity leave practices (for the birthmother). Mothers with kindergarten children are more likely to work part-time. Mothers with school-aged children work longer hours/week – about the same as women without children.

About half of the sample (54%) had gross monthly earnings over the national average income for private households (2675,00 €; Statistisches Bundesamt, 2003), over one quarter (28%) had an 'average' income, and one fifth (20%) had below average income for a private household. (See Table 3 below)

Table 3: Average Monthly Gross Family Income

Gross Income (month)	%
0-1000 €	4%
1001-2000 €	15%
2001-3000€	28%
3001-4000€	25%
4001-5000€	8%
>5001€	21%

The diversity in income was related to current stage of family building and relationship status. Women with no children, i.e. inseminating/pregnant, and mothers with school aged index child were most likely to have earnings in the highest category. Mothers of index children 0-3 years and school aged children were most likely to have below average income. However, the mothers with school aged children in this category were either single or had a sibling child 0-3 years. Birthmothers were more likely to have earnings in the lowest income category than social mothers.

It seems that various factors are associated with income. The phase of family building, i.e. age of children/stage of their development, may influence work hours and, in turn, family income. Women without children (i.e. inseminating/pregnancy stage) or mothers with school aged + children are freer to work longer hours and have higher incomes. Mothers of kindergarten children tend to work part-time and have medium level incomes. (Birth-) Mothers of children 0-3 years are more likely to not be gainfully employed and more likely to be on maternity leave (*Elternzeit*) and families' incomes are thereby reduced at this stage. Also, relationship status, i.e. single motherhood without a financially involved social mother, may also be related to lower income. Gender is related to income level; the Gender Pay Gap in Germany was between 21-23% in the last ten years (Statistisches Bundesamt, 2006) meaning that women's salaries are about ¾ that of men.

The most common family form by far for participants in this study to be living in was the **two mom-one child** family (92% of households had two adults, mean number of children per household was 1.1, average number of members per household was 3.1). The other families consisted of lesbian couples who were inseminating (18%) or families with two moms-two children (18%). The "Grossfamilie" of two moms-three kids (6%) was the exception.

We also found that household size and number of children appear to be a function of stage of family building, i.e. the earlier the stage, the fewer children there are in the family and the smaller the household size. As families progress along the early stages of family building, the number of children increases from 0 to 1 to 2 and the household size from 2 to 3 to 4 people. More than 2 children or a household size >4 was the exception.

Most respondents lived in rented accommodations (60%) while some were homeowners (40%). Home ownership appears to coincide with the phases in which family size increases or become complete and mothers work overall longer hours and income is middle to high (after index or sibling children have surpassed the phase 0-3 years). In the more formative phases of family formation, i.e. insemination, pregnancy, or transition to parenthood, the families are more likely to live in rented accommodations.

Overall, the women in this sample were **not active in religion**. The majority of respondents indicated no religious affiliation (56%). One third of the respondents identified themselves as Evangelical and only one tenth Catholic. One participant identified as Jewish and one as Buddhist. Over half of the participants in this study indicated that they never took part in religious activity and about one quarter participated in religious activity only on special occasions or once a year. 3/4 of respondents do not consider religion important for themselves, whereas ¼ do.

Approximately one third of index children are members of a religion, almost all through baptism. Children of kindergarten age or school age were more likely to have been baptized than children 0-3 years. It is possible that religion re-enters lives of lesbian-headed families through the children, i.e. baptism, school, holy first communion, etc.

7.2 Research Design

A cross sectional research design was used for this descriptive study. Participant's experiences were collected retrospectively using a structured, written questionnaire.

This method was chosen after carefully weighing out the advantages and disadvantages of questionnaires versus interviews. The issue of sensitivity is a major consideration for this study. The data to be collected is highly personal. Although the potential subjects are likely to be highly motivated to aid in increasing awareness of their family form, it was expected that many of the participants would know the researcher personally, which may restrict their ability to be completely open about some topics in some cases. Therefore, a method allowing for more personal distance between the researcher and the subject's responses was considered vital to ensuring their participation. A written questionnaire also had the advantage, aside from assuring anonymity of responses, that it could be implemented throughout Germany, independent of the researcher's resources regarding mobility. Finally, the questions asked of all respondents could be held constant as well as the exposure to all topics.

The study design does not include a control group since the objective of the study is to *describe* the lesbian family building experience, not to compare it to the heterosexual experience.

7.3 Procedure and Instruments

7.3.1 Recruitment

Participation in the study was open to the following women:

- lesbian women and/or couples with a desire to become parents, who had completed at least one insemination cycle
- all women and couples whose first-born child was conceived via DI (they should have no previous children) and they defined themselves as lesbian at the time of conception
- the non-biological mother of a child conceived via DI should fill out the questionnaire for social mothers only if she was involved in the planning of that child

The subject sample was recruited through an aggressive and thorough strategy of accessing various channels to reach the target group.

First, the researcher accessed personal informal networks of lesbian mothers met when participating in:

- family seminars and conferences organized by the *Initiative Lesbisch-Schwuler Eltern (ILSE)* of the *Lesben-Schwulen Verband Deutschland (LSVD)* in Frankfurt (2001), near

Düsseldorf (2002), in Berlin (2003), and in Bad Kissingen (2004)

- regional meetings of ILSE/LSVD
- a lesbian mother group

Second, the researcher installed a website with information material and advertised for subjects on the Internet:

- directly on the general listserv of ILSE/LSVD and the listservs of each regional group
- on the homepage of LSVD
- sent to Senat für Gleichgeschlechtliche Lebensweisen in Berlin for distribution in their newsletter or listserv
- gay-web.de

Third, the researcher advertised in gay and lesbian magazines and newsletters:

- *Stadtrevue*, Köln
- Newsletter of *Lesbenring, e.V.*
- *Lespress*
- *LAG* newsletter from/for lesbians in Nordrhein-Westfalen

Fourth, information material and advertisements to hang up for walk-in public to see in were sent to:

- the gay & lesbian counseling centers in Cologne and Berlin
- (feminist) women's health centers ((F) FGZ (*feministische) Frauengesundheitszentrum)* in Germany: FFGZ Berlin, FGZ Bochum, FGZ Bremen, FFGZ Frankfurt, Frauen & Mädchen Gesundheitszentrum Freiburg, FGZ Göttingen, FGZ Hamburg, FGZ Heidelberg, FFGZ *Hagazussa* Köln, FGZ München, FGZ Nürnberg, FFGZ Stuttgart, FGZ *Sirona* Wiesbaden, das Frauenzentrum in Zürich, Switzerland.

Fifth, a modified snowball technique was employed by including flyers in all questionnaire packets sent to participants with the request that they pass the information materials on to any and all lesbian parents of DI children they knew. One participant was so kind as to pass out flyers and questionnaires at the *CSD* (Christopher Street Day Parade) in

Cologne and to hang up a flyer at a restaurant in Cologne where lesbian mothers groups were known to meet regularly.

All organizations that were asked to hang up flyers and/or distribute information materials regarding this research project, were offered to be informed of the results if they wanted.

The advertisements (see Appendix) included information about the project, such as, topic, intent, target group, method of data collection, contact information of the researcher, and personal information regarding the researcher, i.e. lesbian-identified mother of donor insemination children. The latter was considered essential in order to assure potential participants of a gay affirmative approach to the study and instill faith and trust in the researcher by establishing her as an "insider". Due to recurrent public debates regarding lesbian and gay access to rights of marriage and abilities in the media, it was assumed that the target group would otherwise be skeptical of the researcher's motives and therefore less inclined to participate. As the target group is a relatively small to begin with, the researcher choose to eradicate that fear immediately and was able to refer the interested reader to an article about the researcher's person and family in the publication *LSVD Familienbuch*.

One group of participants, who were part of the researcher's personal, informal social network, were contacted directly by the researcher by phone or email. After describing the project, etc., they were asked if they might be interested in having the questionnaire be sent to them for review. They were instructed to fill out the questionnaire if they felt comfortable responding to the content or to send it back, if they did not want to participate. They were also asked to pass on the information letters to any other potential participants they knew to aid with recruitment. All of them agreed to have questionnaires sent. Questionnaire packets included a consent form, a cover letter with instructions on how to fill out the questionnaire, a questionnaire for the birthmother, a questionnaire for the social mother (if appropriate), flyers/letters to pass on to other known members of the target group, a return addressed and stamped envelop.

The second group of participants was unknown to the researcher personally and had initiated contact independently. Their attention was drawn to the study via the advertising strategies described above. They sent an email with their contact information, any questions/reservations they might have had regarding the project and, most often, with a description of their personal situation. Once the person's situation was assessed to be compatible with the inclusion criteria of the study, the questionnaire packets were sent to them. They were instructed to fill out the questionnaire if they felt comfortable responding to

the content or to send it back, if they did not want to participate. They were also asked to pass on the information letters to any other potential participants they knew to aid with recruitment.

7.3.2 Data Collection

Data Collection occurred June 2004- January 2005 (8 months). Parents of 27 DI families known to the researcher were contacted to see if they would be willing to have the questionnaire packet sent to them. All of them agreed. One couple returned the packet without filling it out and one further couple never returned it. Parents of 45 DI families responded to the various advertising strategies of the researcher. Of these, 38 fulfilled the inclusion criteria and were sent questionnaire packets.

A total of 67 questionnaire packets (containing a questionnaire for birth mother and a questionnaire for the social mother, where appropriate) were sent out and of these 56 were returned (response rate ca. 84%). 55 of the returned questionnaire packets, containing 55 questionnaires for birthmothers and 50 questionnaires for social mothers, could be analyzed for this study.

7.3.3 Questionnaire

For the purposes of this study, a structured, written questionnaire was constructed by the author. The questionnaire assessed demographics and information on the early phases of family formation in LDI families the author aimed to describe with this study. Closed questions and answer probes were developed based on an extensive investigation of the literature on LDI families and experience the researcher had accumulated in the lesbian mother subculture. Questions that were truly exploratory in nature were left open-ended. Items p24-p25 were taken over from the questionnaire constructed by Johnson & O'Connor (2002) and items fh40-fh43 were adopted from the questionnaire constructed by Shelley-Sireci & Ciano-Boyce (1999) for their research.

The woman occupying the role of birthmother with respect to her firstborn DI child was instructed to fill out the questionnaire for birthmothers. The social mother of the first DI child was asked to fill out the questionnaire for social mothers, (only) if she was involved in the planning of the child.

An official pilot test phase of the questionnaire was waived since the target group is so select and small to begin with. The individual sections were nonetheless tested on two independent target group members for clarity of instructions, user-friendliness and

determination of the expected completion time. Their feedback was incorporated into the final version of the questionnaire.

7.3.3.1 Coming-out/ Assessment of Lesbian Identity

This section aimed to assess important aspects of the lesbian identity, such as, age of coming-out, lesbian herstory and heterosexual history, effects of coming-out on normative life plans such as expectations to marry, have children, earn one's livelihood, outing behavior and levels of internalized homophobia.

7.3.3.2 Committed Lesbian Relationship

Questions in this section pertained to the lesbian relationship in which the subject was planning to parent or was parenting. The goal was to assess the length and commitment level of this relationship, whether the couple was registered or 'divorced', pattern of cohabitation, agreements regarding issues of parenthood and monogamy, and levels of couple satisfaction.

7.3.3.3 *Kinderwunsch*: Planning Phase

This section aimed at gaining general insight into the processes involved in the lesbian decision to parent using donor insemination, such as, the trigger, the length of time the couple deliberated before coming to a decision, identifying the issues that were pondered, deciding who will give birth, attitudes of social mothers regarding their role, plans to name parents, methods of becoming parents that were considered, considerations regarding donor/father/men in children's lives, resources that were (un-)available, and emotional well-being during this phase of family formation.

The second part of this section was divided up into four sections with questions regarding choice of donor type. Subjects only filled out the section that corresponded to the donor they were currently inseminating with or had conceived with (in the case of having tried achieving conception with more than one donor type) and had led to the (live) birth of the first-born DI child (in the case of the first pregnancy ending in miscarriage). Data regarding aspects of donor choice such as availability, positive & negative aspects of this donor type, procedure for inseminating, knowledge & internal image of donor, and plans/desires to meet donor were collected.

7.3.3.4 Standardized Psychometric Scales

7.3.3.4.1 *Lesbian Internalized Homophobia Scale* (LIHS) (Szymanski & Chung, 2001)

The construct of internalized homophobia in the subject sample was measured using the *Lesbian Internalized Homophobia Scale* (LIHS) (Szymanski & Chung, 2001). The LIHS was chosen because it is the only scale to date that specifically assesses internalized homophobia in lesbians. It consists of 52 items representing 5 dimensions of internalized homophobia which comprise the subscales:

- Connection with the Lesbian Community (CLC) – 13 items
- Public Identification as a Lesbian (PIL) – 16 items
- Personal Feelings about being a Lesbian (PFL) – 8 items
- Moral and Religious Attitudes Towards Lesbianism (MRATL) – 7 items
- Attitudes Towards Other Lesbians (ATOL) – 8 items

Each item is rated on a 7-point Likert scale from "strongly disagree" to "strongly agree". The LIHS includes reverse response items to reduce response sets. Average subscale and total scores are computed with higher scores indicating higher levels of internalized homophobia.

According to Szymanski & Chung (2001a), the scores on the five subscales had internal reliabilities (coefficient alpha) of .87, .92, .79, .74, and .77, respectively. The inter-scale correlations based on Szymanski and Chung's data ranged from .37 to .57. The alpha for the scores on the LIHS total scale was .94. Correlations between total and subscale scores ranged from .60 to .87. Test-retest correlations for scores of the LIHS total scale and subscales were .93, .91, .93, .88, .75, and .87, respectively (Szymanski & Chung, 2001b). Content validity was supported by five expert raters (Szymanski & Chung, 2001a). Validity of the scores on the LIHS was supported by correlating the LIHS with measures of loneliness, self-esteem, depression, various social support, membership in LGB group, conflict concerning sexual orientation, and social desirability (Szymanski, 2003, 2001; Szymanski & Chung, 2001).

7.3.3.4.2 *Dyadic Adjustment Scale* (DAS) (Spanier, 1976)

The quality of the couple's relationship was measured using the German version of the *Dyadic Adjustment Scale* (Spanier, 1976) called the *Fragebogen zur Beurteilung der Zweierbeziehung* translated by König-Kuske (1977) and adjusted by Krüger-Lebos (1996) for usage with a lesbian subject sample.

The Dyadic Adjustment Scale was developed by Spanier (1976) as a method of measuring adjustment in dyadic relationships. It was specifically intended to be used with

married couples as well as for "any nonmarital dyad which is a primary relationship between unrelated adults living together" (Spanier, 1976, p.16). The DAS has been used in over 1000 studies (Spanier, 1988) and is the most commonly used method of assessing dyadic adjustment (Hahlweg et al. 1992). It has also been used in studies with lesbian samples (Flaks et al., 1995; Kruger-Lebus & Rauchfleisch, 1999).

The DAS consists of 32 items with 4 factor analyzed dimensions:

- Dyadic Satisfaction – 10 items score range: 0-50
- Dyadic Consensus – 13 items score range: 0-65
- Dyadic Cohesion – 5 items score range: 0-20
- Affectional Expression – 4 items score range: 0-12

Subscale scores (score range, see above) and the overall level of dyadic adjustment is determined by adding up the answers (min. 0 – 151 maximum).

Internal reliabilities (Cronbach's alpha) for the subscales are 0.94, 0.90, 0.86, and 0.73, respectively, and 0.96 for the scale as a whole (Spanier, 1976; Hank et. al., 1990). Content validity is accounted for in the scales' original construction with three expert judges' concluding that items fulfilled specific criteria (Spanier, 1976). The criterion- related validity is good (married sample differed significantly from divorced sample). Construct-validity is considered good since the correlation between the DAS and another marital adjustment scale was 0.86 for married respondents and 0.88 for divorced respondents and the factor analysis of the final 32 item scale (Spanier, 1976). The DAS has also been found to be sensitive to change after couples' counseling (Hahlweg et al. 1992).

There are norms from a DIB sample for clients who sought couple's counseling and a control group of "happily" married couples (Hank et al., 1990). No significant differences in the averages of men and women could be found. Total scores under 100 point to a low level of relationship quality (ibid).[26] The DAS should not be interpreted at a scale level (Hahlweg et al., 1992, p.325) due to an inability to replicate the four factor structure of the scale and mediocre internal reliability of the scale *Affectional Expression*.

Despite its weak points, the DAS was chosen as a measure of relationship quality for this study because it is so commonly used in Anglo-American research.

[26] Hahlweg et al. (1992) take a more cautious stand. Many authors regard relationship as "happy" with a total score of more than 100 points, although Spanier & Filsinger (1983) have spoken against this interpretation.

7.4 Data Analysis

The closed questions lent themselves to coding and were entered into the computer using SPSS version 12.0.1 for Windows. For questions with multiple answer possibilities, each answer was treated as an individual variable with the values 1=yes, the respondent marked this answer and 2=no, the respondent did not mark this answer. 8 or 88 denoted that a question was non-applicable to the subject and therefore not answered where as 9 or 99 denoted that the respondent skipped an otherwise applicable question. I chose this differentiation so that if a pattern of skipping particular questions over several respondents occurred, indicating a problem with the item, I could become aware of it and take the answering pattern into account when interpreting the results. A code book (see appendix) was created indicating the code number of each question and the appropriate coding of the answers, as well as an indication of the source which led me to formulate the respective question.

In many cases, the answer possibilities offered for closed questions were not necessarily considered exhaustive. Due to the explorative nature of the study, it was quite possible that aspects of the topic refereed to by an item were overlooked by or not known to the researcher and therefore not included as an answer possibility. Where appropriate, the category "other, please specify" was included to compensate for this short-coming. The data analysis was conducted analogue to the open questions. Categories for qualitative data, i.e. open-ended questions, were developed largely from the text itself, rather than imposed upon it. All answers were then considered. If they could be grouped into a discreet category (defined as three or more respondents having this response), this new category was included as an answer category in the SPSS file.

For data processing, the SPSS data file was then sent to Dr. Christine Green of C&M Research in Half Moon Bay, California. A fixed format ASCII data file was prepared from the SPSS output and used to run tables in UNCLE. All closed ended questions were run against a fixed banner grouping subjects by mother role (birthmother/social mother), sperm type (fresh/frozen) and donor type[27] (anonymous/identity-release/known donor) to identify answering patterns particular to a group. Independent T-tests and Z-tests were run at the 95% and 90% confidence limits. The tables were returned to the author for analysis: The results were extracted from the tables, reported in the results section, and, for economical viewing, transferred into a copy of the questionnaire in the appendix.

[27] The coding of the fourth donor type - fresh sperm from an unknown man with a go-between - was refrained from to preserve respondent anonymity since only two participants had conceived or were inseminating with this donor type. Their responses were, however, included in the total for all participants/users of fresh sperm donors.

8.0 Results

8. 1 Coming-out

Almost all participants identified as lesbian (93%), the rest as bisexual (7%). There was a trend towards birthmothers being more likely to identify as bisexual than social mothers.

8.1.1 Lesbian Herstory

The majority of subjects experienced their **coming-out during young adulthood** (M=21.5 years). All respondents (100%) were satisfied with their sexual orientation and sexual identity.

The average age for entering the **first lesbian relationship** for all mothers was **23.5 years**. More than half of respondents indicated that they had had their first relationship with a woman before they came-out (57%). The remaining 43% identified as lesbian before entering their first relationship.

The subjects indicated that they had experienced an average of **2.4 lesbian relationships** including their current relationship (with whom they are parenting). The mean longest duration of a lesbian relationship was **9.7 years** for all mothers. It appears that, in many cases, the longest lesbian relationship duration was the relationship in which the women were parenting since durations for couples in earlier family building stages were shorter and durations for "later" family building stages were longer.

8.1.2 Heterosexual History

¾ of all participants in the study had had **heterosexual relationships** in the past, while ¼ had no heterosexual past. The subjects indicated that they had experienced an overall average of **1.8 heterosexual relationships**.

The mean number of heterosexual relationships for respondents who had had at least one heterosexual relationship was 2.4. The mean longest duration of a heterosexual relationship was **3.6 years** for those lesbians who had a heterosexual past.

Overall, the participants in this study had more lesbian relationships (M=2.4) than heterosexual relationships (M=1.8). However, when we only compare the number of lesbian relationships with the number of heterosexual relationships for those that had a heterosexual past, the difference in the mean number of relationships disappears (M=2.4). Nonetheless, the lesbian relationships lasted longer (M=9.7 years vs. M=3.6 years).

2/3 of respondents who had a heterosexual past were not involved in a heterosexual relationship at the time of their coming-out. 1/3 of respondents were. For ¾ of the latter group, the new lesbian identity was involved in the decision to break-up. The remainder indicated it had nothing to do with it (25%).

8.1.3 Life Plan

Expectations regarding marriage

The Coming-out process did have an effect on the expectation to marry a man. Initially only one third of participants did not expect to marry a man prior to coming-out while afterwards this raised to 93%. Conversely, initially one third of participants intended to marry and afterwards none indicated the expectation to marry.

Expectations regarding children

The coming-out process did not appear to affect the participant's expectations of having children.

Expectations regarding earning one's livelihood

Coming-out only mildly appears to have influenced expectations regarding providing for one's own living. Approximately two thirds of the women expected to provide their own living. Over one third had already been earning their own living before their coming-out. About 10% of participants did not expect to earn their own living. However, the number of participants who expected to share financial responsibility with someone else increased (19% to 31%) while the number of participants who 'gave money no thought' decreased slightly (14% to 8%).

8.1.4 Outing Behavior

Almost all participants indicated being out to all or most of their friends (96%), families of origins (94%), their child's kindergarten or school personnel (95%), the parents of their children's friends (93%) and their child's physician (88%). Compared to the above mentioned groups, participants indicated lower levels of outing behavior with work colleagues (80%) and neighbors (79%).

91% of the lesbian subjects reported that they decided on a case by case basis whether or not they wanted to out themselves in situations in which the other person does not know

they are lesbian. 9% stated that they always make their lesbian identity very clear to the other person. **None** of the participants behave in such a way that the other person would never know that they're a lesbian.

8.1.5 Internalized Homophobia

The *Lesbian Internalized Homophobia Scale* (Szymanski & Chung, 2001) was used to measure the construct of internalized homophobia in this subject sample of primary lesbian mothers. (See Table 4 below.) Scores range from 1 to 7, with low numbers indicating low levels of homophobia and high numbers indicating high levels of homophobia. With an overall average of 2, these participants have low levels of internalized homophobia and birthmothers and social mothers did not differ on this measure. This result corresponds with the high levels of self-reported outing behavior indicating a strong lesbian identity in the sample population.

Table 4: Scores on the Lesbian Internalized Homophobia Scale (Szymanski & Chung, 2001)

LIHS M=mean S=standard deviation	Point range	My sample: All moms M(s)	Bio-mom M(s)	Soc-mom M(s)
Connection with the Lesbian Community (CLC)	1-7	2.1 (0.7) ~ **2**	2.1(0.6) ~ **2**	2.1(0.7) ~ **2**
Public Identification as a Lesbian (PIL)	1-7	1.9(0.6) ~ **2**	1.8(0.6) ~ **2**	2.0(0.7) ~ **2**
Personal Feelings about Being a Lesbian (PFL)	1-7	1.6(0.5) ~ **2**	1.5(0.4) ~ **2**	1.6(0.6) ~ **2**
Moral and Religious Attitudes Towards Lesbianism (MRATL)	1-7	1.4(0.5) ~ **1**	1.4(0.5) ~ **1**	1.3(0.4) ~ **1**
Attitudes Towards Other Lesbians (ATOL)	1-7	2.1(0.8) ~ **2**	2.0(0.8) ~ **2**	2.2(0.8) ~ **2**
total	1-7	1.9(0.4) ~ **2**	1.8(0.4) ~ **2**	1.9(0.4) ~ **2**

8.2 Lesbian Relationship

8.2.1 Relationship Length

The mean number of years the women had lived in the relationship they had planned to parent or had been parenting in was **9.2 years** (sd 4.1).

8.2.2 Registered Life Partnerships *(eingetragene Lebenspartnerschaft)*

38% of the lesbians in this study were registered life partners. Of the maximum possible duration of the life partnership of 42 months, the mean duration in this sample was 21.6 months (sd 12).

The largest resonance for not entering a registered partnership had to do with rejection of the law in its form from August 1, 2001. The lesbian mother couples in this study were interested in securing the privileges in return for the responsibilities of marriage, creating a legal relationship between social mother and child(-ren), and securing protection for their lesbian family unit. The Lebenpartnerschaftsgesetz in its form from August 1, 2001 did not fulfill these needs and so many chose not to enter the institution. One fifth of participants rejected the law due to a rejection of the institution of marriage.

8.2.3 Lesbian Divorce/Separation

93% of lesbian couples were still living in the relationship in which they had planned to parent. 7% of couples had since separated from the person they had planned their child with.

Seven children had lesbian parents who had separated. 4 were one year or less (57%), 1 was 3 years old and 2 were 5 years old when their parents separated. The **mean age of the child at separation** was **2.3 years**.

8.2.4 Commitment

99% of respondents considered the lesbian relationship in which they were parenting to be a committed relationship.

The lesbian couples in this sample had engaged in numerous forms of outward signs of commitment, such as, joint purchases and investments (98%), attending occasions together (94%), cohabitating (91%), having children together (88%), making provisions for the welfare of partner in the event of death (75%), joint accounts (69%), celebrations of their relationship, i.e. weddings or anniversary celebrations (74%), and using the same last name (28%). Interestingly, less than one third of couples used the same last name. The number of outward signs of commitment was positively related to relationship longevity. Most women also had made provisions for their partner in the event of their death (78%).

8.2.5 Cohabitation

All of the women live or lived together in a household with the female partner they were parenting with or had planned to parent with. The mean duration of relationship length before cohabitation was 2.0 years (sd 1.9).

8.2.6 Issue of Parenthood

More than half of the lesbian couples in this sample entered into the lesbian relationship in which they are parenting/planning to parent with the topic of parenthood being an issue for one or both of the women from the start (57%). Slightly less than half entered into their future lesbian parenting relationship without parenthood being an issue from the beginning (42%).

8.2.7 Issue of Monogamy

Approximately 4/5 of respondents have exclusively monogamous relationships (84%). The remainder stated that they the agreement they came to with their partner regarding monogamy reflected a mixed form on the continuum between monogamy and totally open relationship (16%). However, in comments describing the arrangement, subjects consistently emphasized the more monogamous nature of their relationship, but that either affairs are theoretically 'allowed' or would not cause the end of the relationship.

8.2.8 Couple Satisfaction

The German translation of *The Dyadic Adjustment Scale* (Spanier '76), Fragebogen *für die Beurteilung Zweierbeziehung* (FBZ) from König-Kuske (1977) adapted by Krüger-Lebos (1996) for use with a lesbian population was used to assess couple satisfaction. (See Table 5.)

Table 5: Scores on the Dyadic Adjustment Scale (Spanier, 1979)

FBZ (DAS)		Point range	Hank et. al. ('90)		My sample:		
M=mean S=standard deviation	Subscale		Klienten M(s)	Zufrieden M(s)	All moms	Bio-mom	Soc-mom
Übereinstimmung	Consensus	0-65	*43 (10)*	50 (6)	50.2(5.8)	49.8(5.7)	50.5(6.0)
*Erfüllung	Satisfaction	**0-(50) 44**	***31 (8)***	**41 (5)**	39.3(4.9)	39.2(4.4)	39.3(5.4)
Zusamenhalt	Cohesion	0-20	*13 (4)*	16 (3)	15.8(3.7)	16.1 (3.9)	15.4 (3.5)
Ausdruck von Gefühlen	Affectional expression	0-12	*6 (2)*	9 (2)	8.0(1.9)	7.9(1.8)	8.0(1.9)
Gesamtwert	total	0-147	*93 (23)*	**115 (12)**	**113.2(13.6)**	113.0(13.2)	113.3(14.0)

All mothers indicated high levels of couple satisfaction in the DAS; the total score (M(s)=113.2(13.6)) as well as the subscale scores were comparable to those subjects who rated their couple relationship as "happy" in Hank et al. (1990).

8.3 Kinderwunsch: Planning

8.3.1 Trigger

Approximately one quarter of the women were unable to identify a single trigger, as the desire to have a child had always been there. Birthmothers were more likely than social mothers to say this. One fifth of participants said their *Kinderwunsch* was triggered by their partner's desire to have a child. Social mothers were more likely to give this response than birthmothers.

Further triggers for contemplating parenthood included pleasure at interacting with other people's children, the relationship to the partner, a desire for family life, discovering the possibility of lesbians having children by meeting other lesbian moms or hearing of their existence and age.

> "[Kinderwunsch] war schon immer da, aber ich dachte als Lesbe kann man sich nur zwischen Partner oder Kind entscheiden."
>
> „Den Wunsch Schwangerschaft zu erleben trage ich schon lange in mir. Durch unsere Liebe wurde der Wunsch nach einem gemeinsamen Kind lebendig."

Most commonly, birth- and social mothers noted that the prospective birthmother of the first DI child was the first to experience the desire to parent (46%) or both mothers experienced the desire to parent simultaneously (37%). It was rarer, however, that the prospective social mother be the first to experience the desire to parent (17%).

8.3.2 Issues in the Decision-Making Process

The lesbian couples in this subject sample discussed a multitude of issues related to parenting and parenthood before initiating DI over the course of a mean of 2.1 years (range 0.2-9.0 years) ranging from general aspects to lesbian-specific aspects of parenthood. The most commonly discussed topics included parenting styles (77%), the issue of bonding for the social mother (77%), the power imbalance between the birth- and social mother roles (61%), the potential effect of family background on prospective parenting (56%), plans for childcare (85%) as well as child custody (75%) should the couple break-up.

Regarding plans for childcare, it was striking how participants stressed the aspects of mutuality and egalitarianism as well as flexibility in their descriptions of their planned childcare model. They expected both mothers to be equally involved in child rearing as well as housework and gainful employment. If the childcare plan included the birthmother taking maternity leave or *Elternzeit*, this led to plans for a temporary traditional division of labor (homemaker/bread winner) during this time. However, the 50:50 model was definitely preferred.

Three quarters of participants had also discussed how they would handle the situation in which the adult relationship ended. Though the legal situation was clear for all at the time of decision-making, namely, that the birthmother would retain sole legal custody of the child and the social mother would have no legal recourse, all responses included intended continued parenting of both mothers. One set of responses indicated internal plans for continued but not otherwise specified plans for "joint custody" (28%) while the other responses resembled custody agreements common to heterosexual divorce (64%), i.e. child lives with birthmother and other parent has visitation rights, contributes child support and continues to be involved in major decisions regarding the child. Almost half of these private agreements were written, often notarized, agreements (42%).

8.3.3 Concerns Related to Parenting

The concerns or worries that the lesbian mothers in this sample endorsed regarding the decision-making process included fears of discrimination or teasing the child might experience due to homophobic attitudes towards parents' lesbianism (76%), concerns regarding the fatherlessness of the child (70%), and concerns regarding the financial resources of the couples (66%). In addition, social mothers worried about the continuity of contact to their child in the event of relationship dissolution (72%).

Potential lack of support from immediate family (37%), friends (30%) or work environments (19%), by contrast, worried respondents less. Additionally, birthmothers were secure in their parenting position; they did not worry about being left with the responsibility of parenting by the social mothers should their relationship end (23%).

8.3.4 Model of Family and Parenting

8.3.4.1 Role Models of Lesbian Parenting

Just over one third of lesbian mothers had to make decisions pertaining to lesbian parenthood in the absence of any role models. These women were more likely to have school

aged children at the time of the study and have used anonymous donors. They are the pioneers of the pioneers.

The other two thirds of lesbian mothers in this sample had models of lesbian parenting available to them at the time of decision-making. Many knew other lesbian–headed families personally or at least through others and the media/Internet. These women were more likely to have children kindergarten age or below.

8.3.4.2 Family Model Aspired to

The women aspired to the two mom-kid family model similar to the heterosexual nuclear family (80%). They were not rejecting the concept of nuclear family but modifying it to encompass their lesbian relationship. There is, however, willingness for extended family networks to include people who may or may not be blood relatives of either mother.

All respondents aspired to the model of equal parenting. None of the subjects aspired to the concept of one parent and one "significant other".

8.3.4.3 Advantages of Lesbian Parenting for Children

The lesbian mothers in this sample listed numerous advantages of being raised in a lesbian family that they saw for their children. First of all, all children conceived by lesbian couples are *Wunschkinder;* they are wanted since their parents chose parenthood after much deliberation and planning. As a result, these children can look forward to much parental attention and love.

> "Es sind Wunschkinder, die geplant und gewollt sind. Diese Kinder werden sicher viel liebe bekommen und gut umsorgt sein."
>
> „Das wichtigste für Kinder ist, dass sie geliebt werden und ohne Vorurteile groß werden."

Since both partners are women, the mothers in this sample felt their children would profit from growing up with egalitarian role models, more democratic family systems and enjoy a more liberal upbringing. Their children would experience more flexibility in division of labor in the parental relationship as well as diverse and strong female role models.

> "[Die Kinder] wachsen sensibler, toleranter und mit starken Frauenbildern auf."
>
> „[Sie lernen] Aufgeschlossenheit gegenüber anderen als das traditionellen Mustern."

Being raised in a lesbian household was also expected to benefit children greatly in the areas of personality development/identity and social competence. The lesbians in this sample

felt their children would be more exposed to diverse types of families, partnerships, ways of life and sexual identity/orientations. As a result, their children would be more tolerant with regards to "differentness," in general, and sexual orientation, in particular, as well as more empathetic and sensitive towards others, more creative in their own life planning, and not assume the entire world is heterosexual.

> "[Sie] erlernen keine Vorurteile gegen Homosexualität (zumindest nicht im Elternhaus)."
>
> „Sie wachsen hoffentlich toleranter auf, sind freier ihr Leben zu gestalten, auch in Bezug auf die Wahl des/r Partners/in."

A minority of the lesbian mothers in this sample perceived no particular differences for their children to being raised by heterosexual parents.

8.3.4.4 Perceived Disadvantages of Lesbian Parenting for Children

The lesbian mothers in this sample had several concerns for future children. Interestingly, none of the major concerns lesbian parents had for their children had to do with the parents' lesbianism per se but rather society's homophobia and heterosexist stance on family.

They voiced concerns regarding society's (non-)acceptance of their families and the possible discrimination their children may face as a result. In particular, participants worried that their children may experience teasing and discrimination themselves and were concerned about how these experiences may impact their child's (emotional) well-being. Participants also discussed consideration of coping mechanisms that could aid their children managing societal homophobia and discrimination. The other big concern the participants voiced had to do with the issue of the 'missing' father/male identification figure: how the child would feel about it one day and what effects it may have on them in the long run.

> "Ob [das Kind] Nachteile haben würde, doch ich war überzeugt dies durch unsere persönlichen Qualitäten ...Wett machen zu können."
>
> „dass es leiden könnte, weil es seinen Vater nicht kennt; dass es in der Schule, etc., ausgelacht werden könnte; dass es zu wenig Kontakt zu nahen männlichen Bezugspersonen haben könnte"
>
> „... Angst, dass wenn ich sterbe, unsere Tochter nicht bei ihrer anderen Mutter bleiben darf."

Finally, some respondents did not see any potential problems for their children.

> "Wenig, wenn Liebe und Zuneigung vorhanden sind."

8.3.5 Deciding Who Will Get Pregnant (First)

The strong desire of one person in the couple to experience pregnancy (74%) and/or no desire of one person to experience pregnancy (59%) were the most decisive factors in deciding who will get pregnant (first). Other factors which played at least an influential role in the decision included age of the women (56%), financial (51%) and job related reasons (51%). For a minority of couples the most decisive factor was a logistical reason: foreigner status of one member of the couple (4%), donor was a relative of one member of the couple (6%), and, due to the inability for the partner to achieve conception, the women had switched roles or simply let chance decide (simultaneous insemination) (16%).

On average, at least a second child was also planned (M(s) =1.1(0.6)). In half the cases the birthmother was planned to bare the next child (57%), while, in the other half, a switch was planned so that the social mother to the firstborn child would become the birthmother to the sibling child (57%).[28]

Most mothers had no preference as to the gender of their first child (62%), but if they did have a preference, it was for a girl (32%). Mothers using known donors were more likely to prefer a girl (46% vs. 17%, $p < .05$), where as mothers using anonymous donors were more likely to not have a preference (78% vs. 51%, $p < .05$). Mothers do not have a sexual orientation preference for their children (98% girl/96% boy). All (100%) mothers unanimously agreed that they will support their child no matter what sexual identity the child develops.

8.3.6 Expectations of Social Mother Role

The majority of social mothers expected their mother role to be equal/the same as that of the biological mother, i.e. primary/shared caregiver, only minus the biological connection similar to an adoptive mother (64%).

Social mothers identified numerous positive aspects of their mother role. Their answers stressed a sense of joy and good fortune at having the opportunity to have a child in their lives, help it grow up and simply being a mother (without giving birth):

> "Das Glück ein Kind zu haben"
>
> "Unser Kind aufwachsen zu sehen und daran beteiligt zu sein".

A common theme was emphasis on the equality of the social mother and biological mother roles, especially through the eyes of the joint child:

[28] Some mothers planned more than 1 sibling child.

> "Alles, weil ich mich als vollwertiges Elternteil betrachte und das Kind auch mein Wunschkind ist."
> "[Ich] habe keinen Unterschied zwischen den beiden Elternrollen gesehen."
> "Es ist völlig normal für unsere Kinder zwei Mütter zu haben…wir sind für unsere Kinder beide starke Bezugspersonen."

Social mothers also looked forward to experiences that being a mother would open them up to:

> "die sehr enge Bindung"
> "die Welt mal wieder mit anderen Augen sehen"

One mother summed up her experiences:

> "Ich habe wieder das Staunen gelernt und Freude daran, zu sehen, wie viel Positives so ein kleines Geschöpf ausstrahlen kann."

Nonetheless, social mothers were able to identify anticipated challenging aspects of their mother role. Lack of legal standing and social recognition top the list of negative aspects of the social mother role. Social mothers do not have a legal leg to stand on; They're not on the birth certificate and they fear loosing their child in the event of relationship dissolution with the biological mother or her death since, legally, they are "biological strangers" to the child. They lack social recognition from the outside world. Social mothers feel they must explain their role or 'prove' themselves as mothers. Some are concerned with experiencing jealousy or competition with the biological mother and/or father, if known and involved, and fear being over gone in decisions regarding the joint child. The other major negative aspect includes bonding issues. Some social mothers questioned whether their child would accept and recognize them as a mother or whether the baby would have a stronger bond to the biological mother and she would be 'left out'. Another concern noted by the social mothers was surviving puberty or, due to age, of being available to the child in those turbulent years. Still other mothers felt there were no negative aspects or problems inherent to the social mother role.

8.3.7 Terminology/Issue of What to Call the Mothers

The lesbian mothers in this sample had given the terminology for the mothers, particularly the social mother, a lot of thought. Respondents indicated that the name for each mother should (1) differentiate between them and (2) reflect the respective roles. Most respondents felt it was important to have the names reflect both women's roles as "mother"

and the terms were chosen to signal equality of the mother roles both within the family, but also for the outside world. All names, with the exception of first name and nickname usage, make the "mother" status of each mother role transparent to the outside world.

Popular combinations of names for the two mothers were "Mama-Mami". Mothers using anonymous donors were more likely to use "Mama" for the biological mother and "Mami" for the social mother. Mothers using identity-release donors were more likely to do the reverse. Mothers using known donors were more likely to name the biological mother "Mama", but there was no clear pattern for the name of the social mother.

The names the mothers gave themselves were chosen based on what they had called their own mothers, personal preference and what children generally call their mothers (in that area or where the mother grew up).

8.3.8 Thoughts Regarding Methods of Becoming a Parent

The method of parenting via conception was primarily chosen due to a desire to experience pregnancy and childbirth (76%) as well as to raise a newborn baby (64%). Mothers also saw a lack of adoption alternatives for themselves (38%).

Of all the alternative methods to becoming a parent, the subjects in this sample only pursued conception via DI with sperm from a sperm bank (67%) or known donor (60%) very actively. Interestingly, women who inseminated with known donors did not actively look into the option of inseminating with frozen donor sperm before deciding against it (80%). In contrast, women who eventually opted for a frozen sperm donor also pursued the known donor option actively (39%). Insemination with a go-between (8%) was less common.

Adoption (8%) was less commonly considered though respondents may have shied away from this option due to a perceived or real lack of adoptive alternatives and concerns over multiple oppression for the child. Sexual contact (2%) and foster parenting (6%), however, received little to no consideration as a method of becoming a parent for the lesbians in this sample.

The mothers preferred DI over heterosexual contact as a means of achieving conception because they didn't want to violate their (monogamous) relationship boundaries (71%) and, as lesbians, rejected the idea of sexual relations with a man (63%). Some also rejected it because they preferred not to know the biological father of their child (16%).

Resources

The resources that subjects found <u>helpful in planning to become a parent</u> were:

books/journals/media (86%), other lesbian parents and parenting groups (61%), sperm banks/clinics (53%), organizations lobbying for LGBT interests (44%), *Kinderwunsch* groups (44%), and others, who supported them in their plans (39%). However, not all women had access to these resources. For example, mothers using frozen sperm donors had more support from sperm banks and clinics. In particular, mothers whose first child was of school age + at the time of the study had the least overall amount of resources at their disposal in the planning stage of any cohort, but predominantly in terms of personal support and role models for their family form. They were the pioneers of the pioneers. Their principle resources were books and journals. (Internet was not it wide spread use until after 1996/1997.)

The most important sources of information on how to conceive with DI included books/journals (56%), friends (53%), and Internet (32%). Other sources, that were less commonly used by women in this sample, included physician (15%), lesbian mother groups/conferences, i.e. LFT (Lesbenfrühlingstreffen), ILSE/LSVD (13%), women's health or family counseling centers (10%), i.e. FFGZ Berlin and ProFamilia, and midwife (3%).

Obstacles

There were numerous obstacles to the women's plans to parent to be overcome. The most commonly anticipated difficulties had to do with DI and donor type.

Mothers using anonymous donors expected problems finding a physician/clinic that will inseminate lesbian identified women (74%), gaining access to sperm banks (48%), and the cost of sperm and insemination (44%).

Mothers using identity-release donors anticipated problems in gaining access to sperm banks and identity-release donors (68%), storing sperm (55%), and finding a doctor that would inseminate them (45%).

Mothers using known donors expected difficulties finding a donor who would agree to their idea of his role in their family (87%).

Only 3 of 105 subjects anticipated no problems with DI.

8.3.9 Donor Characteristics

Overall, the only donor attributes considered 'important' by the lesbian mothers in this sample were education level (years in college, 74%), skin tone (67%) and ethnicity (48%).

The remaining donor characteristics were considered less important in the following descending order: weight (34%), hair color/type (33%), height (30%), body build (29%),

occupation (26%), eye color (24%), special interests (15%), blood type (14%), and religion (4%) of the donor. Interestingly, although all of these characteristics were rated unimportant in a donor, physical, and therefore, inheritable attributes, were ranked higher than social characteristics, i.e. occupation, special interests or religion. However, 'hair and eye color' were rated more important by anonymous donor mothers than known donor mothers (55% vs. 11%, respectively, $p < .05$). Also, 'skin tone' was rated 'important' by anonymous and identity-release mothers, but not by known donor mothers (72% and 88%, respectively, vs. 52%, $p < .05$). In contrast, known donor mothers rated 'special interests' more important than the other mothers (39% vs. 5% and 11%, $p < .05$).

Only, 27 women in this sample felt they had adequate knowledge of their sperm donor, either because they knew their donor personally (known donor), had been given detailed information or did not want to know much anyway (frozen sperm donors). Many respondents were interested in additional information about their donor, such as, health history/allergies, the donor's motivation, and the donor's facial appearance/ (childhood) picture.

8.3.10 Men in Children's Lives

Contrary to stereotypes of lesbian women as "man-haters", anti-male sentiment was not evident in this population. In fact, almost all lesbian mothers (93%) in this sample felt it was important for their children to be exposed to and accustomed to dealing with all kinds of people, men and women. It is important to include men in children's lives because:

> "Männer zum Leben gehören und das Kind beides kennen und mögen sollte"
> „mein Kind ein Mann wird"
> „[die Männer] die Hälfte der Gesellschaft bilden und manches anders sehen, anders damit umgehen, was Frauen nicht vermitteln können"
> „[das Kind]alle ‚Arten' von Menschen kennen lernen sollte"

Over half had plans for particular men to play a special role in their child's life (58%). Particularly mothers using known donors had been able concretize this by planning for the donor to have contact to the child. These plans ranged from him having a social father ("papa") role to a role as "uncle" or family friend. Mothers using unknown (anonymous and identity-release) donors had plans for non-related men to be in their child's life, though these plans were more hopes or implicit expectations; They planned to include men in their family by asking a close male friend to be the child's godfather (a role with social implications in German society). In cases were the mothers had made no special plans for male involvement,

it was because, since men are part of everyday life, these mothers felt that their children would have sufficient contact with them.

8.3.11 Attitudes towards "Father"

Mothers agreed that establishing paternity is not the only criteria a man has to fulfill in order to be considered a father (95%). Social aspects, such as, being an attachment figure, taking responsibility for the child and looking after him/her are what make a man a *true* father (87%). The mothers also agreed that mentors and role models to their children do not have to be biologically related to them, that is, it is not imperative that the biological father be the male role model (99%).

Mothers using known donors and identity-release donors felt more strongly that children have a right to know their biological father (90% and 96%, respectively, vs.67%, $p < .05$), agreed more with the idea that not knowing him is damaging to the child (63% and 43%, respectively, vs. 2%, $p < .05$) and agreed less with the belief it is acceptable to bring children into the world when they will not know him than mothers using anonymous donors (74% and 67%, respectively, vs. 91%). These mothers felt that the desire to know one's biological father is more a true biological desire to know one's origins (54% and 46%, respectively, vs. 36%, $p < .05$) rather than a being a result of social pressure making people feel not whole it they don't (46% and 57%, respectively, vs. 64%, $p < .05$).

Mothers using anonymous donors saw less of an imperative for children to know their biological father (67%), disagreed the most with the idea that not knowing him could be damaging to the child (98%) and agreed most with the belief it is acceptable to bring children into the world when they will not know the biological father (91% vs. 67% for identity-release and 74% for known donor, $p < .05$). These mother's held the belief that the desire to know one's biological father is a result of social pressure making people feel not whole if they don't (64% vs. 46% for known donor, $p < .05$) rather than a being true biological desire to know one's origins (36%).

8.3.12 Donor Choice

Donor Choice is made by weighing out the positive aspects against the negative aspects of each donor type. All mothers saw many positives as well as negatives to their donor type choice, but the positives outweighed the negatives for the choice they made. Availability was a modifying factor in this decision-making process as not all mothers had access to all donor types at the time they were choosing their donor.

8.3.12.1 Unknown Frozen Sperm Donor: Anonymous Donor

Mothers who used anonymous donors did not have a free choice between anonymous and identity-release donors; They only had access to anonymous donors (95%) and may have made a choice partly or entirely based on availability. Nonetheless, they named numerous positive aspects to this donor type that made them decide to use it. Mothers who used anonymous donors found the safety aspect due to screening procedures (95%) and the protection it provided for family boundaries (79%) to be key positive aspects of this donor type choice. They did, however, have concerns over the child never being able to known the identity of the donor (71%) and the child possibly resenting this in the future (40%), as well as concerns over the lower pregnancy rate with frozen sperm (45%) and its cost (33%).

Women with kindergarten or school aged children were more likely to get sperm via the medical professional/clinic which performed the insemination. Women with younger children were more likely to get their sperm directly from the sperm bank in the Netherlands and, more recently, Denmark. Both countries have non-discriminatory policies towards inseminating lesbian women.

Women who got their sperm directly from the sperm bank either had it sent by courier to them at home (41%), to a doctor's office (35%) or picked it up personally (35%). The sperm was then stored at the doctor's office (47%), at home (37%), or in the clinic which inseminated (21%).

Inseminating with an anonymous frozen donor most often went hand in hand with clinical insemination (90%). Fewer women with anonymous donors self-inseminated (22%). These results suggest that some women tried both methods of insemination.

Only one fifth of women using anonymous donors had any input regarding their donor. Primarily, the experience was that the medical personnel at the clinic doing the insemination (46%) or the sperm bank (22%) selected the donor. When the mothers had any input in the donor profile, they most often choose to match the donor to the social mother.

Mothers using anonymous donors had very little (60%) or no information (40%) regarding their donors. If they had non-identifying information it usually included physical characteristics (57%) and/or educational level (48%) of the donor. If they could choose, however, one third of mothers who used anonymous donors would want non-identifying information about their donor while two thirds would not. Also, one quarter of mothers who used anonymous donors would prefer for the donor's identity to be available to the child if they could choose while three quarters would not.

About half the responding women who used anonymous donors said they had no internal image of their donor. The remainder did and their image was often based on the physical characteristics of the child, the social mother, a known description of the donor's appearance or based on where the donor is from. Otherwise, internal images included socially desirable characteristics in men, such as, tall, handsome, athletic and nice.

Most women were content not to have met the sperm donor of their child (88%). A minority would have like to meet him (n=5) either before the insemination (n=2), during pregnancy (n=1), or within a year of delivery (n=1). Nonetheless, most women wished their child could meet his/her sperm donor, if the child so wishes (88%).

8.3.12.2 Unknown Frozen Sperm Donor: Identity-Release Donor

Mothers who chose identity-release donors could choose freely between anonymous and identity-release donors (91%); They had access to both types of donors and made a choice based on free will that was not mediated by availability. Mothers who used identity-release donors found the safety aspect (91%), eventual access to the donor's identity for the child (86%), the prospect of siblings being able to have the same donor (59%) and the protection it provided for family boundaries (59%) to be key positive aspects of this donor type choice. They did, however, have concerns over the lower pregnancy rate with frozen sperm (43%), whether the identity release will truly work (38%) and worried that the child could build up an unrealistic image of the donor that could shatter when meeting the real person (38%). Interestingly, mothers with this donor type worried less about raising their child to adulthood in father absence (24%) than mothers using anonymous donors (71%).

The donor's identity will be released to the child only (91%) if the child expresses interest in obtaining the information and has reached a specified age, usually 18 but in some cases 16 years or younger. The information regarding the donor's identity is stored by the sperm bank/clinic itself, at a notary/lawyer, or a *Stiftung*.

In about half the cases, the mothers were certain they would have access to the donor's identity in any case (55%). About one third of mothers were uncertain whether the donor would be consulted again or if they could count on gaining access to their donor's identity (36%). Only one couple knew that the donor would have to agree to having his identity released when the child reached the necessary age.

The majority of mothers who inseminated with identity-release donors got their sperm from the Netherlands (71%). However, due to recent donor policy changes in Holland, German lesbians no longer have access to this donor type from Dutch clinics. To the author's

knowledge, the only country which, at the time of this writing, has identity-release donors that German women can access is the USA (29%).

Mothers who used identity-release donors got their sperm directly from the sperm bank. Some had it sent to them or a doctor's office (36%), but over half picked it up personally (59%). The women stored the sperm at their home (45%) or at a doctor's office (41%), or at the sperm bank that inseminated (27%).

The women with identity-release donors often inseminated in medical environments (68%) but also utilized self-insemination (50%)[29]. Compared to mothers using anonymous donors, mothers using identity-release donors were less likely to have a clinical insemination and more likely to self-inseminate.

Approximately one third of women using identity-release donors had input regarding the donor (29%). The rest, however, did not (71%). They had their donor picked by someone at the sperm bank (52%), or, in a few cases, the medical professional at the clinic (19%) chose the donor. In contrast to women using anonymous donors, women using identity-release donors were less likely to have their donor picked by a medical professional doing the insemination and more likely to have it picked by a person at the sperm bank. Two thirds of mothers using identity-release donors had non-identifying information regarding their donors (64%). If they had information it usually included physical characteristics (59%), educational level (45%), hobbies/interests (36%) and personality description (32%) of the donor.

Over half of the responding women who used identity-release donors said they had no internal image of their donor (60%). Women who indicated having an internal image of the donor described socially desirable characteristics in men, such as, tall, nice and friendly, and images based on knowledge of where the donor is from, i.e. The Netherlands. Two thirds of mothers via identity-release donors were content not to have met the sperm donor (64%). One third, however, would have liked to (36%) at no particular point in time, but to say 'thank you'. Most of the mothers wish their child could meet his/her donor, if the child so wishes (80%).

8.3.12.3 Fresh Sperm Donor: Known Donor

The major incentive for mothers to choose a known donor to conceive their child was that the child may know its biological father (92%). Other positive aspects which were

[29] The women may have tried more than one method of insemination.

considered important included the idea that sibling children may have the same biological father (64%), the donor may be potentially involved in the child's life (56%), the parents can provide the child with information about its donor (54%), pregnancy rates are higher for fresh sperm than frozen sperm (56%), and the sperm is usually for free (51%). They did, however, perceive risks for their family with a known donor: Most women endorsed concerns that the donor may want to be more or less involved with the child and/or family than original agreements planned for (79%) and that he could sue for custody or assert paternal rights (53%). Having an identifiable (biological) father also calls the role of the social mother as a parent into question (53%).

The mothers accessed diverse channels to find a man interested in becoming a known donor to their child. To get the word out that they are looking for a donor, they asked men they knew if they would like to be a donor (53%), spread the word in their friendship networks (32%), and advertised in the general media (24%), gay magazines (8%) as well as the Internet (16%), and "Queer & Kids" (5%). These avenues led the women to their eventual donor.

The known donors were most commonly gay male friends (36%) or a man, previously unknown to the couple, who responded to their ad (26%) or who was introduced to them by a common acquaintance (21%). Less common were donors who were a heterosexual friend to the couple (8%), a relative of the social mother (10%), or introduced via the service "Queer & Kids" (3%).

The majority of mothers communicated directly with their (potential) donor (85%). A minority of women initially intended for the donor to be unknown to them and therefore communicated via a go-between (6%).

The key criteria for donor selection was the donor's willingness to accept and agree to the model of family the lesbian couple aspired to as well as his role as a known donor in it (87%). The donor's health (61%) and willingness to undergo health screening (53%), the donor's personality (50%) and intelligence (41%) were important as well. In contrast, physical attributes (11%) and occupation (5%) were considered less important. The women who asked their donor to undergo health screening had him tested for HIV (77%), Hepatitis B (46%), and, less commonly, a semen evaluation (38%). In comparison to frozen sperm donors, for whom matching was an issue, compatibility stood at the forefront of the known donor selection:

> "Es war wichtig, dass ich ihn mag und sympathisch finde. Außerdem....können [wir] uns vorstellen, ein Leben lang mit ihm in Verbindung zu stehen (was wir wohl werden...)".

Most women perceived their donor's motivation to be related to the donor's own *Kinderwunsch* and his perception of this constellation being an opportunity to become a father as a gay man without having to take on the full responsibility of fatherhood (60%). Some donor's motivation was perceived to be a desire to help the lesbian couple fulfill their wish to become parents (14%) or to express solidarity with lesbians (9%).

From a legal perspective, the birthmother will have sole legal custody of the child (97%), only her name will appear on the birth certificate (82%), and the child will have her last name (85%), or, less commonly, the social mother's last name (10%, due to LPartG). Nonetheless, one fifth of mothers indicated that the donor's name will appear on the birth certificate (18%) whereas it was planned that the child carry the donor's last name only in one case.

The family concept of women who conceived via known donors included the birthmother (100%) and the social mother (97%) as designated parents whereas the donor was less commonly considered a 'parent' (18%). It was planned that the ensuing child refer to his/her donor by first name (76%) when speaking about him. A few women wanted to leave it up to their child to decide this (19%, n=7) or expected the child to call him "Papa" (19%, n=7).

The role expected to be filled by the donor in the lesbian family unit was either 'no role' (36%) or that of 'family friend' (28%), 'uncle' (25%) and social father/"papa" (25%).[30] Recipient-donor agreements regarding donor involvement were reflective of this diversity, though the numbers diverged a bit. Almost half of the sample did not plan to have contact to the donor, unless or until the child requested it (43%). One third of the sample had plans for occasional contact (32%), i.e. 1-2 a year, or per phone or postcards, while a minority of mothers planned for the donor to have 'regular' contact (19%), defined as meeting 1 or more times a month.

In most cases, it was <u>not</u> planned for the donor to have financial responsibilities towards the child (85%), or decision-making power (77%), or childcare responsibilities (62%). Conversely, 6 women indicated that their donor contributes a small sum financially, and 4 women indicated that their donor was involved in 'big decisions' such as choice of school. The arena donors were most expected to contribute to was childcare (30%). Eight women

[30] The conceptualization of the donor may not be so clear cut for these women in the planning phase as there are discrepancies between questions which measures similar features of the donor role. Of particular interest, is the degree to which the donor is expected to be a social father as well as a biological father. For example, 18% identified the donor as a designated parent, as well as intend for the child to refer to him as "papa", and have the donor's name on their child's birth certificate. However, 25% respond that the donor is expected to fulfill the role of social father/"papa" in their lesbian family. In contrast, only four women had described plans for their donor to have a degree of involvement reflective of a social father role.

described childcare arrangements classified as 'babysitting' whereas four women described shared childcare arrangements, such as, caring for the child once a week, every second weekend, and vacations (when its old enough).

The issue of what information the lesbian family and the donor are free to reveal to others was left pretty open. Most had left it to each other's discretion what information was to be discussed with others (64% and 62%, respectively). Those that had specific agreements regarding this issue (15% and 22%, respectively) agreed to reveal vague or little information: anything but their names or only that he is the biological father.

Most mothers generally reported needing little negotiation to define the donor's role (64%). Others indicated that they felt it took a lot (26%) or that they're still negotiating and conceptualize this as an ongoing process (31%). A little more than half of the women had come up with specific agreements with the donor regarding the future should the birthmother die or the lesbian couple divorce (56%). These agreements tended to be oral (77%) with one quarter of women having a written donor-recipient agreement (23%). Most women had not made plans with the donor as to how they intended to handle any changes in the way the parties felt (87%). Five women indicated that their plans were to solve problems amongst themselves by being open for discussion and searching for mutually acceptable solutions to problems:

> "Es muss bei einer veränderten emotionalen Lage neu ausgehandelt werden, wie es weiter gehen soll."
>
> "Wir werden es besprechen und versuchen, zu einer für alle stimmigen Lösung zu kommen."

8.3.13 Social Support

Overall, the mothers perceived support for their plans to become parents via DI (M=2.6). The first mothers (of school aged children, M=2.1 'not very supported') perceived the least amount of social support for their plans to parent while the most recent group of prospective mothers (insemination/pregnancy phase, M=3.0, 'very supported') experienced the most, lending support to the idea that, as lesbian-headed families become more common, prospective parents may receive more social support. Mothers identified friends (M=3.7) and the participant's community (M=3.4) as strong sources of support. Generally, both mothers' families of origin were supportive, but families of birthmothers (M=3.3 'strongly agree') were more supportive than those of social mothers (M=3.1 'agree').

The women described themselves as relatively inactive (mean score <2.5) in the LG 'scene' (M=2.1) and lesbian mother groups (M=2.3). However, mothers of school (M=2.8)

and kindergarten aged children (M=2.5) described themselves as active (mean score >2.5) in groups for lesbian mothers. Many mothers had contact to other lesbian mothers at least once a month (42%), or at least once every three months (25%) and some, even weekly (18%). Nonetheless, nearly three quarters of the sample would like more contact with other lesbian-headed families (72%). Only one quarter feels they have satisfactory contacts to other, like families (28%).

8.3.14 Impact of Plans to Parent

Most mothers experienced an increase in their sense of well-being due to the decision to parent (64%). This effect was stronger for birthmothers whereas some social mothers experienced a decrease in the sense of well-being (17%). The decision-making and planning process was perceived as having had either a positive effect (59%) or no effect (42%) on the partner relationship. During the planning phase, partnership satisfaction was rated high (M=3.7 ‘very satisfied’) while intimacy and conflict frequency was not impacted (M=3.2 and 2.9, respectively, ‘average for us’) by the decision-making process.

9.0 Discussion

9.1 Sample

The lesbian DI mothers in this sample shared several demographic characteristics with planned lesbian mother populations in studies conducted in other countries, such as, USA, Canada, UK, New Zealand, The Netherlands and Belgium. Strikingly similar is their high socio-economic status (university level degrees), division of childcare/gainful employment (egalitarian division of labor but birthmothers do slightly more childcare whereas social mothers work slightly more out of house), strong lesbian identity (high levels of outing behavior, low levels of internalized homophobia), and lengthy, committed and monogamous relationships, and tendency towards urbanization. The sample was also similar to other research with respect to the high participation rate (84%) of lesbian mothers, which has been repeatedly commented on in research on families created by DI (Bos et al. 2003, Brewaeys et al. 1993, Brewaeys et al. 1997, Jacob et al. 1999, Scheib et al. 2000, Scheib et al. 2003, Vanfraussen et al. 2001, Wendland et al. 1996).

This sample was, however, unique to other samples in that, despite being a predominantly German sample, one fifth of the respondents identified their family as bicultural and one tenth as bilingual. Interestingly, none of the 'foreign' women were members of the major cultural minorities in Germany but were all from 'western' countries, i.e. European nations, the United States or Israel. This is pertinent because being from a 'western' nation positively influences these women's social status as a 'foreigner' in Germany and may increase access to resources, i.e. education level and resident permit status, which, in turns influences employment opportunities, etc..

Also, although the majority of parents neither had a religious affiliation, nor participated in religious activity, nor considered it important to their lives, a surprisingly large number of children (ca. 1/3) had been initiated into organized religion via baptism or christening. The lack of interest in organized religion is easily explained by sexist, heterosexist and homophobic attitudes propagated by the Pope and other important Church officials.[31] Against this backdrop, it is seemingly paradox that lesbian parents initiate their children into the church. One explanation may be that parents decide, though organized religion is not for them, they want their children at least exposed to this aspect of society. Another explanation

[31] The Church may, by law, discriminate based on religion and sexual orientation with respect to employees of organizations it funds. An example of this is the fact that, if an employee of a Catholic Church funded organization enters a life partnership under the LPartG, the Church may fire that employee.

may be that parents want to diminish their child's dissimilarity from children of heterosexuals by having the child at least baptized or christened.[32] A further alternative explanation could be that parents found that baptism was a way to celebrate their baby and elicit the support their families of origin and friends.

Lastly, Germany has a unique national history in that the country was divided into two countries - East Germany was communist and West Germany was social democratic - for 41 years and then reunited in 1990. The women who lived in the 'new' states were underrepresented in this study (n=4) so that no information can be derived about how this special background (of being raised in a communist country) may have influenced lesbian identity and family planning for this sub-population.

9.2 Family Planning in LDI Families

This study aimed to systematically describe the **process of family planning** in lesbians planning to parent via donor insemination in Germany, to assess the issues pertinent to each **mother role** and those involved in **donor type choice**.

The process of planning a lesbian-headed family is, in many ways, unique to this family form. First of all, each woman has to successfully **come-out** and develop a positive self-identity as a lesbian. The women in this study generally achieved this milestone by their early to mid twenties. Similar to other studies (Baetens et a., 2002; Dundas & Kaufmann, 2000; Gartrell et al., 1996; McCandlish, 1987), this sample of lesbian mothers described high levels of outing behavior and scored low on an internalized homophobia scale attesting to a positive lesbian self-identity. It is possible that lesbian women with high internalized homophobia are less likely to consciously choose to have children because they would not have the emotional resources to work through internalized homophobic messages about lesbian parenting in order to come to a positive decision for children. However, lesbian women with positive self-identities obviously cope effectively, and they would be able to pass on these skills to their children and may seek out more positive reinforcing environments so that they may be more likely to decide to have children.

Although ¾ of the women had been involved in heterosexual relationships in the past, they all choose to parent in their long term **lesbian relationship**. Dyadic adjustment of the sample was comparable to the norms for satisfactorily married couples in Hank et al. (1990). Their relationships were characterized by high levels of perceived commitment and outward

[32] It may become an issue when children enter school with respect to which religion class they will attend.

signs of commitment to their partner. In fact, the trigger for their *Kinderwunsch* often grew out of the relationship itself. The partners felt they had found the person they want to be with and have a family with. The decision to parent together was, however, a process which took an average of 2 years to complete in order to come to the positive conclusion to parent (together) and to work out the logistics for realizing this dream together. Baetens et al. (2002), Jacob (1997), Jacob et al. (1999) and Wendland et al. (1996) also report long periods of reflection and deliberation before beginning the first cycle of insemination ranging from several months to several years.

The **decision-making process** itself included working through issues that are common to the decision of parenting which are shared by heterosexual couples if they plan becoming parents. There are, however, aspects to this process which are not shared by heterosexual couples, even if they plan becoming parents. These are indeed lesbian specific aspects:

- Lesbian women must actively confront (internalized) societal taboos of lesbians and gays having children and develop strategies for handling homophobia.
- Lesbian women must develop a positive attitude towards a lesbian-headed family.
- In the absence of or outside of legally sanctioned relationships, women planning to parent in lesbian relationships consider the event of relationship dissolution or death of the birthmother for both the social mother and the child.
- The lesbian couple must decide what model of family they intend to build.
- In the absence of traditionally defined roles, the lesbian couple must negotiate and define the birth and social mother roles for their family.
- In the absence of traditional terminology for the birth and social mothers, the lesbian couple must decide what they want the child to call them.
- Lesbian women must decide on the method by which they want to become parents.
- If a lesbian couple decides to become parents by conception, then they must negotiate which of the women will conceive (first).

- Another decision to be made regards that of donor type choice, i.e. how to get sperm and to what degree the male it stems from should be known to and involved in the life of the lesbian couple and child.
- Prospective lesbian parents must decide if, to what degree and in what way they intend to include men in their child's lives.
- In contrast to heterosexual family planning, lesbian prospective parents are choosing a non-normative path and, correspondingly, are faced with the issues of resources, challenges and support.

Lesbian women must actively confront (internalized) societal taboos of lesbians and gays having children and develop strategies for handling homophobia. Prejudiced ideas regarding the (lesbian) mothers discussed in research include assumptions that lesbian mothers are prone to psychological disorder and are not maternal (Brewaeys et. al. 1997a, Baetens & Brewaeys 2001, Jacob 1995, Kershaw 2000). As for their children, homophobic fears, that may even persist today, include ideas that children of lesbians may be more likely to become gay themselves (ibid), and more likely to be teased and ostracized by peers, which would negatively impact their social and emotional development (Brewaeys et. al. 1997a, Baetens & Brewaeys 2001, Kershaw 2000). Though psychosocial research has consistently unmasked these ideas as prejudice and not reflective of reality, the transfer of this knowledge to the judicial-social sector has not been as successful.

As lesbians are also socialized in our society, they may discover that they too have some deep rooted concerns about raising children as lesbians in non-traditional families or difficulties feeling that their *Kinderwunsch* is legitimate. It is probable that, in order to come to a positive decision for a child, the lesbian couple will need to work through these doubts and concerns in a manner similar to a coming-out. Books on lesbians having children, appropriate sites in the Internet and connecting with other lesbians with *Kinderwunsch* or lesbian families can be instrumental in this process. Some of these concerns will not only be due to faulty reasoning or internalized prejudice but based on realistic assessment of the situation. In these cases, fears may not 'go away' but the couple can prepare mentally to handle them, i.e. develop coping strategies.

The lesbian mothers in this sample had several concerns regarding their children. Interestingly, none of the major concerns lesbian parents had for their children had to do with the parents' lesbianism per se but rather society's homophobia and heterosexist stance on family. They voiced concerns regarding society's (non-)acceptance of their families and how

this would affect their children. In particular, participants worried about their children experiencing teasing and discrimination themselves and the potential impact this may have on their child's (emotional) well-being. This is the number one concern of lesbian parents reported in other studies as well (Dundas & Kaufmann, 2000; Gartrell et al., 1996, 1999, 2000; Jiles, 1999; Johnson & O'Connor, 2002; Steeno, 1997). The women in this sample planned to equip their children with coping strategies for managing societal homophobia and discrimination, by **instilling pride**, i.e. supporting positive interpretations of their family, **normalizing**, i.e. interacting with other rainbow families, and **valuing diversity**, i.e. stressing values such as tolerance and acceptance of difference in the family. Other coping strategies that have been reported included (1) conscious, informed parenting (Jiles, 1999), i.e. being active in the child's school environment (Mercier, 1999; Steeno, 1997), preparing the child to respond to homophobic comments through role-playing (Curry, 1999; Gartrell et al., 2000), choosing accepting school environments (Gartrell et al., 1999) and (2) building self-esteem in children by modeling pride, honesty about self, maintaining open communication with their child (Gartrell et al,. 1996).

The other major concern mothers had with raising a child in a lesbian home had to do with father/male identification figure absence. This is also a consistently reported concern of lesbian and gay parents (Johnson & O'Connor, 2002; Leiblum et al., 1995). Martin (1995) asks, "As lesbians considering parenthood, many of us are concerned about our responsibility to our children to ensure they know their biological father. Is there a moral imperative that if you choose to become pregnant and bare a child, you must provide your child with information about his/her father? For many lesbians considering parenthood, this is an emotionally charged and morally challenging issue." It may be the reason that lesbian mothers consistently place such emphasis on including men in children's lives and may be a motivator to pursue insemination with a known donor. However, Brewaeys et al. (1997) and Rauchfleisch (1999) found that research was not able to support negative outcomes for children raised in father absence. It is probable that research on LDI families may shed more light on the issue of father absence.

One issue that the women in this sample did NOT worry about was the future sexual orientation of their child. All mothers reported plans to be supportive of the child irrespective of its future sexual orientation. This result is very consistent with other literature (Gartrell et al., 1999; Gartrell et al., 2000; Jiles, 1999). In fact, this openness towards sexual orientation of the child is interpreted by the author as an advantage of lesbian parenting for future offspring. It probably also sets them apart from mainstream parents.

Lesbian women must develop a positive attitude towards a lesbian-headed family. Due to the structural difference of lesbian-headed families from "traditional" families, they tend to be observed from a deficiency perspective so that the goal becomes 'proving' that lesbian families can 'measure up' and one looses site of the positive potential that lies within this alternative family structure (Jacob, 1995; Thompson, 2002).

The lesbian women in this study saw many important potential advantages for children being raised in a non-traditional, lesbian-headed family, such as, their 'wantedness', exposure to egalitarian systems, higher social competence, and more tolerance towards others. Johnson & O'Connor (2002) also reported their sample naming the same advantages: their children would be more tolerant of others and, since parents had to go through so much to have their child, that made them more appreciative and loving parents. Positive effects of egalitarian division of labor in lesbian households on parent's relationship satisfaction is well documented (Bos et al. 2004, Jacob 1997, Krüger-Lebus & Rauchfleisch 1999, Patterson 1995, 1996) and resultant positive effects on children's adjustment have also been reported (Patterson 1995).

In the absence of or outside of legally sanctioned relationships, women planning to parent in lesbian relationships consider the event of relationship dissolution or death of the birthmother for both the social mother and the child. They provide for these situations by discussing them during the planning phase, and by composing legal documents to document their original intent since the social mother would have no legal recourse in those cases.

This aspect sets lesbians apart from heterosexual couples planning children. Most lesbian couples discussed plans should the couple's relationship end (Curry, 1999; Dundas & Kaufmann, 2000; McCandlish, 1987; Wendland et al., 1996) where as most heterosexually married couples did not (Wendland et al., 1996). This is a necessary step for lesbian couples whose break up would be outside of any kind of regulating system, i.e. courts, in the case of unsettleable differences. It makes good common sense to prepare for a potentially difficult situation at a time when the couple is getting along well.

Also, the availability of some form of second-parent-adoption for LDI children is really important to secure the continuity of the child's relationship to *both* parents in the case of relationship dissolution and to the social parent in the event of the birthmother's passing. The positive influence of second parent adoption is well documented (Gartrell et al.1999, Gartrell

et al. 2000, McClellan 2001) and it has been found to increase the likelihood of shared custody after a break up (Gartrell et al. 2000). Nearly 2/3 of women in this German sample indicated that they intended for the birthmother to have custody and the social mother have visitation rights in the event of relationship dissolution. The women indicated this before 'stepparent' adoption for same sex couples was introduced in Germany. It is possible that, in the meantime, many of the social mothers are now adoptive mothers and would answer this question differently once their parenting status is legally recognized. It is possible that equal mother status legitimizes the demand for shared custody.

The lesbian couple must decide what model of family they intend to build. The dominant model of family in this sample was the two parent (nuclear) family consisting of birthmother, social mother and child. Often a sibling child was also planned. In light of climbing divorce rates, there has been a lot of talk about the 'break down of the family' and, in the USA, one recurring argument *against* 'gay marriage' is that affording gay and lesbian couples the same rights as heterosexual couples would somehow foster this process. In light of this sample, one can only conclude that lesbian parents are not rejecting the nuclear family, but simply modifying it to include their lesbian relationships. However, Muzio (1993) argues that the 'problem' is more that patriarchy feels threatened by these women who live (and reproduce) outside of a male defined system, "The threat that lesbian mothers represent to this patriarchal rule of the father is self-evident in that they circumvent the traditional genealogical order (p. 216)....The fact of alternative insemination...turns the patriarchal order on its ear... Lesbian couples are not dependent upon a phallically-based relationship to give them sexual pleasure, personal identity, or ...their children. They live in the shadow of the dominant order and therein lies the source of both their opportunity and their oppression."(p. 217). This author's experience is that, although lesbian parenting contains a lot of radical feminist potential, lesbian mothers consider theirs very normal, ordinary families.

In the absence of traditionally defined roles, the lesbian couple must negotiate and define the birth and social mother roles for their family. This aspect refers to the second aim of this study – to assess issues pertinent to each mother role.

The parents in this sample aspired to equal parenting of the birth and social mother in decision-making power and involved childcare, which was reflected in terminology chosen to denote the mothers. All social mothers expected to be a primary or secondary caretaker, while none expected not to take on a parenting role. Social mothers in this study also looked

forwarded to becoming a parent and raising a child with their partner without having to go through pregnancy and birth themselves. Social mothers were concerned with (a lack of) social recognition from the outside world, and whether the child would accept them as a mother. The women acknowledged the power differential between the mother roles due to biological and legal asymmetrical parenting.

The discussion of mother role often centers on that of the social mother, since the role of biological mother is already culturally defined while that of social mother is culturally non-existent. The closest culturally defined mother role to that of social mother in a LDI family is the adoptive mother, but her role is usually singular as she *substitutes* the biological mother. Also, as she is legally recognized, her status as 'mother' is legitimized.

Based on the data presented here for the planning phase of lesbian family building, however, the mother roles in the LDI family do not seem to differ a great deal at this stage. In fact, the roles seem more similar than different. Both women consider their *Kinderwunsch*, they work out if and how they want to become parents. There is a great commitment to parent together, even beyond a break up, and to legitimize the social mother role within their family. The only difference between the two seems to be that one woman anticipates entering the 'mommy's club' while the other anticipates becoming a mother on the one hand and an undefined entity on the other. Most mothers said the decision-making process enhanced their well-being, where as some social mothers indicated a decrease in well-being which may be explained by this. The decrease in well-being, however, may also be explained by the sense of impending responsibility to provide for the family, analog 'father blues', at least temporarily.

The mother role definition is also related to the larger issue of division of labor between lesbian partners, which has been a matter of much research interest since there are no gender lines on which to base it. A consistent result has been that lesbian couples favor egalitarian division of labor with respect to housework, childcare, gainful employment (Brewaeys et al. 1997, Shelley-Sireci & Ciano-Boyce 1999, Ciano-Boyce & Shelley-Sireci 2002, Bos et al. 2004). There has been some specialization found towards social mothers working more and birthmothers doing more childcare (Patterson 1995, 1996, Ciano-Boyce & Shelley-Sireci 2002, Bos et al. 2004). Though the data presented here does not allow for conclusions regarding actual childcare practices, it does support social mothers working more. This specialization may, in part, be due to extended maternity leave practices of Elternzeit in Germany which enable mothers extended maternity leave without jeopardizing medical insurance coverage and job security but limits numbers of hours in employment (see footnote 21 in section 1.5.2.2 What the LPartG means for LDI Families/Couples). This author finds it

very likely that, upon closer examination, lesbian couples would demonstrate a flexible arrangement that accommodates changing needs according to the phase of family building which incorporate phases of specialization within a generally egalitarian framework.

In the absence of terminology for the birth and social mothers, the lesbian couple must decide what they want the child to call them. Reflecting the aspiration to equal parenting, terminology included using a word for 'mother' for both the birth and social mother. The women wanted names that would make the 'mother' status of both women transparent to all yet allow for differentiation between the mothers. Most preferred combinations for the women in this sample were 'Mama/Mami', or 'Mama [first name/nickname] + Mama [first name/nickname]'. LDI family research explicitly identifying the naming practices used by the LDI mothers in their samples usually indicates that each is called some form of 'mother'. Only one early study with a small sample size, McCandlish 1987, and two Belgian studies, Brewaeys et al.1993 and Baetens et al. 2002, reported relatively large portions of LDI parent samples using 'mother/first name' approach.

A reason to steer away from a practice of calling each woman 'mother' is that it is thought that the lesbian nature of the relationship is also transparent to everybody. Interestingly, it is this researcher's experience that that is not the case. It is, however, a major route to insure the social mother some societal recognition when her child refers to her as 'mother' but it can also bring on additional outing dilemmas since an unknown person at the playground may turn to her and ask 'Does your child take after your family or your husband's?' or 'Is that your child?'. The social mother may feel faced with ambivalence in claiming the title of 'mother' while feeling pressured to not deny her status with regards to her child in its presence, on the one hand, and needing to model pride for her child yet not wanting to reveal the details of her family to a stranger, on the other. Handling such situations is very similar to the juggling act of regulating outings of lesbian identity.

Lesbian women must decide on the method by which they want to become parents. Pies (1988) writes, "There are a number of ways in which lesbians can become parents. That may seem obvious, but I have talked with many lesbians who think that there is only *one* way to do it. Interestingly, that one way usually varies from person to person (p.151)"

The women in this sample choose conception via donor insemination because of a desire to experience pregnancy and childbirth and to raise a child from infanthood. They preferred DI over heterosexual contact because they did not want to break the fidelity of their

relationship nor did they want to sleep with a man. These are well documented reasons for choosing conception via DI for lesbian (Harvey et al. 1989, Jacob 1995, Jacob et al. 1999, Wendland et al. 1996) and heterosexual women (Daniels 1994). Interestingly, the women in this study did not actively pursue options other than insemination with unknown or known donors.

The women in this study anticipated difficulties in realizing DI. Women using known donors had difficulties finding a man who shared ideas about his role in the LDI family while mothers using unknown donors had problems gaining access to reproductive medicine, sorting out the logistics, and handling the costs involved. Kenney and Tash (1992) also reported these problems. Women intending to use frozen sperm donors in this sample had the additional difficulty that they must look internationally for reproductive services due to German regulation of DI. The Internet may have helped women looking for known donors to find men with similar interests.

If a lesbian couple decides to become parents by conception, then they must negotiate which of the women will conceive (first). This decision is highly idiosyncratic to the couple and its particular situation at the time of decision-making. In this LDI mother sample, it was often indicated that one woman in the couple had a stronger desire to experience pregnancy and childbirth than the other. Age, job and financial reasons were also important to this decision. On average, the women planned to have a second child together when planning the first. It was equally divided as to whether the women planned a mother role switch, i.e. the social mother of the first child becomes birthmother to the sibling child, or if the same woman is birthmother to both children.

Although it may be expected that this decision is difficult to make, for most couples it is reported to be made quite easily (Mohler & Frazer, 2002). Desire to experience pregnancy is the most commonly reported reason for basing the decision on which mother will bare the first child (Baetens et al., 2002; Chabot, 1998; Martin, 1993; Mohler & Frazer, 2002; Pies, 1990; Wendland et al., 1996). In the cases where both women want to give birth, usually the older partner goes first (Baetens et al., 2002) or they try simultaneously (Martin, 1993; Pies, 1990). In this sample, a few women reported simultaneous insemination only after extended periods of waiting for one or both women to get pregnant and it was used to increase chances of any pregnancy occurring. However, it may make for a difficult transition into pregnancy for the couple if both have a strong desire to be pregnant. One woman, who became social

mother after such an arrangement, reported grieving not being the birthmother despite her joy over impending motherhood through her partner.

The majority of mothers had no preference as to the gender of the child. If a gender preference was expressed, however, then a daughter was more likely to be preferred over a son. This result is consistent with the literature (Curry, 1999; Gartrell et al., 1996; Harvey et al., 1989; Rohrbough, 1988) as well as that for heterosexual and single women attempting DI (Leiblum et al., 1995; Wendland et al., 1996). Most prospective mothers are most concerned with having a *healthy* baby.

Another decision to be made regards that of donor type choice, i.e. how to get sperm and to what degree the male it stems from should be known to and involved in the life of the lesbian couple and child. This aspect refers to the third aim of this study – to identify aspects of planning pertinent to donor choice.

The decision regarding whether to use a known or unknown donor to achieve pregnancy is a major issue for lesbian couples choosing parenthood that is not taken lightly. The lesbian prospective parents must (a) make a decision regarding their child's paternity knowing that the child, in end effect, will be the primary bearer of the consequences without being to know what these will be (b) in a societal climate predicting that positive child development is most likely possible when raised by the biological mother and father while (c) regulating the lesbian couple or family unit boundaries' vulnerability to outside intrusion incurred by invisibility.

Women in the sample who choose **anonymous donors** were of the opinion that the gender of the parents was not the major determining factor involved in positive child development and that children can be raised without knowledge of the identity of biological father. They also felt the desire to have knowledge of one's genetic roots was more a result of societal pressures than a true biological need of each individual. The major positive aspect of this choice included physical safety of the birthmother and child (sperm tested for HIV, STD's), having a clear family situation (birthmother-social mother-child) in which particularly the social mother-child bond was best protected from outside intrusion in absence of legal provisions, i.e. gay marriage and second parent adoption, and would be emotionally uncomplicated for all. The women who chose this donor type were very aware of the consequences of this decision for the child and were concerned whether the child may one day resent them for it. Rowland (1985) quotes Sants "A principle in common use in family therapy is that conscious acceptance of the known facts, as intolerable as they may appear to

be, tends to improve rather than worsen relationships" (p.391). Therefore, as in adoption, bringing the child up with knowledge of its origins was considered the best preparation for coming to terms with donor anonymity in adolescence and adulthood. Conception with an anonymous donor often went hand in hand with acquiring sperm from the clinic or sperm bank, performing a clinical insemination that, comparatively, was characterized by having little say in the matter as far as input in donor selection and information about the donor is concerned. Distance was successfully created between recipients and donor as most women reported not giving the donor much thought and being content with not having met him. Interestingly, 88% of women who used anonymous donors endorsed wishing that their child may meet the donor, if it so wishes.

Women participating in this study who choose **known donors** were of the opinion that it would be damaging for a child to be brought into the world without it being able to know its other genetic parent. They also felt the desire to know one's genetic roots is due to an inherent biological need rather than a result of societal pressures. The major positive aspect of this donor choice was that the child could know its other biological parent. Though this model allows for creative combinations of family constellations, i.e. two, three, four parental figures, usually, however, the birth and social mother were intended to be the child's designated parents. While the identity of the biological father should be known to the child, his role, if any, was most often intended to be one of 'family friend' or 'uncle' rather than social father or 'papa'. The major problems with this donor type were difficulty finding a man willing to concede to the lesbian couples' idea of his role in their family and concerns over regulating the donor's role in the family over the long term.

These mothers were creative in accessing channels for getting the word out: the most common methods were asking a man they knew or advertising. Interestingly, the donors were most often men that were previously unknown to the couple and, second, a gay male friend. The donor's motivation was often identified as an individual *Kinderwunsch*. Generally, the family was defined as the lesbian couple and child; the donor was not intended to be registered on the birth certificate which would have legal and financial ramifications nor was he endowed with financial responsibilities, decision-making power or childcare responsibilities. Overall, arrangements with known donors appear to be loose: little negotiation was required to define donor role, agreements for handling lesbian divorce or a change in the way parties felt were oral, if they occurred at all. With this donor type, women had the greatest degree of self-determination of all the donor types, i.e. input in donor selection and were most likely to self-inseminate.

Women in this study who choose **identity-release donors** held opinions similar to women who chose known donors, but less strongly; they felt it may be somewhat damaging for a child to be brought into the world without it being able to know its other genetic parent and they also considered the desire to know one's genetic roots is more due to an inherent biological need than a result of societal pressures. They were looking for the best of both previously mentioned donor types – the safety of using tested sperm and raising a child without a father who could become over involved, etc. but still allowing for the child to have access to the donor's identity in adulthood, should it become important to him/her. Drawbacks to this donor type has been availability since most sperm donors prefer to remain anonymous and identity-release donors are thus in very short supply and the concern that the child builds up expectations regarding the donor that may not be able to be met in reality. Women using an identity-release donor generally picked up their sperm personally or had it shipped to their home or a doctor's office, which introduced storage of samples as a concern for these women. They were more likely to self-inseminate than women using anonymous donors although the majority of women inseminated clinically, but some tried both methods which may be explained by the intracervical nature of self-insemination combined with the lower pregnancy rates with frozen sperm. These women were more likely to have some input in donor selection than anonymous donor mothers although medical personnel at the sperm bank usually selected the donor. Also, women with this donor type were likely to have non-identifying information about their donor. Distance between the recipient and donor was also present as a majority of women indicated no internal image of the donor, nor an interest in meeting him, although most endorsed their children meeting him, if s/he so wishes.

Mothers using anonymous donors were keen to protect family boundaries by insuring non-involvement of the donor in their family and to protect the child from a sense of rejection (i.e. should donor not be traceable, or not want contact, etc.). Mothers using identity-release donors were also keen to protect family boundaries by insuring non-involvement of the donor in their family but, nonetheless, wanted their child to have access to the donor's identity should s/he so wish and be faced with the future challenges of handling identity-releases when the child comes of age. For mothers using known donors, regulating donor involvement and (re-)defining family boundaries may be one of the more challenging aspects of this donor choice. However, mothers who used anonymous donors may have to 'defend' their decision more since it may be interpreted as 'denying children a father' or generally considering 'fathers unimportant' as this model most obviously defies the dictates of heteronormative assumptions of family. In contrast, in this respect, mothers using identity-release or known

donors may 'comfort' themselves and others since their child may (one day) have access to their donor's identity, an approach which is more consistent with heteronormative mores and, therefore, less likely to necessitate (defensive) explanation.

Pies (1988) wrote, "Each [sperm] source presents unique legal, social, emotional, and ethical dilemmas. Thus the task is not simply a matter of finding the sperm. One must also sort out the various questions associated with each source (p.183)." Unfortunately, there is little to no research on the long term impact of donor anonymity, donor identity-release at 18 years or knowledge of donor identity/donor involvement on the DI child or LDI family to assist future mothers in their donor type selection. It is in this area where this author sees the greatest need for future research.

Having three types of donors implies that lesbian women have a 'choice'. *Choice*, however, is only the case if one may choose freely and is not restricted due to finances, sexual orientation and availability. For some women in the sample, this was not the case. Whereas most women who had an identity-release donor could choose freely between a 'yes' and 'no' donor, women who chose an anonymous donor only had this option open to them. Also, some women who eventually choose an anonymous donor indicated that they had also pursued the option of a known donor or would have preferred to have donor identity. It is likely that donor preference is guided by beliefs regarding donor/father issues and that 'choice' is modified by availability. For example, a couple may prefer a known donor, but not know of a man or find a man who would like to become one or, they find one, but he has a serious health risk that makes it unsafe to inseminate with his sperm. Or a couple would prefer an identity-release donor, but can't find a clinic with a donor without a year long waiting list or the costs of shipping are too high. "Often lesbians find themselves choosing one way of becoming a parent over another, not because it is their first choice, but because it is more simple logistically or it is what they can afford financially (Pies, 1988, p.152)".

Nonetheless, all women were able to identify aspects of their donor that were so positive they choose it, even though they still saw potential problems regarding their donor type. There appears to be no blanket solution for everybody, but only solutions for individual couples. "How you feel about your parenting choice will undoubtedly be communicated to your child. If you feel it was a good choice for you, then your child will probably feel good about how s/he was brought into your life." (Pies, 1988, p.152).

Prospective lesbian parents must decide if, to what degree and in what way they intend to include men in their child's lives. The lesbian mothers in this study felt it

important to include men in children's lives because society is composed of men and women and they wanted their children to be exposed to a variety of types of people. None of the lesbian mothers found it desirable or possible to raise their child in lesbian/female 'isolation'. Though all agreed that male role models do not have to be biologically related to the children, mothers differed in plans regarding who the male role models might be. This was, in part, related to the donor type choice.

Women using known donors, in this study, generally planned for the sperm donor to be their child's role model. Usually, known donors are chosen so the child may know its biological father. Therefore, the degree to which the donor is expected to be a social father as well as biological father is of particular interest. However, there were discrepancies between questions which measured similar features of the donor role. For example, 18% of women using known donors identified the donor as a 'designated parent', and intended for the child to refer to him as "Papa" as well as have the donor's name on their child's birth certificate. However, 25% responded that the donor is expected to fulfill the role of *social father/"Papa"* in their lesbian family but only four women described plans for their donor to have a degree of involvement reflective of a social father role. In fact, most lesbian women in this sample with known donors described plans categorized as *no plans for involvement*, i.e. contact can occur 'if and when child asks for it'. An explanation for these discrepancies may be that the conceptualization of the donor's involvement with the child and LDI family may not be so clear cut for women in the planning phase. It is also possible that the desire for the child to be able to simply 'know who the donor is', is different from the desire for the donor to be intimately involved in the family's life as a social father.

Women using unknown donors, i.e. anonymous donors and identity-release donors, planned for a non-related male to be the child's male role model, by asking a good friend to become 'godfather' to the child, or felt the child would find its own models. A non-related male role model has the advantage that he poses no threat to the LDI family since he has no legal or social claim to father status (Dalton & Bielby, 2000). However, it is not always easy to realize plans for unrelated male involvement (Gartrell et al., 2000).

In contrast to heterosexual family planning, lesbian prospective parents are choosing a non-normative path and, correspondingly, are faced with the issues of resources, challenges and support. These aspects varied based on current stage of family planning with mothers with school aged + children having had the least access to resources and therefore facing more challenges and having the least support for their plans to parent.

Later prospective lesbian parents have profited from the wide spread use of the Internet, the organization of lesbians with *Kinderwunsch* or children in the meantime, and simply knowing and being able to network with existing lesbian-headed families and felt more supported in their plans to parent.

The women in this sample reported feeling more supported by birthmothers' families of origins than that of social mothers. It is a common finding in the LDI family literature that social mother's struggle with recognition from their family of origin (McCandlish, 1987; Nelson, 1999). In order for the social mother's family to perceive their daughter/sister as a 'mother', it requires the same redefinition process or reevaluation of mainstream concepts of motherhood as the social mother herself undergoes. Considering, the women in this study reported almost as high levels of perceived support from social mother's families as from birthmothers' families. These accounts may be reflective, in part, to the retrospective nature of this study, i.e. many participants already had children and, from the literature, we know that, over time, families often come around (Gartrell et al., 2000).

9.3 Limitations

The limitations on the generalizability of results due to the non-representative sample that apply to most research on LDI families applies here also. The research relies largely on convenience and volunteer samples recruited through snowball techniques or through LG parent organizations, press, etc. Since the participants in this study were either asked to participate by the researcher or volunteered based on advertising through the ILSE/LSVD or LG media, a bias may have been introduced into the sample, i.e. a researcher bias or bias towards higher functioning and 'out and proud' lesbian participants. It can not be eliminated that families that are 'closeted' may function differently or that families with low functioning may decline to participate in research.

Another limitation of the study presented here is that data was collected retrospectively. Only 20 of the 105 participants were recently in the planning stage as they, or their partner, were either currently inseminating or pregnant. Of the remaining women, 32 had a first born child 0-3 years, 35 had a first-born child that was of kindergarten age (3-6 years), and 18 had a first-born child that was currently of school age or older (6/7+). For these women, the planning phase lies several years in the past and their answers may be modified by their memories or attitudes that they have developed due to experience over the years (selective memory).

Finally, the other limitation has to do with the questionnaire method. Even though it is an efficient method of reaching a large population over a wide geographical area and holds topics constant across all subjects while maintaining distance between the researcher and known subjects, the depth of the exploration is limited. It is only possible to discuss *aspects* of the decision-making process as opposed to learning about the *process* itself, the unfolding of events, and how many factors work together to influence a decision to have children, how to go about it, and what type of donor to use.

9.4 Future Research

The strength of the present study lies in the sample pool: 105 lesbian DI mothers participated in the present study. The development of an organized lesbian mother network in Germany is very recent and this researcher believes these families are among the first LDI family generation in Germany society. Also, few studies have surpassed this large DI sample, one of which is the acclaimed "National Lesbian Family Study" by Gartrell et al. (1996, 1999, 2000). (See Table 6 for sample sizes in other planned lesbian family research.) Also, three different types of donors are represented in the sample (anonymous, identity-release, and known donors) as well as both methods of insemination (clinical and self-insemination). Due to this diversity, it was possible to identify aspects of the planning process that may be specific to the usage of certain types of donors. Also, it was possible to collect information about planning involved in self-insemination with known donors, as this aspect is seldom included in research on DI, which often stems from samples recruited at reproductive medical centers.

The other strength of this study is that it focuses solely on the decision-making phase and does not confuse issues at various stages of the family building process with family planning.

This study lends itself well to future research of the following phases of early LDI family formation - insemination phase, pregnancy phase and childbirth experiences, transition to parenthood and kindergarten experiences – as well as family functioning. At the time data was collected for the planning stage of family building, participants also filled out questionnaires for the following phases of family building that they had already or were currently experiencing as well as information on family functioning. It will be exciting to be able to follow the progression of these women through the various stages and how the birth and social mother roles develop as well as the involvement of known donors as this data is evaluated in the future.

Longitudinal studies that follow family development over time or cross sectional studies that analyze the phases of family building individually would be important for LDI families to understand themselves as well as for providers' and educators' understanding of LDI families. A major research interest is the impact of donor type choice on the children, the lesbian relationship and LDI family as a whole over the long term. As it currently stands, mothers must make a choice for their children and families based on very little information and on a lot of current public and personal opinion without knowing what the future may bring and how public opinion may change. This is a very intimidating situation since the actual long term impact of a donor type may vary greatly from expected impact. For future lesbian couples this information would enable them to make *informed* decisions regarding donor type choice and its repercussions. All donor choices have their pros and cons, but couples could profit from other families' experiences and their handling of the negatives aspects of their donor choice.

Table 6: Sample Sizes in Other LDI Research

Author (year)	Country	N= lesbian DI couples	N= lesbian DI mothers	Donor type	Recruited from DI clinic or General public
Baetens et al. (2002)	**B**	**95**	**190**	**'no'**	**1992-2000 at DI Clinic in Brussels**
Bos et al. (2003)	**NL**	**100**	**200**	**no info**	**DI Clinic and general public**
Brewaeys et al. (1993)	B	25	50	'no'	DI clinic in Brussels
Brewaeys et al. (1995)	B	50	100	'no'	DI clinic in Brussels
Ciano-Boyce & Shelley Sireci (2002)	USA	49 'parents'	unclear	unclear	General public: 49 'parents', 18 lesbian adopt, het. adopt
Chabot (1998) - Diss	USA	10	20	Unknown/ known donor	general public
Curry (1999) - Diss	USA	8	16	'no', known donor	general public
Dundas & Kaufmann (2000)	Canada	no info	(27)	DI/ex-het	general public
Englert (1994)	B	15	30	'no'	DI clinic
Ferrara et al. (2000)	UK	35	70	no info	DI clinic
Gartrell et al. (1996)	**USA**	**70 (+14 birthmoms)**	**154**	**'no', 'yes', known donor**	**General public: (SanFransisco, Washington, D.C., Boston)**
Green (2006) - Diss	**D**	**50 (+ 5 biomoms)**	**105**	**'no', 'yes', known donor**	**general public ("West Germany")**
Harvey et al. (1989)	USA	no info	29	no info	General public
Jacob et al. (1999)	USA	23	46	'no'	DI clinic in Conn.
Jiles (1999) – Diss	USA	13	26	DI, adoption, foster care	General public in Washington State
Johnson & O'Connor (2002)	USA	unclear	unclear	unclear	General public (N=256 LG families of which N=115 are planned lesbian families but no info on source of children)
Leiblum et al. (1995)	USA	no info	14	'no'	DI Clinic in New Jersey
McCandlish (1987)	USA	5	10	'no', known donor	General public

Mercier (1999) – Diss	USA	unclear	unclear	unclear	General public in Michigan (N=125 mothers not specified but n=45 DI children)
Scheib et al. (2000)	USA	no info	55	Identity-release	The Sperm Bank of California
Scheib et al. (2003)	USA	18	36	Identity-release	The Sperm Bank of California
Steeno (1998) - Diss		unclear	unclear	unclear	General public in Florida (n=151 mothers not specified but n=48 DI children)
Vanfraussen et al. (2001)	B	unclear	unclear	'no'	DI clinic in Brussels (n=45 parents to n= 41 DI children)
Wendland et al. (1996)	USA	no info	16	'no'	DI clinic in New Mexico

Studies of the children's perspective would also be very interesting. What experiences do they make with society? How do they handle 'outings' or sensitive questions? What attitudes do they have towards their conception and family form? Information from studies with children may also aid in donor type choice selection, future mothers' decisions about how and when to educate children about their conception, their family, homophobia, their self-definition as lesbian, etc., as well as help younger LDI children handle similar situations. However, these studies are difficult to do since (a) most LDI children are still rather young, at least in Germany, so that many have not quite grasped the specialness of their situation and (b) parents are generally nervous about allowing others to 'probe' their children lest it suggest to otherwise well-adjusted children, that something is not okay with their family. Therefore, future research needs to approach LDI families less from a 'deficiency' or 'measure up' perspective and more from a 'strength' perspective. Creating and maintaining a LDI family is no easy task. That these families are generally so successful may point to useful mechanisms that heteronormative families could also profit from, analog resiliency research.

Finally, studies that document the impact of legislation on LDI families, i.e. gay marriage, second parent adoption and access to reproductive medicine, would be important for LDI families and policy makers deciding on lesbian access to these privileges.

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Questionnaire –Code Book - Results

Demographics

d2. Age:M(s)=38.0 (5.7) years

d3. *Official* marital status:

38%= registered partnership (verpartnert nach dem Lebenspartnerschaftsgesetz)
60%= single
0= (heterosexually) married
0= (heterosexually) separated
2%= heterosexually) divorced
0= (heterosexually) widowed

4. Nationality/-ies:
d4a

89%=German **-->go to question #7**
3%=American
1%=English
1%=Czech
0=Spanish
0=Turkish
1%=Israeli
2%=Swiss
2%=Italian
1%=Austrian
0=Canadian

d4b living in German since: M(s)= 23.6 (11.0) years

d5. What country did you primarily grow up in?

n=3=Germany
n=2=USA
n=1=England or colonies
n=1= Czech Republic
n=0=Spain or colonies
n=0=Turkey
n=0=Peru
n=1=Israel
n=2=Switzerland

d6. Did you immigrate to Germany because of your partner?

n=3= yes
n=6= no

d7. What state/ Bundesland do you live in today? _____

Baden-Württemberg	31	30%
Bayern	23	22%
Berlin	13	12%
Brandenburg *(Ost)*	2	2%
Bremen	0	0
Hamburg	4	4%
Hessen	4	4%
Mecklenburg-Vorpommern *(Ost)*	0	0
Niedersachsen	3	3%
Nordrhein-Westfalen	18	17%
Rheinlandpfalz	0	0
Saarland	0	0
Sachsen *(Ost)*	2	2%
Sachsen-Anhalt *(Ost)*	0	0
Schleswig-Holstein	3	3%
Thuringen *(Ost)*	0	0
Schweiz	2	2%

Ost	West
∑= 4	∑= 101
3%	97%

d8. Size of current place of residence:

9%= village/rural community (bis ca. 2000 inhab.)
7%= small town (2 000 bis 20 000 inhab.)
17%= town (20 000 bis 100 000 inhab.)
22%= large town (100 000 bis 500 000 EinwohnerInnen)
39%= city (mehr als 500 000 EinwohnerInnen)
7%= city-suburb

d9. Highest level of education:

0=kein Abschluß
3%=Hauptschulabschluß
14%=mittlere Reife
19%=Abitur, Fachabitur
8%=Studium(BA + FH) mit Abschluß
54%=Hochschulstudium mit Abschluß
2%=Promotion

d10a,b,c,d. Gegenwärtige(n) Tätigkeit(en):

Ausbildung/Studium:

0= schooling /Schulausbildung
3%= professional training/Berufsausbildung
8%= university education/ Studium
3%= Ph.D./Doktor
0= Habil

Nicht erwerbstätig:

5%= housewife/Hausfrau
1%= pensioner/Rentnerin
7%= unemployed/ looking for work//Arbeitslos/ Arbeitssuchend
13%= maternity leave//Erziehungsurlaub/Mutterschutz

Erwerbstätig:

0= blue collar working woman/ Arbeiterin
0=Facharbeiterin
56%=white & pink collar working woman/Angestellte
4%=government worker/Beamte
26%=self-employed/Selbstständige

11. Amount you work/Umfang ihrer Berufstätigkeit?

d11a+b

38% =fulltime
bio-mom 27% vs. soc-mom 50%, sign. p< .05
47%=part-time
with M(s)= 30.6 (10.7) hours/week
bio-mom M(s)=26.3(10.4) vs. soc-mom M(s)=34.5(9.4), sign. p< .05

d12. Income: Please estimate your total family (gross) income per month:

Average Monthly Gross Family Income (bold type indicates significance p<. 05)

Gross Income (month)	%	Insemination	0-3 yrs	Kindergarten	School
0-1000 €	4%				
1001-2000 €	15%		**23%**	3%	**29%**
2001-3000€	28%	**25%**	**32%**	**36%**	6%
3001-4000€	25%				
4001-5000€	8%				
>5001€	21%	**40%**	10%	12%	**35%**

There is no significant difference in gross family income between birth- and social mothers except in the case of the lowest income category. Significantly more birthmothers (∑=4) than social mothers (∑=0) have a gross family income of 0-1000 Euro (p< .05).

There is no significant difference in gross family income between families grouped by donor type.

There are differences in family income based on current phase of family building. Significantly more **women who are inseminating/pregnant** (40%, p< .05) or **mothers with school aged children** (35%, p< .1) had family earnings in the highest category **(>5000 Euro**/month) than mothers with children 0-3 years (10%) or in kindergarten (12%).

Significantly more **mothers with kindergarten** children (33%) have earnings in the category **3,001-4,000 Euro/month** than mothers who are inseminating (xx%).

Significantly more **mothers who are inseminating/pregnant** (25%, p< .1) or with **children 0-3 years** (32%, p< .05) or with **kindergarten children** (36%, p< .05) have earnings in the category **2,001-3,000 Euro/month** than mothers with school aged children (6%)

Significantly more **mothers with children 0-3 years** (23%) or with **school aged children** (29%) have earnings in the category **1,001-2,000 Euro/month** than mothers with kindergarten children (3%) (p< .05). Three of the five mothers with school aged children in this category were single and the other two were a couple with a sibling child 0-3 years.

d13. How many people live with you in your household? M(s)=3.1 (0.8) people

14. **d14a**_M(S)=2.0 (0.3) adults and **d14b M(s)=1.1(0.8)** children/adolescents.

d15. What is your living sitaution like?

56%=rented apartment
4%=rented house
40%=homeownership/Wohneigentum

There were also differences in housing situation between mothers grouped by current phase of family building. Significantly more women who were **inseminating/pregnant** (80%) and mothers whose **index child was 0-3 years** (75%) lived in **rented** accommodations than mothers whose index child was of kindergarten age (46%) or school age (17%) (p< .05). Also significantly more mothers whose index child was of kindergarten age (46%) lived in rented accommodations than mothers whose index child was of school age (17%, p< .05).

Significantly more mothers whose **index child was of kindergarten age** (49%) or **school age** (72%) lived in **owned homes** than women who were inseminating/pregnant (20%) or mothers whose index child was 0-3 years (25%, p< .05). Significantly more mothers whose index child was of school age (72%) lived in owned homes than mothers whose index child was of kindergarten age (49%, p< .1).

d16. Which religious denomination do you belong to?

10%=Catholic
32%=Protestant /"Evangelisch"
0=Moslem
1%=Jewish
1%=Buddist
56%= no religion
2%= no response

d17. How often do you participate in religious activities?

3%=each/once a week
3%=each/once a month
14%=at least once in 6 months
29%=at least once a year/occasionally/on special occasions
7%=no response

There were no significant differences between mothers grouped by mother role, donor type or, for the most part, current phase of family building. The exception was that significantly more women who were in the **insemination/pregnancy** phase (68%) and mothers whose **index child was 0-3 years** (70%) indicated that they **never** took part in religious activities than mothers whose index child was of kindergarten age (33%) or school age (31%) ($p < .05$).

d18a. Has your child become a member of a religion, for example, through baptism, Holy 1st Communion, or confirmation?

33%=yes
49%=no
18%=NA

d18b. If so, which ritual did it participate in?

94%= baptism
0=other
11%=no response

d19. How important is religion for you?

32%=not at all important
42%=unimportant
23%=important
3%=very important
2%=no response
mean=2.0 (range: 1-2.5 'unimportant' and 2.5 -4.0 'important')

d20a,b. Welche Sprache(n) werden in Ihrem Haushalt gesprochen?

99%=German
0=Turkish
11%=English
0=French
1%=Spanish
1%=Czech
4%=Italian
2%=Hebrew
1%=no response

d21a. Is your family bicultural?

21%=yes
79%=no
1%=no response

d21b,c. If your family is bicultural, which cultures?

German &…
0=Turkish
21%=American
11%=English
11%=Czech
0=Latin-American
21%=Italian
5%=Croatian
11%=Israeli
5%=Dutch
11%=Canadian

2.0 Coming-out/ Lesbian Identity

lid1. How do you identify today? (*Steeno '97)*
93%=lesbian
7%=bisexual

lid2. When did you become aware of your sexual orientation/identity? M(s)= 21.5(5.7) years

lid3. Are you satisfied with your sexual orientation/identity? **100%=yes / 0=no**

lid4. How old were you when you had your first lesbian relationship? M(s)=23.5(5.0) years

lid5. Which statement applies to you?
43%= I identified as lesbian before I had my first relationship with a woman.
57%= I first had a relationship with a woman and then I (began to) identify as a lesbian.

lid6. How many serious/committed relationships with a woman did you have including your current relationship? M(s)=2.4 (1.4)

lid7. What was the longest duration of these lesbian relationships? ***M(s)*=9.7(3.9)** years

There was no difference in relationship length for mothers grouped by mother role or donor type.
There were, however, differences when grouped by current phase of family building. Women who are in the insemination/pregnancy phase had the shortest longest relationship duration (6.4 years). Mothers whose index child was 0-3 years (x=8.3 years) had a significantly longer longest relationship duration than women who were inseminating/pregnant ($p < .1$). Mothers whose index child was of kindergarten age (x=11.7 years) or school age + (x=12.2 years) had a significantly longer longest relationship duration than women who were inseminating/pregnant and mothers whose index child was 0-3 years ($p < .05$).

lid8. Did you have heterosexual relationships in the past? **73%=yes / 27%=no**

lid9. How many serious/committed relationships did you have with a man?
M(s)= 1.8(1.6) base: all respondents
M(s)= 2.4(1.4) base: women with heterosexual past

lid10. What was the longest duration of these heterosexual relationships? M(s)=3.6(3.6) years

lid11. Were you living in a heterosexual relationship during your Coming-out?.....
…….33%=yes / 67%=no -->go to question #14

lid12. Was your Coming-out or lesbian identity development associated (or the cause) of your separation back then*?base:living in heterosexual relationship while coming-out*
46%= yes, that was the main reason
29%= yes, i tone of many reasons
25%= no, had nothing to do with it

Expectations of life path before coming-out and after regarding family planning bzw. Relationship to Kinderwunsch

Die folgenden Fragen beziehen sich auf Ihre Erwartungen/Vorstellungen vor *und* nach Ihrem Coming-out. Please answer the following questions by marking the box for the appropriate answer (as many as apply) for your opinions before *and* after your coming-out.

lid14. Did you think/assume you would marry (a man)?

Antwortmöglichkeit/ Answer possibility	**lid14a,b** ***Before*** Coming-out	**lid 14c,d** ***After*** Coming-out
Ja /yes	**32%**	**0**
Nein /no	**38%**	**93%**
Maybe/unsure	**33%**	**7%**
I was already married	**2%**	**0**
I wanted a divorce	**2%**	**0**

Significantly more **social mothers** (48%) than birthmothers (28%) indicated that **marriage was not included in their life plan** before coming-out ($p < .05$).

lid15. Did you envision your life to include (having) children?

Antwortmöglichkeit/ Answer possibility	**lid15a,b** ***Vor*** Ihrem Coming-out	**lid15c,d** ***Nach*** Ihrem Coming-out
Ja/yes	**63%**	**57%**
Nein/no	**20%**	**27%**
Maybe/unsure	**16%**	**20%**
I already had a child prior to coming-out	**3%**	**0**

Significantly more **birthmothers** (74%) than social mothers (50%) had assumed they would have children ($p < .05$) before their coming-out. Significantly more **social mothers** (38%) indicated that they did not plan to have children prior to coming-out than birthmothers (4%; $p < .05$) before their coming-out.

Significantly more **birthmothers** (68%) than social mothers (45%) assumed they would have children ($p < .05$) after their coming-out. Significantly more **social mothers** (37%) than birthmothers (19%) did not envision their lives to include children after coming-out ($p < .05$) after their coming-out.

16. Did you believe you would have to make your own living/provide for yourself by yourself?

Antwortmöglichkeit/ Answer possibility	**lid16a,b,c** ***Vor*** Ihrem Coming-out	**Lid16d,e,f** ***Nach*** Ihrem Coming-out
Ja/yes	**58%**	**60%**
Nein /no	**11%**	**9%**
I never gave money much thought.	**14%**	**8%**
I thought, I would share financial responsibility with someone.	**19%**	**31%**
I was already earning my own livelihood.	**38%**	**37%**

Please rate your degree of 'outness' in the following social contexts by checking the appropriate answer.
mean range for each rating: 1=1.0-1.80 / 2=1.80-2.60 / 3=2.6-3.4 / 4=3.4-4.2 / 5= 4.2-5.0

lid17. Are you out socially and with friends? M=4.88
5= complete 95% **4=** mostly **1%** **3=** somewhat **2%** **2=** very few 0 **1=** none **2%**

lid18. Are you out professionally, with school or work colleagues? M=4.16
5= out to all 48% **4= out to most** 32% **3=** out to some 13% **2=** out to few 4% **1=** out to none 4%

lid19. Are you out with your family of origin? M=4.76
5= out to all 85% **4=** out to most 9% **3=** out to some 3% **2=** out to few 2% **1=** out to none 1%

lid20. Are you out with your neighbors? M=4.24
5= out to all 56% **4=** out to most 23% **3=** out to some 13% **2=** out to few 5% **1=** out to none 3%

lid21. Are you out with parents of your children's friends? M=4.63
5= out to all 75% **4=** out to most 18% **3=** out to some 4% **2=** out to few 0 **1=** out to none 3%

lid22. Are you out with your children's kindergarten or school personnel? M=4.80
5= out to all 91% **4=** out to most 4% **3=** out to some 0 **2=** out to few 1% **1=** out to none 3%

lid23. Are you out with your child's physician? M=4.59
5= out to all 78% **4=** out to most 10% **3=** out to some 7% **2=** out to few 2% **1=** out to none 2%

lid24. How do you deal with situations, in which it is clear that the other person does not know you are a lesbian?

9%= I always make it very clear that I am lesbian.
0= I behave in such a way so as that the person would never guess I am lesbian.
91%= I decide on a case-by-case basis whether of not I want to out myself.

Lesbian Internalized Homophobia Scale (Szymanski & Chung, 2001)
Please indicate your agreement or disagreement with each of the following statements by writing in the appropriate number from the scale below. There are no right or wrong answers; however, for the data to be meaningful, you must answer each statement given below as honestly as possible. Your responses are completely anonymous. Please do not leave any statement unmarked. Some statements may depict situations that you have not experienced; please imagine yourself in those situations when answering those questions.

1	2	3	4	5	6	7
Strongly disagree	Moderately disagree	Slightly disagree	neutral	Slightly agree	Moderately agree	Strongly agree

1. Most of my friends are lesbians.
2. I try not to give signs that I am a lesbian. I am careful about the way I dress, the jewellery I wear, the places, people and events I talk about.
3. Just as in other species, female homosexuality is a natural expression of sexuality in human women.
4. I can't stand lesbian who are too „butch". They make lesbians as a group look bad.
5. Attending lesbian events and organizations is important to me.
6. I hate myself for being attracted to other women.
7. Female homosexuality is a sin.
8. I am comfortable being an „out" lesbian. I want others to know and see me as a lesbian.
9. I feel comfortable with the diversity of women who make up the lesbian community.
10. I have respect and admiration for other lesbians.
11. I feel isolated and separate from other lesbians.
12. I wouldn't mind if my boss knew I was lesbian.
13. If some lesbians would change and be more acceptable to larger society, lesbians as a group would not to deal with so much negativity and discrimination.
14. I am proud to be lesbian. *(bad item in German)*
15. I am not worried about anyone finding out that I am a lesbian.

16. When interacting with members of the lesbian community, I often feel different and alone, like I don't fit in.
17. Female homosexuality is an acceptable lifestyle.
18. I feel bad for acting on my lesbian desires.
19. I feel comfortable talking to my heterosexual friends about my everyday home life with my lesbian partner/lover or my everyday activities with my lesbian friends.
20. Having lesbian friends is important to me.
21. I am familiar with lesbian books and /or magazines.
22. Being part of the lesbian community is important to me.
23. As a lesbian, I am loveable and deserving fo respect.
24. It is important form e to conceal the fact that i am a lesbian from my family.
25. I feel comfortable talking homosexuality in public.
26. I live in fear that someone will find out I am a lesbian.
27. If I could change my sexual orientation and become heterosexual, i would.
28. I do not feel the need to be on guard, lie, or hide my lesbianism from others.
29. I feel comfortable joining a lesbian social group, lesbian team sports, or lesbian organization.
30. When speaking of my lesbian lover/partner to a straight person I change pronouns so that other will think I'm involved with a man rather than a woman.
31. Being a lesbian makes my future look bleak and hopeless.
32. Children should be taught that being gay is a normal and healthy way for people to be.
33. My feelings towards other lesbians are often negative.
34. If my peers knew of my lesbianism, I am afraid that many would not want to be friends with me.
35. I feel comfortable being a lesbian.
36. Social situations with other lesbians make me feel uncomfortable.
37. I wish some lesbians wouldn't „flaunt" their lesbianism. They only do it for shock value and it doesn't accomplish anything positive.
38. I don't feel disappointment in myself for being a lesbian.
39. I am familiar with lesbian movies and/or music.
40. I am aware of the history concerning the development of lesbian communities and/ort he lesbian/gay rights movement.
41. I act as though my lesbian lovers are merely friends.
42. Lesbian lifestyles are a viable and legitimate choice for women.
43. I feel comfortable discussing my lesbianism with my family.
44. I don't like to be seen in public with lesbians who look „too butch" o rare „too our" because others will then think I am a lesbian.
45. I could not confront a straight friend or acquaintance if she or he made a homophobic or heterosexist statement to me.
46. I am familiar with lesbian music festivals and conferences.
47. When speaking of my lesbian lover/partner to a straight person, I often use neutral pronouns so the sex of the person is vague.
48. Lesbian couples should be allowed to adopt children the same as heterosexual couples.
49. Lesbians are too aggressive.
50. I frequently make neagtive comments about otehr lesbians.
51. Growing up in a lesbian family is detrimental fro children.
52. I am familiar with community resources for lesbians (i.e. bookstores, support groups, bars, etc.).

LIHS	Point range	My sample:		
M=mean S=standard deviation		All moms M(s)	Bio-mom M(s)	Soc-mom M(s)
Connection with the Lesbian Community (CLC)	1-7	2.1 (0.7) ~ **2**	2.1(0.6) ~ **2**	2.1(0.7) ~ **2**
Public Identification as a Lesbian (PIL)	1-7	1.9(0.6) ~ **2**	1.8(0.6) ~ **2**	2.0(0.7) ~ **2**
Personal Feelings about Being a Lesbian (PFL)	1-7	1.6(0.5) ~ **2**	1.5(0.4) ~ **2**	1.6(0.6) ~ **2**
Moral and Religious Attitudes Towards Lesbianism (MRATL)	1-7	1.4(0.5) ~ **1**	1.4(0.5) ~ **1**	1.3(0.4) ~ **1**
Attitudes Towards Other Lesbians (ATOL)	1-7	2.1(0.8) ~ **2**	2.0(0.8) ~ **2**	2.2(0.8) ~ **2**
total	1-7	1.9(0.4) ~ **2**	1.8(0.4) ~ **2**	1.9(0.4) ~ **2**

2.0 Lesbian Relationship

Hinweis: Die folgenden Fragen beziehen sich auf die Beziehung mit der Partnerin mit der Sie Ihr Kind planen bzw. geplant und bekommen haben.

lb1. How long have you been living in this relationship? **M(s)=9.2 (4.1)** years

lb2. Are you living in „eingetragenen Lebenspartnerschaft" (~civil union, registered partnership)?
39%=yes/ 61%=no

lb3. If so, since when? M(s)= 21.6 (12) months

lb4a,b,c. If not, please statement the most important reasons why you have not entered LpartG? (me – ist das Gesetz ungeeignet für Elternpaare?)

63%= rejection of law due to no rights, all responsibilities of marriage, keine"Vorteile"
53%= rejection of law due to do financial disadvantages compared to both single mothers and married couples + no protection of the family (ex. In case of death, etc.)
19%= rejection of institution of 'marriage' for feminist reasons
14%=rejection of law due to no legal relationship created btw. Child and social mother/rejection of law due to no right to adoption (prior to 11/04)
11%= couple not interested/not ready
9%= Want to, but lacking in funds/energy
4%= rejection of law due to issue of family name
2%= threat of being fired from job – Catholic Church is employer

lb5. Have you since separated from your partner (who you had your first child with)?
7%=yes / 93%=no

lb6. If so, how old was the eldest DI child when you separated from the other mother?
M(s)=2.3 (1.9) years

lb7. Do you consider this a committed relationship? 100%=**yes / 0=no**

lb8. Please mark which of the following outward signs of committment you and your partner have engaged in. (Bamberg)
[1=yes, subject marked response/ 2=no, subject did not mark response]
98% joint purchases and investments, ex. Household items, car, furniture
94% taking partner to occassions, ex. Work Christmas party, Granny's 80th birthday,...
91% buying/renting a house or apartment together
88%adopting, having, fostering a child together
75% life insurance or the like providing for partner in event of death
69% joint account
61% wearing rings
41% „wedding"/ Celebration of eingetragenen Lebenspartnerschaft
23% Anniversary of ___(10)_____ years
28% using same last name

lb9. Meine Partnerin und ich leben (bzw. lebten) als Paar zusammen in einem Haushalt. (me)
100%=yes / 0=no

lb10. Wie lang waren Sie mit Ihrer Partnerin zusammen, bevor Sie zusammen gezogen sind?
M(s)= 2.0(1.9) years

lb11. If you didn't or don't live together as a couple, please statement the most important reasons fort his choice. (me) none applicable

lb12. Was parenthood/Kinderwunsch an issue in your relationship from the beginning?

19%= yes, *I* entered the relationship with a desire to become a parent
15%= yes, *my partnen* entered the relationship with a desire to become a parent
23%= yes, *we both* entered the relationship with a desire to become a parent
42%= no

Significantly more mothers said that the prospective birthmother (28%) entered their lesbian relationship with a desire to parent than prospective social mothers (10%;p< .05).

lb13. Sexual intimacy: What agreements had you and your partner come to regarding the issues of sexuality and monogamy?

84%= We are exclusively monogomous.
1%= We have a completely open relationship.
15%= Mixed form, und zwar ____+ [OPEN]_____

Dyadic Adjustment Scale (Spanier, 1976)
Most persons have disagreements in their realtionships. Please indicate below the approximate extent of agreement or disagreement between you and your partner for each item on the following list.

		Always agree	Almost always agree	Occassionally disagree	Frequent-ly disagree	Almost always disagree	Always disagree
Das1	Handling family finances	5	4	3	2	1	0
Das2	Matters of recreation	5	4	3	2	1	0
Das3	Religious matters	5	4	3	2	1	0
Das4	Demonstrations of affection	5	4	3	2	1	0
Das5	Friends	5	4	3	2	1	0
Das6	Sex relations	5	4	3	2	1	0
Das7	Conventionality	5	4	3	2	1	0
Das8	Philosophy of life	5	4	3	2	1	0
Das9	Ways of dealing with parents or in-laws	5	4	3	2	1	0
Das10	Aims, goals, and things believed important	5	4	3	2	1	0
Das11	Amount of time spent together	5	4	3	2	1	0
Das12	Making major decisions	5	4	3	2	1	0
Das13	Household tasks	5	4	3	2	1	0
Das14	Liesure time interests	5	4	3	2	1	0
Das15	Career decisions	5	4	3	2	1	0

		All the time	Most of the time	More often than not	Occasionally	Rarely	Never
Das16	How often do you discuss or have considered divorce, separation, or terminating your relationship?	0	1	2	3	4	5
Das17	How often do you or your mate leave the house after a fight?	0	1	2	3	4	5
Das18	In general, how often do you think that things between you and your partner are going well?	0	1	2	3	4	5
Das19	Do you confide in your mate?	0	1	2	3	4	5
Das20	Do you ever regret that you married (or lived together)?	0	1	2	3	4	5
Das21	How often do you and your mate quarrel?	0	1	2	3	4	5

Das22	How often do you and your mate "get on each other's nerves"?	0	1	2	3	4	5

		Every day	Almost every day	occasionally	rarely	never
Das 23	Do you kiss your mate?	4	3	2	1	0

		All of them	Most of them	Some of them	Very few of them	None of them
Das 24	Do you and your mate engage in outside interests together?	4	3	2	1	0

How often would you say the following events occur between you and your mate?

		Never	<once a month	Once or twice a month	Once or twice a week	Once a day	More often
Das25	Have a stimulating exchange of ideas	0	1	2	3	4	5
Das26	Laugh together	0	1	2	3	4	5
Das27	Calmly discuss something	0	1	2	3	4	5
Das28	Work together on a project	0	1	2	3	4	5

These are some things about which couples sometimes agree and disagree. indicate if either item below caused differences of opinions or were problems in your relationship during the past few weeks. (Check yes or no).

	yes	no	
Das 29	0	1	Being too tired for sex.
Das 30	0	1	Not showing love.

das 31. Which of the following statements best describes how you feel about the future of your relationship?

5= I want desperately for my relationship to succeed, and *would go to almost any length* to see that it does.
4= I want very much for my relationship to succeed, and *will do all that I can* to see that it does.
3= I want very much for my relationship to succeed, and *will do my fair share* to see that it does.
2=It would be nice if my relationship succeeded, but *I can't do much more than I am doing* now to help it succeed.
1= It would be nice if my relationship succeeded, but *I refuse to do more than I am doing* now to to keep the relationship going.
0=My relationship can never succeed, and *There is no more that I can do* to keep the relationship going.

das 32/pfb31. How happy would you rate your relationship at the moment?

0=very unhappy
1= unhappy
2= more unhappy
3= more happy
4=happy
5=very happy

FBZ (DAS)		Point range	Hank et. al. ('90)		My sample:		
M=mean S=standard deviation	Subscale		Klienten M(s)	Zufrieden M(s)	All moms	Bio-mom	Soc-mom
Übereinstimmung	Consensus	0-65	*43 (10)*	50 (6)	50.2(5.8)	49.8(5.7)	50.5(6.0)
*Erfüllung	Satisfaction	**0-(50) 44**	***31 (8)***	**41 (5)**	39.3(4.9)	39.2(4.4)	39.3(5.4)
Zusamenhalt	Cohesion	0-20	*13 (4)*	16 (3)	15.8(3.7)	16.1 (3.9)	15.4 (3.5)
Ausdruck von Gefühlen	Affectional expression	0-12	*6 (2)*	9 (2)	8.0(1.9)	7.9(1.8)	8.0(1.9)
Gesamtwert	total	0-147	*93 (23)*	**115 (12)**	**113.2(13.6)**	113.0(13.2)	113.3(14.0)

3.0 Kinderwunsch: Planning

P1. What triggered your Kinderwunsch?(me) [OPEN]
(categories based on subject's responses)

1= always wanted a child
2= Partner's original desire/Wunsch der Partnerin
3= desire for a family, life with children, watching them grow…
4= relationship to partner
5= realising that it is possible to have children despite lesbian identity, meeting other lesbian mothers
6= Freude an Kindern, contact with other children in social environment
7= age, biological clock

	1	2	3	4	5	6	7	No resposne
total	N=24/27%	N=20/23%	N=10/11%	N=17/19%	N=8/9%	N=18/19%	N=3/3%	16
Bio mom	N=**17**	N=6	N=5	N=8	N=5	N=10	N=3	8
Soc mom	N=7	N=**14**	N=5	N=9	N=3	N=8	N=0	8

P2. Who began experiencing the desire for a child first? (me)

46% prospective birthmother
17% prospective social mother
37% both

4. Which potential trouble spots for parenting have you and your partner discussed? (check as many as apply) **[1=yes, subject marked response/ 2=no, subject did not mark response]**

77% Bonding – how to make it happen for bio- and non-bio moms *(Pies 1988, p.69)*
77%Parenting styles – similarities, differences, conflicts, agreements*(Pies 1988, p.69)*
61%Power (im-)balance between bio- and non-bio mom – how to recognize it and what can you do?*(Pies 1988, p.69)*
56%**Different family backgrounds** and the impact that has on parenting, managing finances, attitudes about education and leisure, etc. *(Pies 1988, p.69)*
37% Different personal rhythms – how and when do you do particular activities and how that affects your parenting partners*(Pies 1988, p.69)*
33% Individual needs for control and discipline *(Pies 1988, p.69)*
18% Different lifestyle choices – how you choose to live and how well do your styles co-exist?*(Pies 1988, p.69)*

P4h___other, please specify: +[OPEN] *categories based on responses:*
n=7= how to balance work & family needs
n=9= questions related to donor, i.e. what kind, level of involvement…
n=3= issues for child, i.e. discrimination, having lesbian parents, not having a "father"
n=6= issues related to having a child, i.e. method of becoming a parent, who pregnant, plans in case of separation
n=3= couple issues, i.e. time & nuturing for relationship with children
n=1= coming-out issues, i.e. telling parents

P5a. Did you discuss childcare before initiating DI?*(Wendland et.al. '96)*
85% yes / 15% no -->go to ##

P5b. If so, how do you plan to divide childcare?*(Wendland et.al. '96) [*OPEN*]*
answer categories based on responses:

N=28	50:50 or "gleichberechtigt"
N=17	"gemeinsame Erziehung"
N=12	First year birth mother takes *Elternzeit*, then switch
N=9	Traditional: birthmother at home, social mother works
N=7	Birthmother takes extended maternity leave (*Elternzeit*)
N=5	Both moms work unequal amounts
N=3	Traditional reversed: social mother at home, birthmother works
N=2	Both mothers take extended maternity leave (*Elternzeit*)

P6. Did you discuss the issue of child custody should the relationship end?*(Wendland et.al. '96)*
75% yes / 25% no -->go to question #9

P7. If so, what agreement did you make? How did you document your intentions?*(Wendland et.al. '96)* [OPEN] *base: had discussed custody*

	'joint custody'	Custody/visitation	other
Total N responses	16	37	5
%	28%	64%	9%

P8. How did you document your intentions?
***58%* oral / 42%written** *base:had discussed custody*

<u>Worries about the prospect of conceiving and/or mothering:</u> *(Leiblum et.al.'95)*
Please rate the following considerations on a scale of 1 (unimportant) -4 (very important):
mean range for each rating: 1=1.0-1.75 / 2=1.75-2.5 / 3=2.5-3.25 / 4=3.25-4.0

P9. Worry about child being without a 'designated' or 'known' father. M= 2.9
4= very important 28% **_3=__ important 42% __2=**not very important 21% **__1=_** unimportant 10%

P10. Worry about discrimination or teasing my child might experience growing up M=2.9
4=very important 21% **_3=important 55% __2=**not very important 20% **__1=**unimportant 4%

P11. Lack of financial resources. M=2.8
4=very important 15% **_3= important 51%** **2**=not very important 30% **__1=_** unimportant 3%

P12. Concern about lack of support, acceptance from immediate family. M=2.2
4= very important 7% **_3**= important 30% **2= not very important** 37% **__1=_** unimportant 26%

P13. Lack of support from work, employer. M=1.9
4=_ very important 4% **3=__** important 15% **2= not very important 44% __1=_** unimportant 37%

P14. (Birthmother ->)Worry that I will be left with responsibility of parenting by my current partner M=1.9
4=very important 4% **_3**= important 19% **2=not very important 37% __1=_** unimportant 41%

P15. (Social mother ->)Worry about loss of child should relationship end. M=3.1
4=very important 46% **_3=important 26%** **2**=not very important 20% **__1=_** unimportant 8%

P16. Lack of support, encouragement from friends. M=2.1
4=very important 4% **_3=__** important 26% **2= not very important** 45% **__1=_** unimportant 25%

P17. Family building/type:

Which family configuration appeals to you most? *(Pies '88, p.72)*
8%= couple with Kinderwunsch
2%= single parent with one (or more) child
80%= two women involved in an intimate relationship with one (or more) child
0= two people who are not in a relationship with one (or more) child (ex. Bio-mom and a male or female parenting partner)
0= three or more adults who are primary parents to one (or more) child
10%= extended family – single lesbian or lesbian couple with one (or more) child and other identified people actively involved on a regular basis with child and family
0= extended biological family
0= cooperative family – two or more families living in close proximity and parenting one another's children

P18. What model of parenting between the female partners describes you best or do you aspire to? (*Rohrbaugh '88)*
100%= equal parenting
0=1 parent, 1 significant other

19. Deciding who will get pregnant, i.e. Become the biological mother (first):
How was the decision as to who would be the birthmother made? What issues were involved? *(Rohrbaugh '88)*
mean range for each rating:
1 =Factor(s), that played **no role in decision**. Mean 1.0-1.67
2 =Factor(s), that were important, but not decisive fort he decision. Mean 1.67-2.34
3 =Factor(s), that were the **most important** and influenced your decision the most Mean 2.34-3.0

(total %)	Most decisive	Influential, non-decisive	No role	Mean score
Age	29%	27%	44%	M=1.84
Health	9%	16%	76%	M=1.33
Financial	17%	34%	49%	M=1.68
Foreigner status	2%	2%	96%	M=1.06
Strong desire	**54%**	20%	26%	**M=2.27**
No desire	38%	21%	42%	M=1.97
Donor is relative	2%	3%	95%	M=1.07
Job reasons	23%	28%	49%	M=1.74
Other:	11%	---	---	
i.e. switched roles i.e. simultaneous	4% 7%	---	---	

Significantly more mothers using **known donors** (76%) than mothers using anonymous donors (39%) or identity-release donors (45%) indicated that "one partner's strong desire to experience pregnancy" was a factor that was most important in deciding which woman would bare the first child ($p < .05$).

Significantly more **social mothers** (29%) than birthmothers (13%) indicated that the factor "one partner had no desire to experience pregnancy" was a very **influential**, though non-decisive factor in the decision as to who would get pregnant (first) ($p < .05$).

[Psoz20, 21,22 are answered exclusively by the prospective social mothers]

Becoming a non-biological or social mother: *(Pies '88, p.100)*

Psoz 20. Often when we think of 'mother', we associate it with tasks customary of the primary caregiver to a child. What do you expect the role of 'social mother' to be?

64% like an adoptive mother, that is, primary or shared caregiver but just not biologically related
34% like a father or secondary caregiver
0 like a 'aunt'
2% other

Psoz21. What do you think will be positive about this parenting option for you? *(Pies '88, p.100)* [OPEN]

10 (21%)	To be with child as it grows up [e.g."Ein Kind aktiv beim Heranwachsen begleiten zu dürfen"]
	To have a child /be a mother
9 (19%)	To experience a close bond with the child/love it
6 (13%)	Don't see any difference between birthmother and social mother role
5 (11%)	Everything!
	To be a mother without (having to) give birth
4 (9%)	To accept responsibility
3 (6%)	See the world through a child's eyes/new perspective on life
	Role is not societally defined – freedom to create role for self
2 (4%)	To pass on something of oneself to one's child
1 (2%)	Share parenting

Psoz22. What do think will be difficult for you in the role of non-biological mother? Describe what you see as potential problems. *(Pies '88, p.100)* [OPEN]

30 (64%)	**Negative social aspects**
19 (40%)	**…with respect to society / outside world**
12 (26%)	- social recognition as a mother
10 (21%)	- social acceptance
2 (4%)	- explaining/ justifying oneself, choices, family
15 (32%)	…within the family
7 (15%)	- competition with other parents to child
5 (11%)	- defining the social mother role for oneself
3 (6%)	- fears of loosing children in case of relationship dissolution/ death of birthmother
2 (4%)	- coming to terms with not being the birthmother of the child
14 (30%)	Negative **bonding** aspects
7 (15%)	-not being accepted by the child as its mother
5 (11%)	-child having a stronger bond to the birth mother or being 'left out'
3 (6%)	-bonding with the child
7 (15%)	Negative **legal** aspects
3 (6%)	- legal non-existence of the social mother
1 (2%)	- not being on the birth certificate
1 (2%)	- children being legally 2. class
5 (11%)	Negative **child development** aspects (concerns about puberty)
3 (6%)	Negative **financial** aspects (disadvantageous position of rainbow families)

P20a. What do you *plan* to have the child call the **biological** mother?

52% ***Mama***
20% *Mami*
2% *Mutti*
2% foreign word meaning "Mutter"
2% first name
4% child should come up with it
1% 'mama' + first name
3% 'mama' + name come up with by child
20% no thoughts yet, don't know
0 nickname

There was a trend towards more mothers using anonymous donors (60%)being more likely than mothers using identity-release donors (36%) planning to call the biological mother "Mama" ($p < .1$).

Significantly more mothers using identity-release donors (36%) than mothers using anonymous donors (10%) or known donors (8%) planned to have the biological mother named "Mami" ($p < .05$).

P21. What do you plan to have the child call the **social** mother?

24% ***Mami***
16% *Mama*
16% 'mama' + first name
13% first name
9% no thoughts yet, don't know
8% child should come up with it
7% *Mutti*
4% nickname
2% foreign word meaning "Mutter"
2% 'mama' + name come up with by child

Significantly more mothers using anonymous donors (40%) than mothers using identity-release donors (9%) or known donors (16%) planned on calling the social mother "Mami" ($p < .05$).

Significantly more mothers using identity-release donors (41%) than mothers using anonymous donors (14%) or known donors (5%) planned to call the social mother "Mama" ($p < .05$).

P20b + P22. Please explain why you choose this name: [OPEN]_____

24 (27%)	Name reflects **role** of 'mother' in family + signals **equality**
23 (26%)	Chose because that's what I/she called our mothers
17 (19%)	Name should differentiate between mothers
15 (17%)	Personal preference
9 (10%)	Name for birthmother is what kids typically call their mother/name for social mother is similar to it
7 (15%)	Name reflects stance that birthmother is 'mother' and social mother is not
6 (13%)	Passive name giving, i.e. kids decided or 'happened'
2 (4%)	Name choice by tossing a coin/drawing straws, etc.

P23a. Did you have any models for being a lesbian mother? (*Mercier '99)* **72%** yes / **28%** no

58% I knew lesbian-headed families personally.
18% I knew of lesbian-headed families through others.
37%I knew of lesbian-headed families through the media/Internet/books.

There were also cohort effects: significantly more **mothers with school aged children** (61%) had **no role models** for lesbian parenthood than mothers with younger children (indemination/pregnant, 15%; 0-3 years, 16%; kindergarten age, 29%; $p < .05$).

Conversely, significantly more mothers with younger children had role models for lesbian parenting (insemination/pregnant, 85%; 0-3 years, 84%; kindergarten age, 71%) than mothers with school aged children (39%; $p < .05$). Significantly more women who were inseminating/pregnant (70%) and mothers with children 0-3 years old (66%) had known other lesbian mothers personally than mothers with school aged children (33%; $p < .05$).

[for P23b,c,d: 1=yes, subject marked response/ 2=no, subject did not mark response]

P24. Which advantages do you see for children growing up in lesbian-headed families? (*Johnson & 'Oconnor '02)*?[OPEN]

∑ (%)	
25 (24%)	***Wunschkinder:*** Children are 100% wanted and planned for
15 (14%)	Children will be loved, receive lots of attention, conscious parents
24 (23%)	**Division of labor**: emancipated, egalitarian, flexible
6 (6%)	Models of women: strong, 2 different ones
13 (12%)	2 close caregivers, open talk of feelings
14 (13%)	Diversity: Children will experience various types of couple relationships, families, ways of life
9 (9%)	Family Environment: Children will be brought up in tolerant, open and prejudice-free environments
	As a result, children will be:
27 (26%)	**tolerant of others,** liberal
20 (19%)	**Open in relation to homosexuality, "differentness", diverse ways of life**
13 (12%)	empathetic, sensitive to others and social
5 (5%)	Develop a strong sense of self, self-confident
4 (4%)	Creative and freer in designing their own life paths
3 (3%)	Not heterosexist, homophobic or prejudice against minority sexual identities
3 (3%)	Learn to deal with differentness of others
3 (3%)	More interested in equality, and less traditional roles in couple relationships
2 (2%)	Reflect on social injustice
11 (10%)	No differences

P25. Which special concerns did you have about raising your children in a lesbian home? (*Johnson & 'Oconnor '02)* [OPEN]

34 (32%)	**(non-) acceptance** by the environment	
	Discrimination	16
	Ostracism	5
	Social mother not being taken seriously	1
43 (41%)	Consequences of homophobic society for child	
	That child will be **teased**/be laughed at	22
	That child will be stigmatized/ ostracised	5
	That child will experience **discrimination**	13
	That child will have explain its family	4
	That child will have to listen to homophobic comments	2
7 (7%)	Impact thereof on child's well-being	
	That child has trouble dealing with the above/develops personal problems as a result	4
	That child feels like an outsider	1
	That child internalizes society's homophobia (temporarily)	3
24 (23%)	The father issue	
	Issue of the missing father/male identification figure for child	17
	How the child is going to feel about anonymous donor/no father	7
5 (5%)	Problems in parent-child relationship	
	Reproach from children regarding having no father	3
	Reproach from children regarding having lesbian parents	2
	Concern that child will reject parents	1
5 (5%)	Coping: preparing children to deal with discrimination, our	

society

7 (7%)	Legal issues	
	Absence of financial/legal protection	5
	In case of bio-mom's death, that child can stay with soc-mom	1
9 (9%)	No concerns	

P26. What was the reason most influential in the decision to biologically parent?*(Harvey, et.al.'89)*
[for P26a,b,c,d,e: 1=yes, subject marked response/ 2=no, subject did not mark response]

76% desire to experience pregnancy and childbirth
64% desire to raise a newborn
38% lack of adoptive alternatives
3% concerns about early infant bonding

Method Conception:
P27. Please indicate if and *how actively you pursued* each method of achieving parenthood by checking the appropriate box ***and*** specifying which activities. *(Daniels '94)*
mean range for each rating: 1=1.0-1.75 / 2=1.75-2.5 / 3=2.5-3.25 / 4=3.25-4.0

		Very active 4	Somewhat active 3	Not very active 2	Not at all active/ did not consider 1	**Mean**
P27a	**DI w/ sperm from Sperm Bank**	61% unkn.d. M=3.9	6%	11% kn.d. M=1.8	22%	**M=3.1** Sign. p< .05
P27b	**DI w/ a known man**	45% kn.d. M=3.8	15%	13% unkn.d. M=2.1	27%	**M=2.8** Sign. p< .05
P27c	DI w/ an unknown man+go-between	6%	2%	17%	76%	M=1.4
P27d	Sex w/a known man	2%	0	1%	97%	M=1.1
P27e	Sex w/a unknown man	0	1%	0	99%	M=1.0
P27f	Adoption	1%	7%	32%	61%	M=1.5
P27g	Foster parenting	3%	3%	21%	73%	M=1.4

P28. Please state the major reasons why you preferred insemination over heterosexual sex as a means to achieve conception.
[for P28a,b,c,d,e: 1=yes, subject marked response/ 2=no, subject did not mark response]

71% to sleep with a person outside of my relationship is not an alternative for me/us
63% I didn't want to have sex with a man
16% I didn't want to know the sperm donor
7% fear of contracting STDs
P28e2: (categories based on "other" responses from subjects)
1= didn't want a man involved: emotional+legal reasons
2=convinction: need sperm for conception, not sex
3=that would be like committing adultry
4=partnerin wollte partnerin "schwängern"
5= misc. response

P29. What difficulties did you anticipate with the method of insemination?
[for P29a,b,c,d,e,f: 1=yes, subject marked response/ 2=no, subject did not mark response]

49% difficulty finding a donor who will agree to our idea of his role in our
46% difficulty finding a doctor that will inseminate lesbian
42% difficulty gaining access to sperm banks/identity-release donors
33% cost

29% difficulties storing

Significantly more mothers using **known donors** (87%) than mothers using anonymous donors (24%) or identity-release (23%) anticipated difficulties with DI in **finding a donor** who will agree to their idea of his role in their family (p< .05).

Significantly more mothers using **anonymous** donors (74%) than mothers using identity-release donors (45%) and known donors (18%) anticipated difficulties **finding a doctor** who will inseminate lesbian identified women (p< .05).

Significantly more mothers using **anonymous** donors (48%) and **identity-release** donors (68%) expected difficulty gaining **access to sperm banks/identity-release donors**.compared to mothers using known donors (23%; p< .05).

Significantly more mothers using **frozen sperm** donors (44%) than mothers using fresh sperm donors (17%) identified difficulties due to the **cost** of DI (p< .05).

Significantly more mothers using **identity-release** donors (55%) anticipated problems related to **storing sperm** than mothers using anonymous donors (29%) or known donors (15%; p< .05).

30. What were important sources of information on how to conceive with DI?*(Harvey '89;Chabot '99)*
[for P30a,b,c,d,e,f: 1=yes, subject marked response/ 2=no, subject did not mark response]

53% friends
56% books/Journals
15% physician
3% midwife
32% internet
12% lesbian mother groups, conferences, i.e. LFT, ILSE/LSVD
10% (Feministische) Frauengesundheitszentrum (Berlin & Utrecht), ProFamilia
P30i ___ Klinik/Spermabank directly

Significantly more birthmothers (64%) identified friends as a source of information on how to conceive with DI than social mothers (42%, p< .05). Significantly more mothers who used identity-release donors (68%) identified this information source than mothers who used anonymous donors (41%, p< .05). Significantly more women who were inseminating/pregnant (65%) and mothers whose first DI child was of kindergarten age (65%) identified this source than mothers whose first child was of school age (p< .05).

Source: Internet
Significantly more mothers who first child was 0-3 years (66%) identified the Internet as an important source of information on conceiving with DI than mothers in all current family stages (insemination/pregnant, 35%; kindergarten, 12%; school, 6%; p< .05).

Donor considerations:

31. What characteristics do you consider most important in a donor? Please rate the following on a scale of 1 (unimportant) -4(very important).*(Leiblum et. al. '95)*

mean range for each rating: 1=1.0-1.75 / 2=1.75-2.5 / 3=2.5-3.25 / 4=3.25-4.0

	3+4	1+2	Mean	Anon.D.	Id.-Rel.	Kn.D.
Years of college	74%	25%	2.7			
Ethnicity	48%	53%	2.4			
Height,	30%	69%	1.9	2.1 p< .05	2.1	1.7
Weight	34%	65%	2.1			
Hair color/type	33%	66%	2.0	2.4 p< .05	1.9	1.6
Eye color	24%	76%	1.8	2.2 p< .05	2.7	1.5
Skin tone	67%	32%	2.8	3.0 p< .05	3.3 p< .05	2.4

Occupation	26%	73%	1.9			
Special interests	15%	85%	1.6	1.5	1.4	1.9 p< .05
Body build (fat, skinny, muscular)	29%	70%	2.0			
Religion	4%	96%	1.2			
Blood type	14%	86%	1.6			

P32. What addition knowledge would you like to have about your sperm donor? *(Leiblum et. al. '95)* [OPEN]

∑	Anonymous donors	Identity-release donors	Known donors	
16	5	3	8	**Health history/allergies**
27	13	8	6	none
9	1	2	6	We knew the donor well/had detailed information
8	5	3	0	**Facial appearance/ (childhood) picture**
4	1	1	2	Personality
9	5	2	3	**Motivation to be a donor**
2	1	0	1	Hobbies
1	1	0	0	Occupation
3	1	1	1	Social situation of donor/family history
1	0	0	1	Experience with how donor reacts in conflicts
3	1	2	0	Age
1	0	1	0	Sexuality
1	1	0	0	Family status
1	0	1	0	What form of contact donor wants to child

33**.** Which statement better represents your opinion? Please explain.

P33a. **1=**important **2=**unimportant **3=** both important + unimportant

93% I feel it **is important** to include men in children's lives
because_____**P33b**_____[OPEN]_____

7% I feel it **is *not* important** to include men in children's lives
because_____**P33b**_____[OPEN]_____

Men are part of society/ every day life			*Children should have contact to/interact with men and women*			*Parents desire male role models for child or think it important for development*			*Child is male and will become a man himself*		
no	yes	known	no	yes	known	no	yes	known	no	yes	known
16 (46%)	13 (68%)	20 (56%)	10 (29%)	6 (32%)	10 (28%)	14 (40%)	2 (11%)	9 (25%)	2 (6%)	0 (0%)	4 (11%)
49 (54%)			26 (29%)			25 (28%)			6 (7%)		

P34a. Are there any plans for particular men to play a special role in the child's life? *(Gartrell et. al. '99)*

58% yes/ **42%** no-->go to question#36

Significantly more mothers using identity-release donors (73%, p< .05) and known donors (64%, p< .1) had made plans for men to be involved in their child's life than mothers using anonymous donors (45%).

Significantly more mothers using anonymous donors (55%) had made no specific plans than mothers using identity-release donors (27%, p< .05) or known donors (36%, p< .1).

P34b. If so, what is/are the plan/s? [OPEN] /**8=** NA

∑ responses	Anonymous donor	Identity-release donor	Known donor	Answer categories
14	**5**	**6**	3	Role of godfather
10	0	0	10	Known donor
6	0	0	6	Biological father known to child, but life/home is with mothers
6	2	1	3	Regular contact and activities
5	0	0	5	Social father role
4	1	2	0	Male role model/identification figure
4	3	1	0	Will solve itself; child will locate its own role models
2	1	1	0	Occasional contact and activities

35. This plan ...(me)

[for P35a,b,c: 1=yes, subject marked response/ 2=no, subject did not mark response / 8=NA]

58% of mothers who indicated that they had made special plans to include men in their future child's life had actually **discussed the plan with the men in question** and he explicitly agreed to it. Significantly more mothers using known donors (88%, n=22) had done this than mothers using anonymous donors (26%, n=5) or identity-release donors (47%, n=7; $p < .05$).

47% of mothers who indicated that they had made special plans to include men in their future child's life said **their plan represented a hope** that they have. Significantly more mothers using anonymous (68%) and identity-release donors (67%) indicated this than mothers using known donors (20%; $p < .05$).

15% of mothers who indicated that they had made special plans to include men in their future child's life said that **their plan was more an implicit expectation** they had of the man in question.

Der Vater Frage:

Please describe your personal position with regards to the following issues by rating the degree to which you agree with the following statements.

mean range for each rating: 1=1.0-1.75 / 2=1.75-2.5 / 3=2.5-3.25 / 4=3.25-4.0

Mean level of agreement	Anonymous donor	Identity-release donor	Known donor	statements
1.3 Disagree completely	1.3 Disagree completely	1.5 Disagree completely	1.2 Disagree completely	The only criteria a man needs to fulfil to be considered a father is to establish paternity.
3.4 Agree completely	3.4 Agree completely	3.4 Agree completely	3.4 Agree completely	A man is *father* when he is a role model for a child, takes responsibility for him, and is concerned for its welfare.
1.1 Disagree completely	1.1 Disagree completely	1.0 Disagree completely	1.1 Disagree completely	Men who become mentors and role models to our children do necessarily also have to be biologically related to them.
3.2 Agree somewhat	2.8 Agree somewhat	**3.5 Agree completely**	**3.4 Agree completely**	Children have the right to know their father.
2.2 Disagree somewhat	1.6 Disagree completely	2.4 Disagree somewhat	2.8 Agree somewhat	I think it would be damaging for a child if s/he is never able to know the biological father.

3.2 Agree somewhat	**3.5** **Agree completely**	2.8 Agree somewhat	2.9 Agree somewhat	I believe it is acceptable to bring a child into the world when they will not be able to know their biological father.
2.7 Agree somewhat	**3.0** **Agree somewhat**	2.7 Agree somewhat	2.4 Disagree somewhat	The desire to know one's biological roots is a result of social pressures that make us think no one is whole or fulfilled if they do not know each of their biological parents.
2.5 Disagree somewhat	2.2 Disagree somewhat	**2.6** **Agree somewhat**	**2.7** **Agree somewhat**	The desire to know one's biological roots is a true biological desire of the individual to know their origins and therefore their biological roots.

Means in bold type are significant.

44. Resources/Things that are helpful

What resources available to you in the community have been helpful in planning to become a parent?*(Chabot '99)*

[for P44a,b,c,d,e,f,g: 1=yes, subject marked response/ 2=no, subject did not mark response]

61% other lesbian parents/lesbian parent support groups
44% organizations lobbying for LGBT interests
44% groups for lesbians planning parenthood
86% books/journals/internet
53% Sperm banks/ clinics
39%others, who supported us in our plans
P44g1 ___ other, _____+ [OPEN]_____

(categories based on "other" responses from subjects)
P44g2: **1**= keine
2=uns
3=Arzt

Significantly more mothers using identity-release donors (86%) indicated that the resource "other lesbian parents/lesbian parents support groups" was available and helpful to them than mothers using anonymous donors(54%) or known donors (26%; $p < .05$).

Significantly more mothers using frozen sperm donors (71%) indicated that the resource "sperm banks/clinics" was available and helpful to them than mothers using fresh sperm donors (24%; $p < .05$).

Significantly less mothers whose first child was of school age+ (29%) indicated that the resource "other lesbian parents/lesbian parents support groups" was available and helpful to them than mothers in all other stages of family planning (insemination/pregnancy, 70%; 0-3 years, 66%; kindergarten, 66%; $p < .05$).

Significantly less mothers whose first child was of school age+ (12%) indicated that the resource "others, who supported us in our plans" was available and helpful to them than mothers in all other stages of family planning (insemination/pregnancy, 50%; 0-3 years, 44%; kindergarten, 43%; $p < .05$).

45. What obstacles made it harder to realise your plans to have a child? Welche damalige Missstände erschwerte es Ihnen, Ihren Kinderwunsch zu verwirklichen?
[for P45a,b,c,d,e,f,g,h,i: 1=yes, subject marked response/2=no, subject did not mark response]

67% not having the same access to reproductive medicine, doctors, sperm banks as heterosexual couples (in Germany) do

47% finding a (known) donor
40% finding a doctor who will inseminate lesbians
31% own and other's reactions questioning whether child can develop healthily in a lesbian family
29% finding a sperm bank that will work with lesbian couples
17% own and others reactions questioning the ability of lesbian mothers to be „fit" or "good" mothers
16% not having access or knowing of other lesbian families
12% not having information about how lesbians can have children
5% cost of insemination, financial restrictions
4% none

P45i2: **1**= cost of insemination
2=concerns regarding absent father
3=anti-Kinder Haltung der Lesbenszene
4=nicht geregelten Stand der sozialen Mutter
5=lack of support form family & friends
6=nichts

Significantly more mothers using anonymous donors (90%) and identity-release donors (86%) encountered the obstacle "not having the same access to reproductive medicine, doctors, sperm banks as heterosexual couples (in Germany) do" than mothers using known donors (33%; p< .05).

Significantly more mothers using anonymous donors (64%) encountered the obstacle "finding a doctor who will inseminate lesbians" than mothers using identity-release donors (36%) or known donors (18%; p< .05).

Significantly more mothers using anonymous donors (50%) and identity-release donors (32%) encountered the obstacle "finding a sperm bank that will work with lesbian couples" than mothers using known donors (5%; p< .05).

Significantly more mothers using known donors (72%) encountered the obstacle "finding a (known) donor" than mothers using anonymous donors (26%) or identity-release donors (36%; p< .05).

Significantly less women who were inseminating/pregnant (0) didn't know any other lesbian family than mothers in all the family building stages (0-3 years, 13%, p< .05; kindergarten, 9%, p< .1; school age +, 56%, p< .05).

Significantly more mothers whose first child was of school age + (39%) encountered the obstacle "not having information about how lesbians can have children" than mothers in all other stages of family planning (insemination/pregnancy, 5%; 0-3 years, 3%; kindergarten 11%; p< .05).
(categories derived from "other" responses)

P46. Overall, how supported do you feel in your plans to parent? M=2.6
55% of respondents felt very support (21%) or moderately supported (34%) in their plans to parent.

45% of mothers felt not very supported (30%) or not at all supported (15%) in their plans to parent.

The mean level of perceived social support for all mothers was **2.6** (**moderately supported**). Mothers whose first child was of school age + (x=2.1) perceived significantly less social support in their planning stage than mothers in earlier family building stages, i.e. who parented more recently (insemination/pregnancy, x=3.0; 0-3 years, x=2.7; kindergarten, x=2.7; p< .05)

48. What effect did this decision making and planning process have on.....

61% of mothers indicated that the decision-making and planning process **increased** their sense of well-being. There was a trend towards significantly more birthmothers (69%) indicating an increase than social mothers (52%; p< .1).

17% of mothers indicated that the decision-making and planning process **decreased** their sense of well-being. Significantly more social mothers (28%) than birthmothers (7%) indicated a decrease in well-being with the decision to parent (p< .05).

22% of mothers indicated that the decision-making and planning process brought **no change** to their sense of well-being.

Die folgenden Fragen befassen sich mit dem Spendertyp, den Sie ausgewählt haben. Bitte gehen Sie zu dem Abschnitt mit Ihrem speziellen Samenspender-Typ, den Sie entweder für Ihr erstes DI Kind benutzt haben oder, zur Zeit nutzen, falls Sie bzw. Ihre Partnerin noch am inseminieren sind/ist.

Gefrorenes Sperma von einer Samenbank:

***Ja-Spender (*identity-release donor*)**

....Gehen Sie bitte zu Seite #16 und beantworten Sie Fragen #49 bis #66.

***Nein-Spender (anonymous)**

...Gehen Sie bitte zu Seite #19 und beantworten Sie Fragen #67 bis #82.

Frisches Sperma von einem Mann:

***Bekannter Spender** (=die lesbischen Eltern **kennen diesen Mann persönlich** und haben bzw. hatten direkt mit ihm Kontakt)

.....Gehen Sie bitte zu Seite #22 und beantworten Sie Fragen #83 bis #106.

***Unbekannter Spender** (=die lesbischen Eltern **kennen diesen Mann nicht** und haben bzw. hatten **keinen direkten Kontakt** mit ihm. Kommunikation erfolgte über einen Vermittler.)

.....Gehen Sie bitte zu Seite #26 und beantworten Sie Fragen #107 bis #128.

Gefrorenes Sperma von einer Samenbank: *Ja-Spender (*identity-release donor, frozen sperm*)

Bitte beantworten Sie Fragen #_49_ bis #_66_, wenn Sie bzw. Ihre Partnerin mit einem Ja-Spender inseminieren bzw. inseminiert haben, um Ihr erstes DI Kind zu bekommen.

49. Where both ‚yes' and ‚no' donors available to you at that time?
[for P49a,b,c,d: 1=yes, subject marked response/2=no, subject did not mark response]

0 theoretically, you could choose, but there was a waiting list of ____ months for a ‚yes' donor
0 no, there was only the option of a ‚no' donor
9% no, there was only the option of a ‚yes donor
91% yes, we could choose freely between a ‚yes' and ‚no' donor

50. What are/were the **(**positive**)** aspects of this type of donor and sperm source that made you chose it?*(Pies '88, p.184)*
[for P50a,b,c,d,e,f,g,h,I,j,k,l,m,n: 1=yes, subject marked response/2=no, subject did not mark response]
with respect to frozen sperm...
91% is screened for sexually transmitted diseases and HIV
45% can be shipped to your home or inseminating physician – not dependent on a donor cooperating, having time, etc.
59% additional children can have the same biological father

since the donor is unknown...
55% there will be no third party that is involved in our family and decision-making regarding our child
23% das Kind is nur unser Kind
59% the status of the social mother as a full parent is (best) protected
36% in the event of death of the birthmother, the chances of the social mother gaining custody of the child is greater
41% the donor cannot exercise his rights as father of the child, i.e. We don't have to worry that he will change his mind and want to be more involved in parenting than we feel comfortable with or want custody of the child
9% the child can experience no sense of rejection by the donor

in the case of Ja-spender, even though the donor is unknown...
64% the child can still have access to its "geneological roots"
86% the child may theoretically meet its biological father, should it so wish

Comments: +[OPEN]

51. What **concerns** do you have regarding your type of donor and sperm source?*(Pies '88, p.184)*
[for P51a,b,c,d,e,f,g,h,I,j: 1=yes, subject marked response/2=no, subject did not mark response]
with frozen sperm...
43% lower pregnancy rates than with fresh sperm
10% higher number of male births than with fresh sperm
5% sperm have been subjected to a process that alters their natural environment
24% is costly
19% to increase pregnancy rates, you have to inseminate intra-uterine which requires inseminating with a medical professional

for a Ja-Spender...
24% the child will have to live with not knowing its geneological roots/who the biological father is until it is an adult
38% the child may build up an unrealistic image of its donor that the actual person, upon meeting, shatters
38% the donor may not agree to have his identity released upon child's request after all

Comments: + [OPEN]

P52. Please explain under which circumstances or conditions will the donor's identity be released? (me) [OPEN]
(categories based on subjects responses)
36% when the child expresses interest in meeting him or asks to
50% when the child reaches 18 yrs. Of age
36% when the child reaches 16 yrs. Of age
9% if donor can be found and he still agrees
9% äußerliche Merkmale ab 14 J
n=1 when child is 3 months old

P53. The donor's identity will be released :(me)
n=1 to the parents only
91% to the child only
n=1 both (parents & child)

P54. Who has the information?(me) +[OPEN]
[for P54a,b,c: 1=yes, subject marked response/2=no, subject did not mark response]
(categories based on subject's responses)
p54a Notar/Anwalt
p54b Samenbank /Klinik
p54c Stiftung

P55. What will be the procedure for the donor's identity being released? (me) The sperm bank/notary/Stiftung will release the donor's identity:

10% only after first consulting with the donor to see if he is still willing to have his identity released.
55% in any case/ without consulting the donor to see if he is still willing to have his identity released
36% I don't know exactly whether a or b will be the case

P56. Where will you get the sperm from?

14% (n=2NL, 1 USA))	The medical professional/clinic performing the insemination will provide the sperm.
68% (n=15)	Directly from the sperm bank in Holland.
0% (n=0)	Directly from the sperm bank in Denmark.
27% (n=6)	Directly from the sperm bank in USA.

57. If you get it directly through the sperm bank, how will the sperm bank get the sperm to you?
[for P57a,b,c: 1=yes, subject marked response/2=no, subject did not mark response]

18% it will be mailed/sent by courier directly to me
36% it will be mailed/sent by courier only to a doctor's office
59% it will be picked up from the sperm bank personally

58. Where will the sperm be stored?
[for P58a,b,c: 1=yes, subject marked response/2=no, subject did not mark response]

45% at my home
41% in a doctor's office
P58c *___other, please specify _____ +[OPEN]_____*
(further categories based on subject's responses)
27% in the spermbank/clinic that inseminated
9% at another's house, i.e. friends, other's sharing container

59. How was it planned for the inseminations to be performed?
[for P59a,b,c: 1=yes, subject marked response/2=no, subject did not mark response]

50% self-insemination
68% clinical insemination in an IVF clinic or other reproductive specialist

60. Who picked the donor?
[for P60a,b,c,d: 1=yes, subject marked response/2=no, subject did not mark response]

48% I/we did.
19% The medical professional of the klinik /practice that performed the insemination
52% the personal at the sperm bank

P61. Did you have any input regarding the donor profile?(me)

71% no
29% yes, and the following was important to me/us:__+ [OPEN]_____

47% (n=7)	General physical attributes
20% (n=3)	Skin color-ethnic group
20% (n=3)	Size-figure
13% (n=2)	Should resemble social mom
7% (n=1)	Eye-hair color
7% (n=1)	Health: hereditary disease
7% (n=1)	Personality characteristics: empathetic
27% (n=4)	No choice in donor because there was only one identity-release donor to chose from

62. What knowledge do you have of your sperm donor?*(Dundas & Kaufmann '00* (formulation of questions is my own))
[for P62a,b,c,d,e,f,g,h: 1=yes, subject marked response/2=no, subject did not mark response]

23% nichts
64% non-identifying information:
59% physical characteristics,i.e.Hair and eye color,height, weight, age
45% education
36% hobbies/interests
32% personality description
32% medical history
41% ___ other _____+ [OPEN]_____

P63. Describe your internal image of your donor. *(Dundas & Kaufmann '00*) [OPEN]

60% (n=12)	No internal image
20% (n=4)	Tall
15% (n=3)	Nice, friendly, pleasant person
10% (n=2)	Dutch/skandinavian/ based on origin of donor
10% (n=1)	Resembles social mom
10% (n=1)	Based on characteristics of child
10% (n=1)	Based on physical description of donor

P64. Did you ever wish to meet your sperm donor? *(Leiblum et.al. '95)*
36% yes / **64%** no

65. If yes, when would you have liked to have met him?
[for P65a,b,c,d: 1=yes, subject marked response/2=no, subject did not mark response/8=NA]
base: those 8 subjects who would like to meet donor
n=1 before the insemination
0 during pregnancy
n=3 within a year after delivery
n=5 ___ other, please specify _____+ [OPEN]_____
Categories based on responses:

P66. Did you ever wish your child could meet his/her sperm donor? *(Leiblum et.al. '95)*
30% yes / **10%** no / **50%** if child so wishes / **10%** we don't yet have a child

Gefrorenes Sperma von einer Samenbank: *Nein-Spender (*anonymous*)

Bitte beantworten Sie Fragen #67 bis #82, wenn Sie bzw. Ihre Partnerin mit einem Nein-Spender inseminieren bzw. inseminiert haben, um Ihr erstes DI Kind zu bekommen.

67. Where both ‚yes' and ‚no' donors available to you at that time?
[for P67a,b,c,d: 1=yes, subject marked response/2=no, subject did not mark response]

7% theoretically, you could choose, but there was a waiting list of _[OPEN]___ months for a ‚yes' donor
95% no, there was only the option of a ‚no' donor
0 no, there was only the option of a ‚yes donor
2% yes, we could choose freely between a ‚yes' and ‚no' donor

68. . What are/were the **(**positive**)** aspects of this type of donor and sperm source that made you chose it?*(Pies '88, p.184)*
[for P68a,b,c,d,e,f,g,h,I,j,k: 1=yes, subject marked response/2=no, subject did not mark response]

with respect to frozen sperm...
95% is screened for sexually transmitted diseases and HIV
52% can be shipped to your home or inseminating physician – not dependent on a donor cooperating, having time, etc.
48% additional children can have the same biological father

since the donor is unknown...
79% there will be no third party that is involved in our family and decision-making regarding our child
60% das Kind is nur unser Kind
69% the status of the social mother as a full parent is (best) protected
57% in the event of death of the birthmother, the chances of the social mother gaining custody of the child is greater
74% the donor cannot exercise his rights as father of the child, i.e. We don't have to worry that he will change his mind and want to be more involved in parenting than we feel comfortable with or want custody of the child
26% the child can experience no sense of rejection by the donor

Comments: [OPEN]

69. What **concerns** do you have regarding your type of donor and sperm source?*(Pies '88, p.184)*
[for P59a,b,c,d,e,f,g,h,I,j: 1=yes, subject marked response/2=no, subject did not mark response]

with frozen sperm...
45% lower pregnancy rates than with fresh sperm
10% higher number of male births than with fresh sperm
2% sperm have been subjected to a process that alters their natural environment
33% is costly
21% to increase pregnancy rates, you have to inseminate intra-uterine which requires inseminating with a medical professional

Regarding a 'no' donor...
71% the child will have to live with not knowing its geneological roots/who the biological father is
40% at some point in the child's life, it may experience resentment or anger towards the parents for making the decision to use an anonymous donor
43% the parents have to carry the responsibility for the child not knowing its biological father for better or worse
17% in the case of a medical emergency (i.e. Transplantation), the other genetic parent can not be found

Comments: [OPEN]

70. If you could choose, would you want non-identifying information about your donor?
(Wendland et.al. '96; Baetens & Brewaeys '01)

_13% yes	20% tendency yes	20% tendency no	48% no

71. If you could choose, would you prefer for the donor's identity to be available to the child?
(Wendland et.al. '96; Baetens & Brewaeys '01)

10% yes	13% tendency yes	40% tendency no	38% no

P72. Where will you get the sperm from?

55% (n=22)	The medical professional/clinic performing the insemination will provide the sperm.
28% (n=11)	Directly from the sperm bank in Holland.
15% (n=6)	Directly from the sperm bank in Denmark.
3% (n=1)	Directly from the sperm bank in USA.

73. If you get it directly through the sperm bank, how will the sperm bank get the sperm to you?
[for P73a,b,c: 1=yes, subject marked response/2=no, subject did not mark response]

41% it will be mailed/sent by courier directly to me
35% it will be mailed/sent by courier only to a doctor's office
35% it will be picked up from the sperm bank personally

74. Where will the sperm be stored?
[for P74a,b,c: 1=yes, subject marked response/2=no, subject did not mark response]

37% at my home
47% in a doctor's office
P74c *___other, please specify _____ +[OPEN]_____*
(based on subject's responses…)
21% spermbank/clinic where inseminated
0 another home, i.e. friend's house

75. How was it planned for the inseminations to be performed?
[for P75a,b,c: 1=yes, subject marked response/2=no, subject did not mark response]

22% self-insemination
90% clinical insemination in an IVF clinic, spermbank, other reproductive specialist

76. Who picked the donor?
[for P60a,b,c,d: 1=yes, subject marked response/2=no, subject did not mark response]

46%	The medical professional at the clinic that performed the insemination.
44%	I/we did.
22%	The person at the sperm bank.

P77. Did you have any input regarding the donor profile?(me)
80% no
20% yes, and the following was important to me/us:__+ [OPEN]_____

	Categories from responses
22	General physical attributes
12	Should resemble social mother
10	Eye-hair color
6	Personality characteristics : 1 stable, 1 nice, 3 *Lebensfreude*, 1 intelligent
4	Skin color-ethnic group
4	Size-figure

2	Health: 1 blood group, 1 allergies
2	education
1	occupation
4	Had no wishes regarding profile

78. What knowledge do you have of your sperm donor?*(Dundas & Kaufmann '00* (formulation of questions is my own))
[for P78a,b,c,d,e,f,g,h: 1=yes, subject marked response/2=no, subject did not mark response]

40% nichts
60% non-identifying information:
57% physical characteristics,i.e.Hair and eye color,height, weight, age
48% education
7% hobbies/interests
12% personality description
12% medical history
19% ___ other _____+ [OPEN]_____

P79. Describe your internal image of your donor. *(Dundas & Kaufmann '00*) [OPEN]

	Categories based on responses
51% (n=20)	No internal image
15% (n=6)	Tall
13 % (n=5)	Image based on characteristics of child
13 % (n=5)	Handsome
8% (n=3)	Resembles social mom
5% (n=2)	Dutch/skandinavian/ based on origin of donor
5% (n=2)	Based on physical description of donor
5% (n=2)	Sporty, athletic
3% (n=1)	Nice, friendly, pleasant person

P80. Did you ever wish to meet your sperm donor? *(Leiblum et.al. '95)*
12% yes / 88% no

81. If yes, when would you have liked to have met him?
[for P81a,b,c,d: 1=yes, subject marked response/2=no, subject did not mark response/8=NA]
base: those who wish to meet sperm donor
40% before the insemination
20% during pregnancy
20% within a year after delivery
40% other, please specify _____+ [OPEN]_____

P82. Did you ever wish your child could meet his/her sperm donor? *(Leiblum et.al. '95)*
17% yes / **12%** no / **71%** if child so wishes / 0 we don't have a child yet

Dieser Abschnitt ist hier zu Ende.
Gehen Sie bitte vor zur Seite #30

4.0 Kinderwunsch:Insemination.

Frisches Sperma von einem Mann:

***Bekannter Spender** (=die lesbischen Eltern **kennen diesen Mann persönlich** und haben bzw. hatten direkt mit ihm Kontakt) Donor known to prospective parents

Bitte beantworten Sie Fragen #83 bis #106 , wenn Sie bzw. Ihre Partnerin mit frischem Sperma von einem bekannten Spender inseminieren bzw. inseminiert haben, um Ihr erstes (DI) Kind zu bekommen.

83. What are the positive aspects of this type of donor and sperm source that made you chose it?
[for P83a,b,c,d,e,f,g,h,I,j,k,l,m,n: 1=yes, subject marked response/2=no, subject did not mark response]
Fresh sperm....

56% higher pregnancy rates than frozen sperm
28% more equal ratio of female-to-male births than with frozen sperm
46% more natural
51% less costly or for free

since the donor is known....

92% the child may know its biological father
26% the parents are flexible as to when to release the identity of the donor to child and/or having them meet
54% the parents can provide the child with information about its donor
56% the donor may be a person involved in the child's life
21% the father of the child is identifiable to the world
3% the situation is more similar to a heterosexual nuclear family
64% additional children may have the same biological father
31% in the case of a medical emergency (i.e. Transplantation), the other genetic parent can be found

Comments: [OPEN]

84. What **concerns** do you have with your choice of donor type and sperm source?
[for P84a,b,c,d,e,f,g,h,I,j,k,l,m,n: 1=yes, subject marked response/2=no, subject did not mark response]

Fresh sperm

42% every sperm sample can not be tested for sexually transmitted diseases and HIV before use
42% sperm must be used quickly, which means organizing to have donor, recipient and inseminator in close physical proximity of one another
47% obtaining sample can be embarrassing for all involved

since the donor is known...

79% there is the risk that he may want to be more or less involved with the child than the parents want or originally agreed upon
53% there is the risk that he may sue for custody or assert paternity rights against the parents' will
53% it calls into question the role of the social mother as a parent to the child if there is an identifiable mother and father to the child
Comments:

P85. What method(s) of getting the word out that you're looking for a donor did you use?*(Pies '88, p.191*) [OPEN]
(categories created based on subject's responses)
[1=yes, subject marked response/2=no, subject did not mark response]

p85a ___directly asked the man, who came in question
p85b ___told friends you're looking for a donor
p85c ___ Anzeige
p85c1 ___ in general or not specified media
p85c2 ___ in Internet

p85c3 ___ in gay magazine
p85d ___ service, z.B. "Queer & Kids"

P86. How did you eventually find your donor?(me) [OPEN]
(categories created based on subject's responses)
1= ___directly asked the man, who came in question
2=___told friends you're looking for a donor
3= ___Anzeige, in general or not specified media
4= ___ Anzeige, in Internet
5= ___ Anzeige, in gay magazine
6= ___ service, z.B. "Queer & Kids"

Method of getting word out	N tries	% tries	N success	% success
directly asked the man, who came in question	20	44%	15	75%
told friends you're looking for a donor	12	27%	8	67%
Anzeige, in general or not specified media	3	7%	3	100%
Anzeige, in Internet	5	11%	4	80%
Anzeige, in gay magazine	4	9%	3	75%
service, z.B. "Queer & Kids"	1	2%	1	100%

P87. Did you use a go-between to communicate? *(Pies '88, p.191*)……
15% yes / **85%** no

P88. Was your donor originally intended to be unknown to you?(me)
11% yes / **86%** no / **3%** was left up to the donor

89. Which category does your donor fall in? *(Pies '88, p.191*)
[for P89a,b,c,d,e,f,g,h,I,j: 1=yes, subject marked response/2=no, subject did not mark response]
5% brother of the social mother
5% other relative of the social mother
8% heterosexual friend
36% homosexual friend
26% man, previously unknown to us, who responded to our ad (in newspaper/magazine/internet) or we to his ad
21% man, previously unknown to us, introduced to us by a common friend/aquaintance
P89g *___ sonst, und zwar ___[+OPEN]_____*
(new answer category based on subject's responses)
n=1 service, ex. "Queer & Kids"

90. Which criteria were most important to you when looking for a donor?*(Pies '88, p.195)*
[for P90a,b,c,d,e,f,g,h: 1=yes, subject marked response/2=no, subject did not mark response]
11% specific physical attributes
61% health
50% specific personality traits
42% intelligence
5% occupation
53% willingness to undergo health screening
87% willingness to accept and agree to our model of family and his role of donor in it
13% other, und zwar _____+ [OPEN]_____
(last 3 categories based on subject's responses)
p90h *___ interpersonal issues (liking eachother, know eachother well, getting on well, imaging being in contact forever)*
p90i *___ flexibility of donor w/ respect to inseminations*
p90j *___ blood relation of social mother (so child will also be blood related to social mother)*

91. Please check the appropriate statement

18% I/we did *not* have our donor go through any health screening.

82% =I/we asked our donor to have the following health screening:

[for P91b1,2,3,4,5,6,7,8: 1=yes, subject marked response/2=no, subject did not mark response / 8= NA, since no request for health screening]

38% semen evaluation
8% personal and family health history
0 physical examination
8% laboratory tests, general
46% Hepititis B *+/or C*
77% HIV test
0Cyto-megalo virus or C.M.V., a virus that causes miscarriage and birth defects
8% other, _____+ [OPEN]_____
(change in category due to subject's answers)
P91b8 ___ Blutspendeausweis

P92. Why, in your opinion, did your donor agree to become a 'known donor'?*(Martin '95; Cooper '97)* [OPEN]
(categories based on subject's snwers)

Categories based on responses	N	%
eigener Kinderwunsch, evtl. Chance Vater zu sein ohne Verantwortung bzw. Trotz eigener homosexualität	21	60%
uns zu liebe; um uns zu helfen, diesen Wunsch zu erfüllen	5	14%
politischen Gründen (z.B. Solidarität mit Lesben)	3	9%
don't know exactly	3	9%

93. Who are the designated parents to this child (in planning)? (women only, the donor as well?) *(Martin '95,p.89)*

[for P93a,b,c,d: 1=yes, subject marked response/2=no, subject did not mark response]

100% biological mother
97% social mother
18% donor/biological father
P93d ___other, und zwar _____+ [OPEN]_____
(new category based on subject's answers)
8% ___ Lebensgefährte des biolog. Vaters bzw. Social father

94. What terminology should your child use when speaking about the donor?(me)

[for P94a,b,c,d,e,f: 1=yes, subject marked response/2=no, subject did not mark response]

19% "*Papa*"
0 "*Onkel ...*"
76% first name
3% nickname
P94e ___other, please specify _____
(new category based on subject's answers)
p94e ___ time will tell
19% the child should come up with it

95. What (social) role should the donor/biological father take on in your family?(me)

[for P95a,b,c,d,e,f: 1=yes, subject marked response/2=no, subject did not mark response]

36% none
28% family friend
25% uncle
3% Patenonkel
25% social father/"papa"

P95f ___other, please specify _____
(new categories based on subject's answers)
6% *"väterliche Aussensatelit"; betw. Uncle-papa, da Lebensmittelpunkt bei den Müttern*
11% *biological father with sporadic contact, i.e. holidays or 1-2 /J*

P96. Who will have custody of the child? *(Martin '95,p.89)*
97% the birthmother, only
3% the biologic parents, jointly

97. Will the name of the donor appear on the birth certificate? *(Martin '95,p.89)*

P97a. damals	***P97b. heute***
18% yes/82% no	**18% yes/82% no**

P98. The child's last name will be the last name of the ....*(Martin '95,p.89)*
85% birthmother
10% social mother (in the case of Eingetragene Lebenpartnerschaft)
2% biological father/ donor

P99. Welche Vereinbarungen haben Sie zwischen dem Spender bezüglich Kontakt zur Familie und dem Kind getroffen? [OPEN]

Categories from responses	N	%
No contact, until child asks	16	43%
Occassional contact	12	32%
Regular contact	7	19%

100. If the plan is for your child and the donor to interact regularly, will he have: *(Martin '95,p.89)*
P100a decision-making power? **15% yes/ 77% no / 8=NA, since no contact planned**

If so, how much?_____ ____+ [OPEN]_____
4 women (2 couples): 'big' decisions, ex. School choice

P100b Financial responsibilities?..... **8% yes/ 85% no / 8=NA, since no contact planned**
If so, how much?_____ ____+ [OPEN]_____
6 women (3 couples) similar to child support

. **P100c** Childcare responsibilities?..... **30%yes/ 62% no / 8=NA, since no contact planned**
If so, how much?_____ ____+ [OPEN]_____
8 women ~ babysitting
4 women ~ divorced father visitation (1x wk/ 2x weekend/vacations)

P101. When/What information about the child and/or your family is the donor allowed to reveal to his friends and family members?*(Martin '95,p.89)* [OPEN]

Categories from responses	N	%
Anything he wants	22	62%
Haven't discussed	7	19%
other	8	22%

P102. When /What information about the donor will you reveal to your family, friends, etc.?*(Martin '95,p.89)* [OPEN]

Categories from responses	N	%
Anything he wants	25	64%
Haven't discussed	6	15%
No info	3	8%
other	5	14%

P103. Did you come up with specific agreements regarding future attempts to gain custody should recipient die, become disabled or partnership split, etc.? *(Martin '95,p.89)* …….**56% yes / 44% no**

P104. Was it concrete in writing, i.e. Donor-recipient-agreement?*(Martin '95,p.89)*….**23% yes / 77% no**

105. How much negotiation took place to define the role? *(Martin '95,p.89)*
[for P105a,b,c,d,e: 1=yes, subject marked response/2=no, subject did not mark response]
26% a lot
64% a little
10% none at all
5% we have yet to come to an agreement
26% we're still negotiating/its an ongoing process

P106. Were any plans made as to how to deal with changes in the way parties felt?(Martin '95,p.89)**13% yes / 87% no** If so, what are they?(me) + [OPEN]

N=5 Discuss and try and to come to solution that is acceptable for all

Dieser Abschnitt ist hier zu Ende.
Gehen Sie bitte vor zur Seite # 30,

→Miscellaneous questions to round it out:
Insemination: (bio mom#27, 30, 31, 32) (in)

in27/soz23. Over what period of time did you consider parenthood from the first thought until undergoing the first insemination cycle? M(S)=2.1 (1.7) years

Schwangerschaft (bio mom # 30, 31, 32, 33) (sch)

Gender Preference:
sch30/soz18. I hope my baby is …

32% a girl
5% a boy
62% I don't care which sex it is

Significantly more known donor mothers (46%) endorsed preferring a girl than anonymous donor mothers (17%; p< .05).

Significantly more anonymous donor mothers (78%) endorsed no having a preference than known donor mothers (51%; p< .05).

Sexual Orientation/Identity Preference:
sch31/soz19. When I imagine my child is a **girl**, then I hope it will be …

1% heterosexual
1%homosexual
0 bisexual
98% I don't care what sexual orientation/identity the child develops.

sch32/soz20. When I imagine my child is a **boy**, then I hope it will be …

2% heterosexual
2% homosexual
0 bisexual
96% I don't care what sexual orientation/identity the child develops

sch33/soz21. I will support my child no matter what sexual orientation/identity it later develops. M=4.0

4=agree completely	**3=** more agree	**2=** more disagree	**1=** disagree completely
97%	3%	0	0

Family heute (bio mom# 1,2,18, ?19, ?22, ?23, ?24, ?25, ?26, ?27, ?37, 38, 39, 40-47, 58, 59, ?69a, ?70a, ?71a) (fh)

fh1a. What phase of family formation are you and your partner currently in? (me)

11% I/we are inseminating. -->go to ##
8% I/my partner is pregnant. --> go to ##
19% Our first child is 0-12 months old.
10% Our first child 1-3 years old.
36% Our first child attends Kindergarten.
12% Our first child attends elementary school.
4% Our first child attends weiterführende Schulen.

[1=yes, subject marked response/ 2=no, subject did not mark response]
7% We separated **M(s)= 3.6 (3.2) years** ago
2% I no longer have any contact to the woman I planned my first DI child with.

2. How many childern belong in your family?		**Born (year)**	**age (years)**	**Biological child from...**
1.Kind **fh2a1** **56% yes**	**fh2a2** **1**= Mädchen **2**=Junge **8=NA**	**fh2a3** **[year]** **88=NA**	**fh2a4** **[# age]** **88=NA**	**fh2a5** **1**=me **2**= my partner **3**=other person **8**=NA
2.Kind **fh2b1** **22% yes**	**fh2b2** **1**= Mädchen **2**=Junge **8**=NA	**fh2b3** **[year]** **88=NA**	**fh2b4** **[# age]** **88=NA**	**fh2b5** **1**=me **2**= my partner **3**=other person **8=NA**
3.Kind **fh2c1** **6% yes**	**fh2c2** **1**= Mädchen **2**=Junge **8=NA**	**fh2c3** **[year]** **88=NA**	**fh2c4** **[# age]** **88=NA**	**fh2c5** **1**=me **2**= my partner **3**=other person **8=NA**
4.Kind **fh2a1** **0 yes**	**fh2a2** **1**= Mädchen **2**=Junge **8=NA**	**fh2a3** **[year]** **88=NA**	**fh2a4** **[# age]** **88=NA**	**fh2a5** **1**=me **2**= my partner **3**=other person **8=NA**

Total 87 children: 48% (n=42) are girls and 52% (n=45) are boys.
Mean age of children is M(S)= 4.2 (2.9) years of age.

[OPEN]

Outer familial support:
Mean score range: 1=1.0-1.75; 2= 1.75-2.5; 3= 2.5-3.25; 4= 3.25-4.0
fh40/soz41. The birth mother's family of origin is supportive of the way we are forming/ have formed our family. *(Shelley-Sireci & Ciano-Boyce '99) M=3.3*

4= strongly agree	**3=** agree	**2=** disagree	**1=** strongly disagree
44%	40%	13%	3%

fh41/soz40. The social mother's family of origin is supportive of the way we are forming/ have formed our family.*(Shelley-Sireci & Ciano-Boyce '99)M=3.1*

4= strongly agree	**3= agree**	**2=** disagree	**1=** strongly disagree
33%	**49%**	13%	6%

fh42. Our community is supportive of the way we are forming/have formed our family.*(Shelley-Sireci & Ciano-Boyce '99)M=3.4*

. 4= strongly agree	**3=** agree	**2=** disagree	**1=** strongly disagree
44%	50%	6%	0

fh43. Our friends are supportive of the way we are forming/have formed our family.*(Shelley-Sireci & Ciano-Boyce '99)M=3.7*

. 4= strongly agree	**3=** agree	**2=** disagree	**1=** strongly disagree
73%	25%	2%	0

Contact to LGBT scene/community:
fh44. Wie engagiert/aktiv sind Sie heute in der schwul/lesbischen Szene? M=2.1

4= very active 6%	**3=** more active 14%	**2= more inactive 61%**	**1=** completely inactive 20%

fh45. Wie engagiert/aktiv sind Sie heute in Gruppen für und von lesbischen Müttern? M= 2.3

4= very active 8% **3=** more active 36% **2= more inactive 32%** **1=** completely inactive 24%

School aged (M=2.8) and kindergarten (M=2.5) aged children mothers are significantly more active in LG mother groups than inseminating/pregnant women (M=1.8) or moms with kids 0-3 years (M=2.0, p< .05)

fh46. How muc/how often do you have contact with other lesbian mothers or lesbians with Kinderwunsch?

5% none
18% at least once a week
42% at least once a month
25% at least once every 3 months
4% at least once every 6 months
2% at least once a year
? daily
3% seldom/by chance/not personal(Email)

fh47. Would you like to have more contact to other lesbian headed families or lesbians with Kinderwunsch? **72% yes / 28% no**

---

fh58. How many additional children did you and your partner plan to have after the birth of your first child? (*McCullough*) [#children]/ **8=NA, b/c no child yet**

M(s)= 1.0 (0.6) children

59. If further children were planned, which mother was supposed to have these additional children?

[1=yes, subject marked response/ 2=no, subject did not mark response]

57% Birthmother of first child
57% Social mother of first child

fh69: Please check the appropriate box to indicate how **satisfied** you were with your relationship during each phase of the family building process.

4= very satisfied 3=more satisfied 2=more dissatisfied 1=very dissatisfied

For each phase, please ask yourself the question: "How satisfied was I with our relationship during ....

fh69a: the planning phase.

4= 74% 3=21% 2=5% 1=1% **M=3.7**

fh69g: Did you separate from your partner in any of the above phases? **1=yes/2=no**

fh69h: When? 1=planning phase

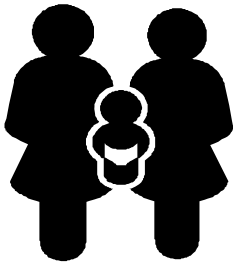
fh70a: please ask yourself the question: "How often did my partner and I have sexual contact during ....the planning phase.

fh71. For each phase, please ask yourself the question: "How often did my partner and I have conflicts during ....the planning phase.

fh71a: the planning phase.

5= much > than average **4=** more than average **3=**average **2=**less than average **1=**much < than average

Planning Phase	Intimacy	Conflict
5	7%	3%
4	6%	10%
3	**84%**	**70%**
2	1%	8%
1	2%	9%
Mean	3.2	2.9



Konstanz, den 24. Mai 2004

Liebe Teilnehmerinnen!

Vielen Dank, daß Sie sich bereit erklärt haben, an dieser Untersuchung teilzunehmen! Ich freue mich riesig darüber, da es mir sehr am Herzen liegt, Familien mit lesbischen Eltern in die wissenschaftliche Diskussion zu bringen und damit sichtbar(-er) zu machen. Während es in anderen Ländern, z.B. USA, Großbritannien, und den Niederlanden, Untersuchungen zu Familien mit lesbische Eltern seit 10 Jahren gibt, bleibt dieses Thema in Deutschland weitestgehend unberührt und ungefördert. Mit dieser Studie möchte ich einen Betrag leisten, diese Situation zu ändern. Ihre Angaben sollen dazu beitragen, erste Information darüber festhalten, wie wir den Familienbildungsprozess und danach erleben.

Die Untersuchung ist Teil einer Dissertation in Psychologie an der Universität Basel, Schweiz unter der Supervision von Prof. Dr. Udo Rauchfleisch. Die Idee für diese Studie stammt aus einer Zeit, in der ich lange inseminiert habe und vergebens auf eine Schwangerschaft gehofft hatte. Diese Untersuchung sollte 'mein Baby' werden. In der Zwischenzeit ging meine Ursprungshoffnung doch noch in Erfüllung – sogar zwei Mal – aber dieser Traum, eine Untersuchung über Lesben mit Kinderwunsch und Familien mit lesbischen Eltern in Deutschland auf die Beine zu stellen, ist trotzdem geblieben. Nun ist es so weit. Der Fragebogen ”Unconventional Conceptions: Lesbische Frauen im Familenbildungsprozess und danach” ist fertig konstruiert und bereit an Sie zu verteilen!

Teilnahmeberechtigt sind :
*lesbische Frauen und Paare mit Kinderwunsch, die bereits mindestens ein Inseminationszyklus unternommen haben.
* alle Frauen oder Paare, deren **erstes** Kind per Insemination mit Spendersamen gezeugt wurde und zu diesen Zeitpunkt sich als lesbisch definierten. Das engere Kriterium ist, daß die lesbische Frau oder Frauen keine vorherige Kinder hatte(n), z.B. aus vorangegangener Ehe. Sollten Sie das engere Kriterium nicht erfüllen, melden Sie sich bitte bei mir, damit wir feststellen können, ob Sie trotzdem an der Untersuchung teilnehmen können! Sie erreichen mich unter tel. xxxxx/xxxxxx oder Lisa.Green@uni-konstanz.de .

Die gewünschte Information wird **anonym** per Fragebogen erhoben. Die erste Seite des Fragebogens erfragt persönliche Information; diese Seite wird bei Rücksendung abgetrennt und gesondert aufbewahrt. Dieses Vorgehen ermöglicht es, den Fragebogen anonym auszuwerten. Also seien Sie bitte mit Ihren Angaben **ehrlich** – es gibt keine richtige und keine falsche Antworten. Es kommt allein auf Ihre Erfahrungen und Erleben von dem Familienbildungsprozess darauf an!

Die Veränderungen, die der Übergang zur Elternschaft mit sich bringen, sind am deutlichsten beim erstgeborenen Kind zu spüren. Mit diesem Kind wird aus einer Dyade (das Paar) eine Triade (die Kleinfamilie). Dieser Prozess ist Gegenstand dieser Untersuchung. Aus diesem Grund befasst sich der Fragebogen ausschließlich mit dem ersten Kind, das ein lesbisches Paar durch Insemination bekommen hat.

Der Fragebogen "Unconventional Conceptions: Lesbische Frauen im Familenbildungsprozess und danach" gibt es in zwei Versionen: Fragebogen für die Geburtsmutter und Fragebogen für die soziale Mutter. Die Einteilung der Mutterrolle erfolgt anhand der **Rolle jeder Frau bei dem ersten Kind, die sie per Insemination bekommen haben.** Die leibliche Mutter des ersten Kindes bearbeitet bitte den Fragebogen für die Geburtsmutter, während die soziale Mutter des ersten Kindes den für die soziale Mutter bearbeiten soll. Halten Sie bitte diese Einteilung ein, auch wenn es weitere Kinder in einer Familie gibt und wenn die Frauen beide Mutterrollen zur Zeit innehaben. Eine Comutter soll nur dann den Fragebogen für die soziale Mutter ausfüllen, wenn sie schon bei der **Planung des Kindes** beteiligt war.

Der Fragebogen ist organisiert in zwei Teile. Der erste Teil ist chronologisch nach Phasen aufgebaut: Coming out – Kinderwunsch: Planung – Kinderwunsch: Insemination – Schwangerschaft – Geburt – Übergang zur Elternschaft – Kindergarten. Ihre Angaben sollen aus der **damalige** Perspektive gemacht werden. Sie bearbeiten allerdings nur die Phasen, die Sie schon durchlebt haben. Der zweite Teil befasst sich mit dem **heutigen** Stand Ihre Familie.

Eine Warnung: Mir ist bewußt, daß der Fragebogen **sehr lang** ist**.** Zum Teil liegt es daran, daß Antwortmöglichkeiten geboten werden und um es optisch ansprechend zu machen. Zum Teil liegt es daran, daß es **eine Fülle von Information zu erheben** gibt! Ich habe in mehreren Durchgängen diesen Fragebogen gekürzt. Es war nicht möglich noch mehr zu kürzen, ohne wesentliche Qualitätseinbüssen hinzunehmen. Sie beantworten aber nur die Fragen, die zu Ihrer Situation passen. Die Ihnen vorliegenden Fragebögen benötigen ca. x Stunden auszufüllen. **Daher arbeiten Sie bitte zügig, antworten Sie spontan und überlegen Sie nicht zu lang bei einzelnen Fragen.** Machen Sie bitte Pausen und bearbeiten Sie den Bogen in zwei oder mehrere Sitzungen wenn nötig. Arbeiten Sie bitte **sorgfältig** und achten Sie darauf, daß Sie keine Seiten überspringen. Halten Sie durch. Sie haben so viel wichtige und interessante Information zu vermitteln!

Ich würde mich sehr freuen, wenn Sie sich nach Durchsicht der Unterlagen zu einer Teilnahme bereit sind und danke Ihnen ganz herzlich für Ihre Mitarbeit!

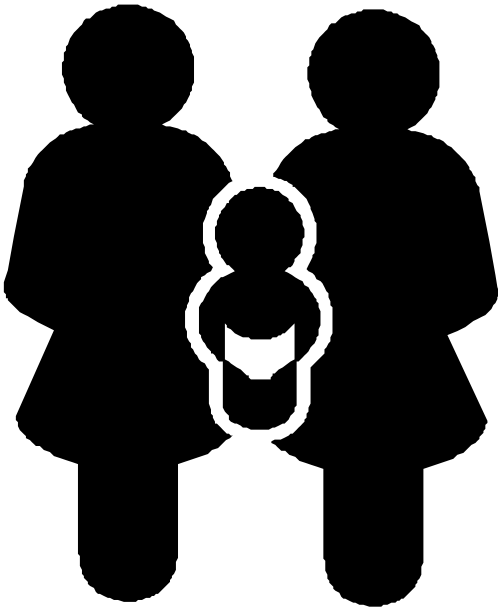
An dieser Stelle möchte ich mich auf alle Fälle recht herzlich im voraus bedanken, für Ihre Bereitschaft Ihre Erfahrungen mitzuteilen. Ich denke, die Gesellschaft hat eine Menge von und über unsere Familien zu lernen! Ich freue mich auf jeden ausgefüllten Fragebogen, der bei mir in den nächsten Wochen eintrudeln wird! Fröhliches ausfüllen!

Mit freundlichen Grüßen

Lisa Herrmann-Green

Unconventional Conceptions:

Lesbische Frauen im Familiengründungsprozess und danach



Fragebogen für die Geburtsmutter

Name:

Adresse:

Telefonnummer:

Email:

Einverständniserklärung:
Hiermit erkläre ich mich damit einverstanden, daß die von mir in dem Fragebogen „Unconventional Conceptions: Lesbische Frauen im Familienbildungsprozess und danach" erhobenen Daten in anonymisierter Form für die Untersuchung zum Themenkomplex Lesben mit Kinderwunsch-Familien mit lesbischen Eltern verwendet werden.
Ich bin ebenfalls damit einverstanden, daß diese Daten in anonymisierter Form im Rahmen dieser Untersuchung veröffentlicht werden.

_____

Ort Datum Unterschrift

 Appendix D: Instructions for Participants

Dies ist der Fragebogen für die **Geburtsmutter**. Bitte füllen Sie ihn nur dann aus, wenn Sie die **leibliche Mutter des erstgeborenen Kindes**, das Sie und Ihre Partnerin durch Insemination bekommen haben, sind.

Füllen Sie bitte die vordere Seite aus. Besonders wichtig ist es die Einverständniserklärung zu unterschreiben, die es mir erlaubt, Ihre Angaben für diese Untersuchung auszuwerten.

Der Fragebogen ist gegliedert in zwei Teile:

Teil I ist chronologisch nach Phasen aufgebaut: Coming out – Kinderwunsch: Planung – Kinderwunsch: Insemination – Schwangerschaft – Geburt – Übergang zur Elternschaft – Kindergarten. Ihre Angaben sollen aus der **damalige** Perspektive gemacht werden. Bearbeiten Sie nur die Phasen, die Sie schon durchlebt haben.

Teil II befasst sich mit dem heutigen Stand Ihrer Familie. Ihre Angaben sollen aus der **heutigen** Perspektive gemacht werden.

Ein Wort zur **Terminologie**:

DI = „donor insemination" = Insemination mit Spendersamen

DI Kind = ein Kind, das durch Insemination mit Spendersamen gezeugt wurde

lesbische DI Familie = „lesbian-headed donor insemination family" = eine Familie mit lesbischen Eltern, die Ihren Kinderwunsch durch Insemination mit Spendersamen realisiert haben

Ich differenziere zwischen den Mutterrollen mit den Begriffen „*leibliche*" oder „*Geburtsmutter*" und *soziale Mutter*". Ich habe diese Begriffe ausgesucht, weil sie, meiner Meinung nach, am **wertneutral**sten eine Unterscheidung zwischen den Müttern ermöglichen.

Eine konotationsfreie Benennung des Samenspenders war nicht so einfach. Ich habe den Begriff „*Spender*" oder „*Donor*" gewählt, weil es keine Annahmen impliziert, welche soziale Rolle dieser Mensch in einer Familie (z.B. „Papa") hat oder welche gesellschaftliche Bedeutung eine Familie ihm zuzuschreiben hat (z.B. „Vater").

Bedenken Sie, daß der Fragebogen anonym ist. Die erste Seite des Fragebogens erfragt persönliche Information; diese Seite wird bei der Rücksendung abgetrennt und gesondert aufbewahrt. Dieses Vorgehen ermöglicht es, den Fragebogen anonym auszuwerten. Also seien Sie bitte mit Ihren Angaben **ehrlich** – es gibt keine richtige und keine falsche Antworten. Es kommt allein auf Ihre Erfahrungen und Erleben an!

Der Ihnen vorliegende Fragebogen benötigt ca. 1 ½ Stunden Zeit, um ihn auszufüllen. **Daher arbeiten Sie bitte zügig, antworten Sie spontan und überlegen Sie nicht zu lang bei einzelnen Fragen.** Machen Sie bitte Pausen und bearbeiten Sie den Bogen in zwei oder mehrere Sitzungen wenn nötig. Arbeiten Sie bitte **sorgfältig** und achten Sie darauf, daß Sie keine Seiten überspringen. Halten Sie durch. Sie haben so viel wichtige und interessante Information zu vermitteln!

Bitte beantworten Sie alle nachstehenden Fragen **alleine**. Wenn Sie sich mit Ihrer Partnerin über die Fragen oder Ihre Antworten austauschen möchten, dann tun Sie dies bitte erst nach dem Ausfüllen des Fragebogens.

Fragebogen für die Geburtsmutter : Einleitung

Das Model der lesbischen Kleinfamilie liegt diesem Fragebogen zugrunde, eine leibliche Mutter + eine soziale Mutter, die zusammen mindestens ein Kind planen bzw. geplant und bekommen haben und gemeinsam die elterliche Sorge tragen. Es trifft sicherlich nicht in allen Fällen zu, z.B. bei Trennung, Formierung von „Stieffamilien" durch neue Partnerschaften, Mehrlingsgeburten, oder wenn Frauen alleine ein Kind bekommen. Wenn daher manche Fragen nicht auf Sie zutreffen sollten, überspringen Sie bitte die jeweiligen Fragen.

Zur Klärung: Wenn von **„Ihrer Partnerin"** in den folgenden Seiten die Rede ist, **bezieht es sich IMMER auf die Frau mit der Sie das erstgeborene (DI) Kind geplant und bekommen haben!**

Falls Ihnen beim Ausfüllen der Fragebogen etwas unklar sein sollte, melden Sie sich ruhig bei mir. Sie erreichen mich unter **tel. xxxxx/xxxxxx oder** Lisa.Green@uni-konstanz.de **.**

Senden Sie bitte den Fragebogen möglichst bald, spätestens jedoch bis zum 2004 **im beiliegende frankierten Umschlag an mich zurück.**

An dieser Stelle möchte ich mich auf alle Fälle recht herzlich im voraus bedanken, für Ihre Bereitschaft Ihre Erfahrungen mitzuteilen. Darüber hinaus hoffe ich, daß die Teilnahme an diesem Projekt nicht nur mühsam, sondern durchaus auch interessant und anregend für Sie sein wird!

Viel Spaß beim ausfüllen!

 Appendix E: Cover Letter for Recruitment at Women's Health Centers

Dipl.-Psych. Lisa Herrmann-Green
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D-xxxxx Konstanz
lisa.green@uni-konstanz.de

FrauenGesundheitsZentrum e.V.
XXXstrasse XX
D-xxxxx Berlin

2. Juli, 2004

Betreff: **Suche nach Teilnehmerinnen für Studie über lesbische Mütter**

Sehr geehrte Frauen des FrauenGesundheitsZentrums!

Mein Name ist Lisa Herrmann-Green. Ich bin Diplom-Psychologin und promoviere zur Zeit an der Universität Basel, Schweiz unter der Supervision von Prof. Dr. Udo Rauchfleisch. Im Rahmen meiner Promotion führe ich eine Untersuchung durch, die sich mit dem **Familiengründungsprozess von Lesben mit Kinderwunsch und Familien mit lesbischen Eltern, die ihren Kinderwunsch per Insemination realisiert haben**, beschäftigt.

Mir liegt es sehr am Herzen, Familien mit lesbischen Eltern in die wissenschaftliche Diskussion zu bringen und damit sichtbar(-er) zu machen. Während es in anderen Ländern, z.B. USA, Großbritannien, und den Niederlanden, seit 10 Jahren Untersuchungen zu Familien mit lesbischen Eltern gibt, bleibt dieses Thema in Deutschland weitestgehend unberührt und ungefördert. Mit dieser Studie möchte ich einen Beitrag dazu leisten, diese Situation zu ändern.

Zu diesem Zweck habe ich den Fragebogenkatalog „**Unconventional Conceptions: Lesbische Frauen im Familenbildungsprozess und danach"** konstruiert. Die Verteilung läuft sehr gut an, aber ich bin (natürlich) auf der Suche nach weiteren willigen Teilnehmerinnen, speziell Lesben mit Kinderwunsch und Lesben, die Kinder per Insemination bekommen haben (sowohl Geburtsmütter wie auch soziale Mütter).

In diesem Zusammenhang wende ich mich an Sie. Ein FrauenGesundheitsZentrum stelle ich mir als geeignete Anlaufstelle für meine Zielgruppe vor, da Sie möglicherweise Listen lesbenfreundlicher FrauenärtzInnen/Hebammen führen und Kurse/Beratung zum Thema „Lesben und Kinderwunsch" und „Ungewollte Kinderlosigkeit" anbieten. **Beigelegt habe ich ein paar Aushänge und Informationsblätter über diese Studie, und bitte Sie, sie <u>Ihren lesbischen Klientinnen/Patientinnen zugänglich zu machen bzw. sie darauf aufmerksam zu machen.</u>**

Ich danke Ihnen recht herzlich im voraus!

Mit freundlichen Grüßen

P.S. Es ist möglich, dass die Ergebnisse teilweise für Sie oder Ihre Kolleginnen von Interesse sind, da ich in meinem Fragebogen explizit auf die Erfahrungen der Frauen mit der Gesundheitsversorgung während der Insemination, Schwangerschaft und Geburt eingehe. Die bisherige Forschung zur lesbischen Gesundheit (aus dem englischsprachigen Raum) zeigt eine Tendenz, dass Lesben gefährdet sind, eine minderwertige gesundheitliche Versorgung zu erhalten, und dass sie negative Erfahrungen mit medizinischem Personal machen. Ich bin sehr gespannt darauf, welche Erfahrungen die Teilnehmerinnen in Deutschland gemacht haben! Sollten Sie Interesse an den relevanten Ergebnissen dieser Studie haben, bitte ich Sie, mir das per Email (oben) mitzuteilen.

Helfen Sie, die Realität von Lesben mit Kinderwunsch und lesbischen Müttern empirisch zu dokumentieren!

Teilnehmerinnen gesucht für die Untersuchung .....

Unconventional Conceptions:
Lesben im Familiengründungsprozess und danach.

Ihre Hilfe wird benötigt, um mehr zu erfahren über Lesben mit Kinderwunsch und Familien mit lesbischen Eltern, die ihren Kinderwunsch per Insemination mit Spendersamen realisiert haben. Diese Studie wird im Rahmen einer Dissertation in Psychologie an der Universität Basel, Schweiz unter der Supervision von Prof. Dr. Udo Rauchfleisch durchgeführt. Es soll erste Information darüber geben, wie der Weg vom Paar zur Familie für diese Familien aussieht. Die Informationen werden anonym per Fragebogen erhoben.

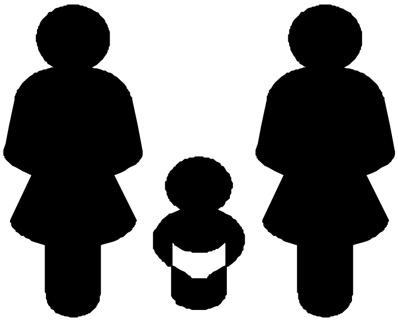
Melden Sie sich bitte bei mir als Teilnehmerin an der Untersuchung über Lesben mit Kinderwunsch/Lesbische Mutter! **Teilen Sie mir bitte ihre Name, Anschrift, Email und Telefon mit.** Selbstverständlich werden alle Angaben von Ihnen vertraulich und privat behandelt. Für Fragen über dieses Forschungsvorhaben stehe ich Ihnen jederzeit zur Verfügung!

Zu meiner Person: Ich und meine langjährige Partnerin haben zusammen 3 Kinder (8,4,2 Jahre) durch Insemination bekommen. (Mehr über unsere Familie gibt es im *LSVD Familienbuch* nachzulesen.) Ich hoffe, mit der Untersuchung, zu einem realistischen Bild lesbischer Familien beitragen zu können, und hoffe auf Eure Unterstützung.

Vielen Dank schon mal vorab!

Dipl.-Psych. Lisa Herrmann-Green
Doktorandin, Universität Basel
Email: Lisa.Green@uni-konstanz.de

Teilnehmerinnen gesucht für eine Studie über Lesben, die Mutter sind bzw. werden wollen.



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Ich hoffe, mit der Untersuchung, zu einem realistischen Bild lesbischer Familien beitragen zu können, und hoffe auf Eure Unterstützung.

Wenn Sie Interesse haben, an der Untersuchung teilzunehmen, melden Sie sich bitte bei mir!

Teilen Sie mir bitte ihre Name, Anschrift, Email und Telefon mit.

Selbstverständlich werden alle Angaben von Ihnen vertraulich und privat behandelt.

Dipl.-Psych. Lisa Herrmann-Green
Doktorandin, Universität Basel
Email: Lisa.Green@uni-konstanz.de

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Ja, ich möchte an die Studie über Lesben mit Kinderwunsch /lesbische Mütter teilnehmen.
Lisa.Green@uni-konstanz.de

Ja, ich möchte an die Studie über Lesben mit Kinderwunsch /lesbische Mütter teilnehmen.
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