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Excellence in Practice

Understanding mental health and wellbeing during the transition to parenthood: LGBTQI+ parents

This Good Practice Point provides health visitors with an overview of key aspects relating to mental health and wellbeing in LGBTQI+ parents and good practice tips for supporting parents, with a focus on the perinatal period spanning from preconception to 2 years after birth.
This resource aligns with the 2022 NMC Standards for Proficiency for SCPHN Health Visiting, with a focus on Sphere C: Promoting human rights and addressing inequalities: assessment, surveillance, and intervention.
Please note that this publication uses gendered terms when referencing research which is gender specific.

Who are LGBTQI+ parents?

Lesbian, gay, bi, trans, queer, and intersex (LGBTQI+) parents may be raising children as same-gender couples, as single LGBTQI+ parents, or as different-gender couples where at least one partner is LGBTQI+. In some families, children may be genetically related to all parents, some parents, or none of the parents. In couples, one parent, both parents, or neither parent may have given birth. LGBTQI+ parents may have become parents by conceiving through sexual intercourse, home or clinic insemination (with or without a donor), In Vitro Fertilisation (IVF), surrogacy or adoption.

LGBTQI+ people continue to experience discrimination both generally and within healthcare, which can negatively impact on physical and mental health. The perinatal experiences of LGBTQI+ parents are under-researched and under-recorded[1]. However, we do know that lesbian, gay, bisexual, transgender and non-binary people are more likely to have: a history of trauma; anxiety and depression; self-harm; and suicidal behaviour[2]. Research suggests that intersex adults may face poorer physical and mental health compared to the general population. For those who may have undergone unnecessary cosmetic surgeries in infancy, the consequences may result in lasting physical and emotional harm[3].

Perinatal mental illness (PMI) encompasses a range of mental health conditions which can affect parents during the perinatal period, including depression, anxiety disorders, post-traumatic stress disorder/birth trauma, obsessive compulsive disorder, eating disorders, and postpartum psychosis[4]. Any parent can experience mental health difficulties which can have significant short- and long-term impacts for parents, their babies, and other children in the family. These impacts are not inevitable or irreversible, and health visitors are well placed to promote mental health, identify difficulties early, and offer timely support.

Incidence

The number of LGBTQI+ parents is unknown. However, there is evidence that the prevalence of same-gender female parent couples is increasing[5,6]. A recent NHS survey of maternity services[7] indicates that for 1% of birthing people, their gender differs to the sex they were registered as at birth. This may include people who are trans, non-binary, intersex, or born with some variations of sex characteristics but do not identify as intersex[8].

Rates of mental health difficulties in LGBTQI+ parents are unknown but may be higher for birthing trans and non-binary people[9] and birthing lesbian, gay and bi (LGB) women[10,11], than for cisgender heterosexual birthing women. LGBTQI+ people are often treated as a single homogenous group in research and practice despite comprising multiple groups. So far, there is no perinatal mental health research with trans non-birthing parents, intersex birthing or non-birthing parents, and parents who have been both birthing and non-birthing parents.

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Vulnerability factors for perinatal mental health difficulties

- History of mental illness
- Family history of mental illness
- History of childhood trauma and poor parenting
- Assisted conception/IVF
- Pregnancy-related complications
- Birth trauma
- Pregnancy loss & baby loss (including termination of pregnancy and child removal)
- Baby with special needs/ admitted to neonatal unit
- Major life events/stresses
- Low social support
- Domestic abuse
- Substance misuse
- Relationship problems
- Being a young parent
- Poverty, unemployment, debt
- Housing problems[12-20]

LGBTQI+ parents may also experience additional challenges which could further increase vulnerability to perinatal mental health problems.

Negative interactions with healthcare professionals increase vulnerability to mental health difficulties and create barriers to care. Perinatal mental health care systems have been shaped by assumptions that families involve one birthing mother and one non-birthing father (i.e. are cisheteronormative). As a result, LGBTQI+ people are more likely to have experienced discrimination, microaggressions (including insensitive comments or questions), invisibility, misgendering and wrong assumptions about their relationship to their partner or their baby[21-24], in addition to facing daily stress as members of a minority group. These experiences are referred to as minority stress and may add an additional layer of vulnerability[25].

Distinct considerations exist concerning different groups. Non-birthing mothers – like non-birthing fathers – may feel excluded by services, but also have role insecurity as non-birthing or non-biological parents who are parenting without role templates[26]. Gender dysphoria describes the discomfort or distress that a person may feel relating to mismatch between their gender and the gender they were assigned at birth. Some trans, non-binary and intersex parents may experience heightened gender dysphoria during the perinatal period, linked to physical changes and the responses from people around them, whilst others may experience a reduction[9].

Signs and symptoms of perinatal mental health difficulties in LGBTQI+ parents

Many of the common signs and symptoms of perinatal mental health difficulties can present in any parent. Although evidence-based tools exist for helping to identify depression and anxiety, it is important not to be limited to these. For example, research finds that cisgender heterosexual fathers may show psychological distress in ways that would not be identified by commonly used tools, such as irritability, conflict or anger, and increased behaviours such as overworking, alcohol consumption and risk-taking[27]. Such findings show the value of approaching mental health holistically, taking a person-centred approach and using evidence-based tools as an adjunct to wider conversations on wellbeing, as indicated in NICE guidance[4]. This is relevant for working with all parents, including LGBTQI+ parents.

Seeking and accepting support

Stigma and shame about mental health can be a barrier for all parents in accessing support. LGBTQI+ parents may face additional barriers, including fear of their parenting being scrutinised, fear of homophobia, transphobia and assumptions around gender and sexual orientation (cisheterosexism), uncertainty about whether services will be available or appropriate, and concerns that disclosing difficulties may confirm others' negative judgements about LGBTQI+ parents[26]. Non-birthing parents may also question the validity of their distress, consistent with research with non-birthing fathers[26].

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Good practice points for health visitors

- Work within the NMC Code, prioritise all people, treat people as individuals and uphold their dignity.
- Care for LGBTQI+ parents should be trauma-informed, personalised, and rooted in an understanding of minority stress. Delivering personalised care may require adaptations to current policies.
- Language is powerful. When talking to groups, use additive language that affirms all genders and serves all parents, ensuring everybody is represented and included. Tailor your language for an individual or family, this can include using the correct pronouns, relationship or parenting names, and the parents' preferred terms for body parts (e.g. in discussing physical recovery from birth). A review of the NHS position on gender inclusive language is currently underway and services are advised to follow national guidance.
- Do not make assumptions about people's genders, relationships, sexual orientation, conception method, intended parental roles, lactation/ feeding, contraception or future reproductive choices. Instead, think inclusively about the family, remembering family formations may differ, and may contain more than one birthing parent. If it is appropriate to record information, ask, but avoid asking questions to satisfy personal curiosity.
- Consider the needs of the whole family, including any caregivers and the needs of other children in the family. Be aware that extended family support may be variable and that LGBTQI+ parents' chosen families may include close friends.
- Challenge discrimination. Ensure that documentation and policies are inclusive and aligned with the Equality Act[28] and in place for staff to moderate in any group settings if needed (i.e. homophobia or transphobia from staff or other parents).
- Monitor sexual identity and gender to help identify needs and inequalities in incidence of perinatal mental health problems in LGBTQI+ parents, and access to care.
- When assessing mental health, use evidence-based assessment tools but be aware that mental health difficulties may manifest in different ways and adapt practice appropriately. Be aware that gender dysphoria experiences may vary considerably, and omitting this from discussion of mental health risks missing or dismissing a parent's needs.
- Understand that LGBTQI+ parents may face different barriers to seeking and accepting help.
- Identify appropriate resources for parents:
  - Check whether existing resources are suitably tailored to the needs of LGBTQI+ parents, including information, language and imagery.
  - If recommending a group or resource to an LGBTQI+ parent, check that it is inclusive before recommending it. If a service is not inclusive, health visitors may need to advocate on behalf of LGBTQI+ parents.
  - Support networks for LGBTQI+ parents will vary regionally; online/ national support may be more accessible.
  - Offer proactive, individualised infant feeding support in line with BFI guidelines. This may include information on induced lactation, co-nursing, and infant feeding for trans or non-binary parents.
- Identify your learning needs. Seek out and access regular training and updates, alongside reflective clinical supervision.

To continue your professional development, access iHV's LGBTQI+ People and Perinatal Mental Health training programme, or contact training@ihv.org.uk

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Definition of terms

- **Lesbian** - Refers to women who have a primary romantic and/or sexual orientation towards women. Some non-binary people may also identify with this term.
- **Gay** - Primarily sexually or romantically attracted to people of one's own gender. Commonly used for men, but some women and non-binary people may identify as gay.
- **Bisexual/Bi** - Umbrella term used to describe a romantic and/or sexual orientation towards more than one gender. Bi people may describe themselves using one or more of a wide variety of terms, including, but not limited to, bisexual, pan, queer, and some other non-monosexual and non-monoromantic identities.
- **Trans/Transgender** - Umbrella term for anyone whose gender is not the same as the gender they were assigned at birth.
- **Intersex/Variations of Sex Characteristics** - These terms refer to variations in chromosomal, hormonal, reproductive and/or sex characteristics. The variations may be apparent at birth or much later.
- **Queer** - Umbrella term for anyone who is not cisgender and heterosexual. Individuals may vary with the extent to which they use this term with queer having been used pejoratively.
- **Cisheteronormative** - The set of ideas, social norms, beliefs, and culture that considers heterosexual relationships as the default, preferred or norm, and assumes that gender identity is binary, everyone identifies as the gender they were assigned at birth, and that this is the preferred or norm.
- **Cisheterosexist** - The privileging of cisgender heterosexual people and relationships above people or relationships that involve other genders or sexual orientations.
- **Minority stress** - The minority stress model connects the amount of stress someone faces to their health. Minority groups face a higher level of daily stress through stigmatisation, marginalisation, prejudice and discrimination, which may include from sources such as family, work, society, and from healthcare interactions.
- **Same-gender relationship** - Romantic or sexual relationship between people who have the same gender identity, they may or may not have the same biological sex.
- **Same-sex relationship** - Romantic or sexual relationship between people who have the same biological sex.
- **Birthing parent (or gestational parent)** - Sometimes the preferred term for pregnant trans men or non-binary people. It can also describe which mother-to-be is pregnant within same-gender women couples.

Resources

- NHS: Having a baby if you're LGBT+
- Co-Parent Pad "A quick reference baby guide for non-birthing parents"
- Having a child through surrogacy (England and Wales)
- Surrogacy: legal rights of parents and surrogates (England and Wales)
- Tommy's LGBT Baby Loss Support
- INIA (Intersex: New Interdisciplinary Approaches) has resources and recommendations for health professionals.
- Interconnected (ICON) UK provides peer support and a safe space for people with intersex traits or variations of sex characteristics and their families to connect, and also offers consultancy on policy, inclusion and representation.
- Reprofutures has produced healthcare policy and practice recommendations to address support needs and preferences of adults with variations in sex characteristics in relation to various issues including reproduction, fertility and parenting.

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