Negotiating who gives birth and the influence of fear of childbirth: Lesbians, bisexual women and transgender people in parenting relationships

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Abstract

Background: Fear of childbirth (FOC) may affect family planning in lesbian, bisexual and transgender (LBT) couples with two potential carriers of a pregnancy. FOC has previously been researched in heterosexual women, while experiences of LBT people have remained unattended. The choice of birth-giving partner in same-sex couples has gained some attention in previous research, but the potential complexities of the decision have not been studied.

Aim: The aim is to explore how LBT people negotiate the question of who gives birth, in couples with two potential birth parents, and where one or both partners have a pronounced FOC.

Methods: Seventeen self-identified LBT people were interviewed about their expectancies and experiences of pregnancy and childbirth. Data were analysed following a six-step thematic analysis.

Results: FOC was negotiated as one of many aspects that contributed to the decision of who would be the birth-giving partner. Several participants decided to become pregnant despite their fears, due to a desire to be the genetic parent. Others negotiated with their partner about who was least vulnerable, which led some of them to become pregnant despite FOC. Still other participants decided to refrain from pregnancy, due to FOC, and were delighted that their partner would give birth. Several participants described their partner’s birth-giving as a traumatic experience for them, sometimes also when the birth did not require any obstetric interventions. The partner’s experience was in some cases not addressed in postnatal care.

Conclusions: It is important that healthcare staff address both partners’ prenatal expectancies and postnatal experiences.
**Keywords** Same-sex parents; transgender parent; fear of childbirth; decision-making process; secondary traumatisation; traumatic birth

**Statement of significance**

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**Introduction**

Many studies have focused on the experiences of pregnancy and childbirth for women in same-sex relationships, in lesbian and bisexual women, and a few have studied transgender people’s experiences of childbirth. Researchers have studied pathways to parenthood, and experiences of reproductive healthcare.\(^1,2,3,4,5,6,7\) In couples where both partners have a childbearing capacity, the question of who should give birth is often raised at an early stage of family planning.\(^8\) Many different considerations can contribute to the decision, including age, health, gender identity, and desire to undergo pregnancy and childbirth.\(^8,9\) In couples where one or both partners have a pronounced fear of childbirth (FOC) this may also affect their family
planning. However, experiences and effects of FOC in lesbian, bisexual and transgender (LBT) people have not gained much attention.\textsuperscript{10}

FOC has mainly been studied among heterosexual women.\textsuperscript{11} While these women often struggle with decisions such as whether they should have children at all or remain childfree,\textsuperscript{12} and whether they should become pregnant themselves or find other pathways to parenthood (e.g. adoption),\textsuperscript{12} they do not have the option for their cisgender male partner to become pregnant (cisgender can be defined as the opposite of transgender, i.e. people who are not trans are cis). The impact of FOC on childbearing negotiations between intimate partners where both partners have the ability to become pregnant remains unstudied.

The present study explores how FOC affects the decision of who gives birth, in couples where both partners have a childbearing capacity, and where one or both have a pronounced FOC. The study draws on interviews with 17 participants who are self-identified lesbian, bisexual or transgender persons. Before engaging with the interview data, a brief overview is given of research on FOC, followed by a brief overview of research on LBT families.

\textit{Family-making in the presence of fear of childbirth}

In a recent meta-analysis it was shown that around 14\% of pregnant women experience FOC,\textsuperscript{13} and 2.5\% experience phobic levels of fear.\textsuperscript{12} Commonly FOC includes fear of pain, fear of losing control, and fear of injuries to oneself or the offspring.\textsuperscript{14} Severe FOC affects quality of life negatively both prior to and during pregnancy, and increases the risk of prolonged labour, and instrumental and caesarean births.\textsuperscript{13,15,16} Further, FOC increases the risk of a traumatic birth experience, and correlates with prevalence of post-traumatic stress disorder postpartum\textsuperscript{12,17} as well as with postpartum depression.\textsuperscript{18} As the attachment to the child is
considered to start already during pregnancy, severe FOC has a negative influence on the pregnant person’s bonding to the child.\textsuperscript{19} Fear prior to childbirth has also been studied among male partners to pregnant women, who show similar prevalence of FOC (10-14\%).\textsuperscript{20} Their fears often concern injuries to their partner and offspring. In addition, they often express feelings of hopelessness or lack of knowledge.

Mental ill-health and previous traumatic experiences are identified as vulnerability factors strongly associated with FOC.\textsuperscript{21} Belonging to an ethnic minority is known as a risk factor for FOC.\textsuperscript{22} On the other hand, stability in the partner relation and support from the partner have been shown to reduce FOC,\textsuperscript{23} as has access to a social network and social support.\textsuperscript{23,24}

A desire to have genetic offspring is a strong incentive that can even make people with severe FOC go through planned pregnancies.\textsuperscript{12} People with anxiety problems often control their situation by avoiding the feared object.\textsuperscript{25} A pregnant person with severe FOC cannot do this, as the most feared situation is unavoidably slowly approaching.\textsuperscript{26} In cisgender heterosexual couples, the woman with severe FOC can feel trapped in the situation, as she is the only part in the relationship who can carry a pregnancy. In couples where both partners have a childbearing capacity, the situation is fundamentally different, as the question of “who should give birth” may be raised and negotiated between the partners.

\textit{Pregnancy and childbirth among lesbian, bisexual and transgender people}

Family-making processes in female same-sex couples have been studied widely in the past decades. E.g.\textsuperscript{1,2,3,4,5,27,28,29,30} The process of having children generally includes a range of decisions. Once the primary decision of having a child rather than remaining child-free is settled,\textsuperscript{1,2} a number of additional decisions arise.\textsuperscript{4,30} The prospective mothers may consider
different routes to parenthood, depending on their personal preferences and values, as well as the broader societal, legal and economic context. While some couples adopt children or raise foster children, others have children through assisted reproduction. Couples who decide on assisted reproduction must then decide whether they wish to involve an active father in their family life, or to have donated semen from a known or unknown donor. Further, a couple with two potential birth parents must decide who will try to become pregnant (first). Commonly, age, health and (expected) fertility contribute to this decision. Further, the desire (or lack of desire) to carry the pregnancy is often raised when deciding who will give birth. Gender identity plays an important role for the family formation in some couples, e.g. some butch-identified women and transgender men consider pregnancy to be in conflict with their gender identity or expression.

The choice of birth-giving parent does not only affect the period of time of pregnancy and infancy. Rather, this choice is likely to affect a couple’s parenting for many years. It is well established that birth mothers in female couples on average spend more time on childcare, and less on employed work (compared with their partners), and that this has effects on their relationship equality, child bonding and financial situation. Depending on the legislation, non-birth parents may face obstacles in having legal parenthood secured. Further, many non-birth mothers struggle with their parenting role, both on a personal level and in relation to their others’ attitudes and prejudices.

In Sweden, where the present study took place, adoption is highly uncommon among same-sex couples, due to huge practical obstacles. However, assisted reproduction treatment is available for couples (and singles) where at least one partner has a child-bearing capacity, and is offered at low cost, as it is partly tax funded. A study on female same-sex couples in Sweden
showed that most couples had two children, and that the majority switched birth mother for the second child. However, some couples decided to have just one child, or to let one partner carry all the pregnancies. In most couples the choice of birth mother was presented as something that was decided with little or no negotiation. Commonly, couples choose to let the older partner become pregnant first, while the younger went through the second pregnancy. In other couples only one partner had the desire for pregnancy, and in some families, age or fertility problems in one partner made the decision for them. Some couples described how they had more extensive negotiations regarding choice of birth mother, and a few described conflicts arising from different opinions on the matter.

Pregnancies in transgender men and non-binary people have also been the subject of some studies. A British interview study reported common experiences of loneliness during pregnancy among transgender men. They had to negotiate their identity in relation to themselves and others, as pregnancy is highly associated with femininity. In Sweden, forced sterilisation as a requirement for legal gender reassignment was terminated in 2013. Transgender people with a childbearing capacity are since then included in the fertility treatment programme of public healthcare. If coupled with a partner with a childbearing capacity, the decision of who gives birth arises in these couples as well. No empirical studies on pregnancies and childbirth among transgender people in Sweden have been published.

**Aim**

Fear of childbirth has, to the authors’ knowledge, not previously been studied in lesbian and bisexual women, or in transgender people. As it is known that belonging to an ethnic minority increases the risk of FOC, it is highly relevant to also address the topic in the social minority group of LBT people. The authors show in a separate publication from the present project how
minority stress, including fear of insufficient or prejudicial treatment in healthcare, adds an additional layer of stress to FOC in LBT people.¹⁰

FOC in western countries has been widely studied in cisgender heterosexual women,¹² and – to some degree – their partners.³⁷ When it comes to birth-giving, LBT people differ from cisgender heterosexual women, because of the risk of minority stress in gender and sexual minorities, but also because of the option of negotiating birth-giving between partners in couples where both have the potential. The aim of the present study is to explore how LBT people negotiate the question of who gives birth, in couples with two potential birth parents, and where one or both partners has a pronounced FOC.

**Methods, Participants and Ethics**

**Data collection**

The present study analyses interview data from 13 semi-structured interviews with 17 self-identified LBT persons (nine individual interviews and four couple interviews). Fifteen interviewees had an expressed FOC, while two partners in couple interviews did not express FOC.

The data originates from two different research projects. In 2010, Anna Malmquist interviewed female same-sex parenting couples for a research project on lesbian-headed families in Sweden.³⁸ The interviews regarded the couples’ paths to parenthood, but had no explicit focus on FOC. However, four participants spontaneously brought up the topic of FOC and explained how their fear had affected their family formation. These narratives captured the interest of the researcher, who decided to analyse them in detail.
In order to obtain more comprehensive data on FOC, Malmquist invited an expert on FOC, Katri Nieminen, to jointly apply for funding of a research project specifically focusing FOC in LBT people. As the project was funded by The Royal Swedish Academy of Sciences (AM2017-0005) in 2017, additional data was collected in 2018. LBT people with personal experience of FOC were invited to participate. Ten additional interviews were made with 11 participants. (One couple was interviewed together, upon their request, while the remaining participants were interviewed individually.) Most interviews were conducted by Louise Jonsson and Johanna Wikström who conducted their master’s thesis in psychology within the project. Participants in all stages of family formation were included in order to capture both experiences and expectancies of childbirth. The interview guide included questions on FOC, experiences and expectancies of reproductive healthcare, and experiences and expectancies of one’s own and/or one’s partner’s pregnancies and birth-giving. The participants were also inquired to fill out the Wijma Delivery Expectancy/Experience Questionnaire after the interview.

Participants were recruited through an advertisement posted in social media groups for LGBT families. The ad invited participants with a fear of giving birth, who self-identified as lesbian, bisexual woman, or transgender (assigned female at birth). An information letter was sent by email to those who responded to the ad and if they were still interested in participation, the time and location for the interview was scheduled. The participants were encouraged to decide on the location for the interview. One interview was conducted at the participant’s office, after work hours. The remaining were all conducted in the participants’ homes.

*Transcription and analysis*
All interviews were audio-recorded. The recordings lasted between 61 and 180 minutes. The interviews were transcribed verbatim, with pseudonyms replacing names. The interview data was analysed following a six-step thematic analysis, as described by Braun and Clarke. A detailed coding of the entire data set was undertaken, and codes were sorted into broad themes. For this article, all chunks of data that regarded the choice of birth-giving parent were collected in a separate document and analysed in detail. The results are presented below in four themes.

**Participants**

An overview of the participants is shown in table 1 and 2. [Insert table 1 and 2 here]

The 17 participants were assigned female at birth. They were between 25 and 42 years of age at the time of the interview. All were married or cohabiting in a committed relationship, commonly with a same-sex partner. A majority had university level exams, and most were employed. Nine participants resided in larger cities, and six of them in smaller towns. Most identified as lesbians, and a few as bisexual women, transgender men or non-binary persons.

The participants had between zero and four children; the majority had one or two children. As mentioned previously, 15 participants had a pronounced FOC, and two were non-afraid partners. Both non-afraid partners had given birth. Of the 15 participants with FOC, seven had given birth themselves, and three were first-time pregnant at the time of the interview. Of the 15 participants with FOC, seven parented children born by their partner. Two participants with FOC had no children, but planned to have children in the near future. A few participants had stepchildren or foster children living in their homes.
As mentioned previously, participants from the second data collection completed the Wijma Delivery Expectancy/Experience Questionnaire immediately after the interview. Their scores varied from 81 (moderate fear) to 123 (phobic fear), with a mean of 97 (severe fear). The vast majority (80%) scored above cut-off for severe fear.

**Ethics**

The study was approved by the regional ethics board at Linköping University. Each participant was informed about the structure of the interview, the purpose of the study and in what form the results would be published. Participants gave their written informed consent to participate.

**Results**

For most participants, FOC had been one of the factors that formed their decision of birth giving parent. FOC led a few of them to refrain from pregnancy, while most decided to get pregnant despite their fear, or aimed to try to get pregnant in the near future. In the following, their reasoning is presented in four themes: *Desiring pregnancy despite fear of childbirth, Letting the non-afraid partner do the birth-giving, Negotiating who is least vulnerable,* and *Traumatised from partner’s birth-giving.* One participant was in a relationship with a transgender woman; thus her partner had no childbearing capacity and the choice of birth-giving parent could not be negotiated between them. Another participant described how FOC had arisen during her pregnancy when she found out that she expected twins. Since the couple did not want more children, FOC had not affected negotiation of birth-giving partner. The remaining 15 participants all described how FOC affected childbearing decisions, including who should give birth.

*Desiring pregnancy despite fear of childbirth*
Several participants with a pronounced FOC had given birth themselves. Additionally, some participants were pregnant at the time of the interview, and some planned to get pregnant in the near future. At some point, these participants had been determined to get pregnant, despite fearing childbirth. For some participants, their own desire for pregnancy and/or a genetic parenthood was central in the decision. Viktoria explained her desire for a genetic child in relation to her own background as adopted.

*Who’s going to carry the child, um she [Viktoria’s partner] was very clear that “No, I’ve never felt that longing”, while I, as adopted, maybe felt that, well, I’ve never resembled my parents purely in terms of appearances [...] so I was maybe more curious about it, so, then, let’s try it with me. So that’s how we ended up there. (Viktoria, pregnant)*

Viktoria described how she feared the upcoming childbirth because of her fears of pain and of losing control during labour. She also explained how uncomfortable she felt being pregnant in relation to her own body image. She described herself as “a bit trans” (although preferring the personal pronoun “she”), and felt alienated from norms about the female gendered pregnant body. Despite her fear and discomfort, she depicted the decision of her carrying the couple’s child as quite simple. Due to her curiosity about having a child who resembled her, and her partner’s disinterest in getting pregnant, they made their decision.

Another interviewee, Cecilia, had recently given birth to her first child. She explained how she had longed for pregnancy for many years, and strongly desired to be a “full-time parent”. Her FOC was primarily related to a phobic fear of injections. When she did not become pregnant after several inseminations, she decided to undergo IVF treatment:

*I cried enormous amounts every day, I collapsed several times a day,*

*um (laughs) there was a nurse at the local healthcare centre, she was*
like “But are you really going to do this thing, you’re so scared”, I was like “Yes, I’m going to”. So the thing was, that I know that if I do this, I have a larger chance of becoming a parent. And it, it was super-hard, it really was, but I wanted it so very much, so that then... What I said to myself was like, “It’s ok if it’s hard, and you’re going to feel everything all the time, but you can do it”. (Cecilia, had given birth)

The excerpt above illustrates how strong the motivation for pregnancy can be. For the participants who, like Cecilia, describe such a strong desire, FOC had made the process of getting, and being pregnant a major challenge, but fear had not stopped them from undergoing reproductive treatment. In the end Cecilia had a positive birth experience, but went into postpartum depression afterwards, a depression she assumed had been caused by the strenuous pregnancy.

**Letting the non-afraid partner do the birth-giving**

In contrast to the participants who had braved their FOC and decided to go through pregnancy and childbirth, a few other participants had decided not to become pregnant, but were delighted that their partner was willing to give birth. These participants were in relationships with partners who did not fear childbirth, and who were motivated to carry the couple’s child or children. When asked how they decided that her partner should become pregnant, Jeanette responded like this:

    Well, the biggest reason is that I’ve always had phobic fear of childbirth and haven’t had the desire or any longing to get pregnant, so I was hugely relieved that she wanted to do it, that you wanted to do it, and also, I have epilepsy too. (Jeanette, partner had given birth)
Jeanette presented FOC as the “major reason” for her to refrain from pregnancy. In addition to this she explained how she had never desired pregnancy, and that she had medical reasons for refraining. Likewise, most participants who decided not to give birth, or were reluctant to do so, presented FOC as a central, but not single, reason for their unwillingness. For those who did not desire to experience pregnancy, and who did not consider the genetic aspect of parenthood to be particularly important, the motivation to challenge their FOC was rather low. In cases where the partner was willing to go through pregnancy and birth-giving, the choice to let the non-afraid partner give birth was presented as a simple and obvious decision. Another interviewee, Jenny, depicted it as a simple decision that her partner was to give birth to their first child:

*I’ve always wanted children, but I’ve always decided, since I was young, that I wanted a caesarean, because I don’t want to give birth. I guess I saw something on TV, when I was young, that I shouldn’t have seen, showing a birth. Because giving birth didn’t feel like an option. And Vendela wanted to, so the choice was easy. Then we said that I would have the second child, but then later I didn’t feel ready, after the horrifying experience with Frej [the first child]. I was terri-, and giving birth when you’re already super-afraid of childbirth, it was, like, not an option. (Jenny, partner had given birth)*

Jenny explained how she had feared vaginal childbirth since her own childhood, and presented this as the major reason for her to refrain from giving birth. Jenny had a desire for parenthood, and was delighted that her partner, Vendela, was motivated to carry a pregnancy. The birth of their first child had been highly complicated, and was described as a traumatic experience for both partners. For Jenny, the experience had increased her FOC, and made her even less motivated for pregnancy when the couple discussed having another child. In the end, Vendela
carried the second pregnancy as well. The theme of experiencing the partner’s birth-giving as traumatic was raised by several participants, and is presented as the last theme in this article.

**Negotiating who is least vulnerable**

Several participants depicted the choice of birth parent as a complex issue, where each partner’s situation had been considered. They described both partners as unwilling or reluctant to go through pregnancy and/or labour. In some couples both partners expressed severe FOC. In other couples one partner feared childbirth, while the other partner had other medical, social or personal reasons for not being willing to get pregnant. One participant, Emelie, was pregnant with her first child at the time of the interview. She primarily feared strong pain and loss of control during birth. Despite her fear, she and her partner, a transgender man, had decided that Emelie was least vulnerable in relation to childbearing. Emelie described their considerations:

> So, strictly, on a personal level, my partner would probably be better suited in terms of pain, he has like no problem with pain, umm, yes he likes pain, I mean, and he thinks the body and how the body can change, and stuff like that, is very fascinating. Umm so for a while we thought that, like, “Okay, could you carry the child?” Umm but I mean [...] he is, you know, non-white, like, non-cis (laughs), and like, he has quite a few factors. [...] Umm he has previously come up against quite a lot of structural discrimination, umm, and maybe that was why we thought that it would be too much, like. (Emelie, pregnant)

The excerpt shows a complexity in the decision-making process, where FOC was just one of many considerations. Emelie described in the interview how, prior to her present relationship, she had hoped to find a partner willing to carry their child, because she wanted children, but did not want to give birth herself. However, in the present situation, the couple assumed that
the risk of experiencing racism and transphobia during pregnancy and birth would be too harsh for her partner. When deciding to become pregnant, Emelie was determined to have a caesarean, which for her felt like the best way of tackling her FOC.

Another couple, Moa and Susanna, described how both had a severe FOC, but decided to take turns and go through one childbirth each. In the interview they were asked if either of them had thought of having children prior to their relationship:

Moa: No, I was quite sure I didn’t want children.

Susanna: Same here.

Moa: Because I didn’t want to give birth. (Interviewer: Okay.) I thought, as long as I thought I was heterosexual, that I would adopt. So I wouldn’t have to be pregnant and give birth. (inaudible).

Susanna: Exactly, we both thought the very same thing, I think. Because I definitely didn’t want to be pregnant. Because it wasn’t on the table, at all. But then I met Moa and suddenly it felt okay to be pregnant.

(Moa and Susanna, both partners had given birth)

Adopting as a same-sex couple is complicated in Sweden, therefore Moa and Susanna saw birth-giving as their only option to become parents. Prior to their relationship, both had excluded the option of giving birth, but when they were in a trustful relationship, their attitudes changed. Both partners had requested and been granted caesarean, due to their FOC. They had decided that the most afraid partner should become pregnant first, so that if she would be frightened during her partner’s birth-giving, her own would not be next in turn. Another couple described a similar consideration, but they decided that the least afraid partner would go first, and that the most afraid partner was to wait and possibly carry their second child, if she felt
more comfortable later on. Regardless of what had been decided in the end, the participants showed how FOC can be an important aspect of a complex decision-making process.

**Traumatised from partner’s birth-giving**

Some participants described how they had been affected by their partner’s birth-giving. One participant whose partner had given birth prior to their relationship, said that her partner’s sharing of her positive birth experience had affected her positively before and during her own pregnancy. However, several other participants described their partners’ birth-giving as traumatic events for them as the non-pregnant partner.

One participant, Jenny (as quoted above), described how her fear had increased significantly as she witnessed her partner’s dramatic birth-giving which ended with an emergency caesarean. Both partners were given professional psychological support afterwards, but Jenny’s FOC was continuously severe. Therefore, she explained, they decided that her partner would carry the second pregnancy as well, despite their initial plan to take turns. Jenny expressed her gratitude that her partner was willing to go through another pregnancy, despite her experience with the first birth. In contrast, another interviewee, Petra, described her partner opposing Petra’s desire to have another vaginal birth. Petra’s first birth had been a traumatic experience for both partners. However, Petra had been able to process the trauma better than her partner. At the time of the interview the couple discussed the option of having an additional child.

* I think, today I think that Amelia finds it’s harder than I do, so. Because for a while she has been “I can’t be there if you give birth to another child”, or like, “Then you’ll have to get a caesarean”. Whereas I’m more like, “Now, I want to [give birth vaginally]”  
  (Petra, both partners had given birth)
Petra described how she had been able to process the birth trauma with professional psychological support. While she shortly after the birth had been convinced that she would need a planned caesarean if she were pregnant again, she had grown stronger in her desire for another vaginal birth. As she put it, she felt the need for “revenge” on birth-giving. However, her partner did not share this desire. Rather, Petra explained how her partner would prefer her to have a caesarean, if Petra were to become pregnant again. Thus the issue of an additional pregnancy and the preferred birth method remained unsolved at the time of the interview.

Another participant, Ester, attributed her FOC to be the consequence of her partner’s traumatic pregnancy loss and birth-giving. Her partner had gone through a dramatic pregnancy loss in the second trimester, with their first child. Ester had been out of town and was not present during the sudden birth. Her partner had been offered psychological support afterwards, but Ester felt excluded from the contact, and her loss was not taken into account by the psychologist. Later her partner carried a full-term pregnancy, but Ester described the birth as complicated, and it finished with an emergency caesarean. Both these events were experienced as traumatic for Ester, who began to have second thoughts about becoming pregnant herself.

We had, like, sort of decided that we would each have one child. Then I became uncertain, for a really long time. Really really long, maybe, well more than a year... maybe that “You have to have the next one”, sort of too, “Or we won’t have any more”, yes we couldn’t make up our minds, and Caroline didn’t know if she wanted to do it again, she was like “No”, so finally it was as if we started to decide not to do it, and then I panicked and said “No! We want another!” and then... also that I actually, I mean, somehow I wanted to experience it. (Ester, pregnant)
Ester’s experiences show the importance of paying attention to both partners’ experiences of pregnancy, pregnancy loss and giving birth. It is possible that Ester would have been able to mourn the pregnancy loss and process the traumatic birth experience better if she had been included in the psychological treatment. Instead she felt excluded, and explained in the interview how she felt uncomfortable with showing her own feelings, both together with her partner and in the contact with the psychologist.

Another participant, Stina, had a similar experience of concealing her own feelings after her partner’s birth-giving. Stina described the birth as medically uncomplicated, but she was shocked to see her partner in huge pain. She explained how the couple had planned to take turns in birth-giving, but Stina experienced her partner’s birth-giving as traumatic, and described this event as the debut of her severe FOC. Stina said that her partner had had a positive birth experience, while she as the partner was traumatized and terrified of giving birth herself. Her previous history of psychological ill-heath may have affected her experience. However, she was never asked by the staff at the postnatal ward how she had experienced the situation, and she did not tell anyone spontaneously either.

*It never occurred to me that I could have said anything about it, or that I would have the right to say anything about, it doesn’t feel like, I also felt, like, a lot about this, like “Does my experience matter?”, because I mean, she’s the one who had the massive pain, and who had a super-difficult birth, that is, who am I to start talking about that I thought something was hard?* (Stina, partner had given birth)

Stina’s experience pinpoints the importance of healthcare staff addressing both the birth-giving and the non-birth-giving partner when asking about their experiences of and feelings after childbirth. Despite her strong reactions, Stina did not feel comfortable highlighting her feelings
herself, rather she felt that a focus on her would have been unfair as it was her partner who had gone through the pain. Unlike the other participants who experienced their partner’s birth-giving as traumatic, Stina described a medically uncomplicated birth where the birth-giving partner was not traumatised. This calls attention to the importance of acknowledging that each partner gains a unique experience of a birth. Therefore, must each partner’s unique experience be addressed and taken into account, also when births are medically uncomplicated.

Discussion

Giving birth is highly a unique, individual experience, which is influenced by the person’s previous experiences and how the birth-giving proceeds, but also by the context where it happens. Negative expectations increase the risk of a negative experience. Fear of childbirth is a serious health issue, which in general populations is experienced by about 14% of pregnant women, and similar numbers of male partners. No study has yet shown the prevalence of FOC in pregnant LBT people specifically, nor in their partners, but it is known that FOC is strongly associated with other forms of psychological ill-health, and is more common in ethnic minorities. Due to the common experience of minority stress in lesbian, bisexual and transgender people, and the increased psychological ill-health caused by this stress, FOC can be expected to affect many LBT persons before, during and after pregnancy.

The present article describes how FOC affects family planning in LBT couples with two potential carriers of a pregnancy. The choice of birth-giving partner has received some attention in previous research, investigating how age, health, fertility, desire for pregnancy, and gender identity and expression affect the decision. Despite this research, the potential complexities of the decision have not received much attention. This is surprising given the major effect that
roles such as birth-giving or non-birth-giving parent can have on the many years of future parenthood. Previous research has not discussed how FOC in one or both partners affects the decision.

The present article shows how FOC is negotiated in relation to many other considerations, including desire for pregnancy and/or genetic parenthood, physiological and psychological health, age, gender and race. This finding shows that choice of birth parent can be a rather complex issue, where different motives and concerns come into play. The highlighting of gender and race in relation to choice of birth partner shows how social injustice, and the risk of experiencing prejudice, is taken into account and affects the choice. Several participants explained how they had negotiated which partner is least vulnerable in relation to childbirth, and let this inform their decision, either deciding that the least vulnerable partner would get pregnant, or that the most vulnerable would, with a great deal of support from the other. Given that this is a small-scale interview study, patterns should not be generalized. Rather it is of interest for further research to explore how social injustice and personal vulnerability, including FOC, affect the decision of who gives birth in couples with two potential birth-giving parents. Several participants in the present study had given birth despite their FOC, and additionally some were pregnant or planned to become pregnant. It has previously been shown how a desire for a genetic parenthood is a strong incentive for heterosexual women to become pregnant despite FOC. The present study shows that the desire for a genetically related child, and/or the desire for the close parent-child bond that is associated with the birth-giving parent, had been important motivating factors for several of these participants too. Others depicted their decision to go through pregnancy as being the result of their partner’s unwillingness (or incapacity) to do so, and/or the reality that adoption was not an option. These results pinpoint the importance of vigilant care givers, who notice the different needs of the individuals with
FOC. Reproductive health care often has special units to support pregnant persons with identified FOC. The help offered can vary from practical planning of the birth to therapeutic contact during the pregnancy.\textsuperscript{45} Most therapies used are based on cognitive behavioural therapy and show promising results.\textsuperscript{46}

Some participants had refrained from becoming pregnant and explained that their FOC had contributed to the decision that their non-afraid partner should carry the child. Unlike those whose longing for a genetically related child motivated them to become pregnant, these participants expressed low interest in genetic parenthood per se. However, FOC was often cited as the major reason to opt out of pregnancy. Thus, had it not been for their FOC, they might have decided differently. As described previously, effective treatments of FOC are available, and when well cared for, people with FOC can have positive birth experiences.\textsuperscript{46,47} With this in mind, it is unfortunate if LBT people refrain from pregnancy because of FOC, and leave pregnancy to a non-afraid partner. In healthcare, FOC is mostly dealt with during pregnancy and after birth\textsuperscript{45} For people with FOC struggling to decide whether to get pregnant or not, it would be helpful to have therapy before the decision.

The partner of a pregnant person is generally expected to be present and to support the pregnant partner before, during and after childbirth. With severe FOC, the partner’s ability to be calm and supporting may be limited. Rather, a partner with severe FOC may require support for themselves during childbirth.\textsuperscript{10} This calls attention to the importance of preparing both partners well before childbirth, and when relevant, discussing the option of involving someone else to be present and supportive of both partners during the birth. If therapy is offered during pregnancy to a partner with FOC, the partner’s ability to support for the pregnant person might increase, and a secondary traumatization may be prevented.
The partner’s experience is not always fetched in the delivery ward. It is well known that even a normal birth (i.e. without complications requiring obstetric interventions) may be experienced as traumatic, for the birth-giving person as well as the partner. This highlights the importance of always addressing both partners’ mental health postpartum. Addressing the partner’s experience is especially important when dealing with LBT couples, where the non-birth-giving partner might give birth to a subsequent child. Not identifying a traumatised partner might give an already vulnerable couple a new challenge to deal with.

Several participants in the present study described how they had experienced trauma when witnessing their partner giving birth. Some of these had been complicated births, traumatic for both partners. In these cases, the birth parent had been offered psychological support after the birth, but not always the non-birth parent. Generally, the non-birth partner had not been able to process the trauma very well. One participant described how she was traumatised from a birth with no complications requiring obstetric interventions, but her birth-giving partner had gained a positive birth experience. In this case the non-birth-giving partner’s experience was not addressed at the delivery ward, and she refrained from addressing it herself.

In previous research on FOC, focusing on women in heterosexual relations, scholars differentiate between primary and secondary FOC. While primary FOC is defined as FOC in nulliparous women, secondary FOC arises from a traumatic birth experience. Primary FOC is mostly characterised by anxiety and specific phobia, whereas posttraumatic stress can dominate secondary FOC. The participants in the present study, who experienced their partner’s birth-giving as traumatic, show that such a differentiation does not always capture the experience of LBT people with FOC. When nulliparous persons have experienced trauma from witnessing
their partner’s birth-giving, and the birth of their child, their situation includes features of both primary and secondary FOC. The way in which these people have acquired FOC can be described as both through a vicarious experience of witnessing the partner’s birth-giving, and through informational transmission, where the approaching or imagined birth is catastrophised. Anxious people are often prone to interpret threatening information in a biased way. This is seen in the present study, where several participants who experienced their partner’s birth as traumatic also described previous psychological ill-health. With this in mind, it is of particular relevance to address both partners’ psychological health during pregnancy, and to attend to any signs of a need for professional support before, during and after childbirth.

Conclusion

The decision of who gives birth in a couple with two potential birth parents may be negotiated in relation to a number of considerations. The present study shows how fear of childbirth in one or both partners affects the decision-making process. While many LBT persons have a strong desire to go through childbirth, and do so despite their FOC, others are delighted that their partner is willing to carry their child, and refrain from becoming pregnant themselves. Witnessing the partner giving birth may be a traumatic experience, in particular in the presence of previous psychological ill-health. Therefore, it is important that both partners’ expectancies of childbirth are addressed during pregnancy, and that treatment is offered when either partner fears childbirth. Further, it is important that both partners’ birth experiences are attended to postpartum, and that treatment is offered either partner with a traumatic experience.

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