

The German Lesbian Family Study: Planning for Parenthood via Donor Insemination

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SUMMARY. This is the first study to explore the issues and decisions that lesbians residing in Germany face when striving to create a family by donor insemination. Using a self-constructed questionnaire, information pertaining to the first phases of lesbian family formation (coming-out, lesbian relationship, and decision-making) was collected from 105 lesbian mothers. The participants in this sample demonstrated a strong sense of lesbian identity, were in committed relationships, had taken part in lengthy deliberations about general and lesbian-specific aspects of

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parenting, and had aspirations of equal parenting which were reflected in their choice of terms for identifying themselves as mothers. Potential advantages for children included wantedness and diversity in up-bringing. Coping strategies for possible discrimination of children included valuing diversity, maintaining open communication, instilling pride, normalizing, and buffering. Maternal role allocation was based on desire to experience pregnancy. Plans for male involvement in children's lives had been made. Women generally experienced support for plans to parent. Co-mothers looked forward to becoming mothers but were sensitized to the consequences of legal and biological asymmetrical parenting. The choice of anonymous, identity-release, or known donor was related to attitudes towards biological fathers/donor issues and availability. The impact of German legislation regarding same sex marriage and lesbian access to reproductive services on family formation is discussed.

KEYWORDS. Lesbian parenting, lesbian co-parenting, planned parenthood, sperm donor insemination, lesbian family formation

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). What is recent, however, is that more and more lesbians are choosing to parent in their lesbian relationships or alone as a sole parent. The dramatic increase of lesbians choosing to parent has led several U.S. authors to speak of a lesbian baby boom (Patterson, 1994) or "gayby boom" (Pies, 1988).

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 with sperm obtained from a sperm bank or a male friend (donor insemination [DI]) or, less commonly, conceive via heterosexual sexual relations with a man. The child or children are then born into a family of origin with a mother or mothers who identify as lesbian from the beginning and may or may not have additional parents such as a known (biological) father. These planned lesbian families are characterized by maternal lesbian identity, a high intentionality to parent (Golombok et al., 1996), and, in some cases, biological father absence.

Much of the psychosocial research that has studied planned lesbian families has focused on the relationship between the families' structure and family functioning. Aspects of lesbian parenting function such as parental division of labor (Patterson, 1995), parenting goals (Bos, van Balen, & van den Boom, 2004), and nurturance (Ciano-Boyce & Shelly-Sireci, 2002) as well as parent-child interactions (Brewaeyns, Ponjaert, Van Hall, & Golombok, 1997; Golombok et al., 2003) have been investigated. Studies have also researched the cognitive, social, emotional, and gender development and psychological adjustment of the children of lesbian parents (Brewaeyns et al., 1997; Chan, Raboy, & Patterson, 1998; Flaks, Ficher, Masterpasqua, & Joseph, 1995; Golombok, Tasker, & Murray, 1997; Golombok et al., 2003; Maccallum & Golombok, 2004; Patterson, 1994, 1995) as well as their social interactions outside of the nuclear family such as contact with grandparents (Fulcher, Chan, Raboy, & Patterson, 2002; Patterson et al., 1998) and experiences with disclosure of family form to peers (Vanfraussen, Ponjaert-Kristoffersen, & Brewaeyns, 2002). Groups that have been chosen for comparison include single heterosexual women and heterosexual couples who became parents via natural conception, DI, or adoption as well as lesbian adoptive parents. Studies consistently report more similarities between lesbian families and the comparison groups than differences lending support to the conclusion that family structure *per se* is not the mediating variable determining quality of any families' functioning. These studies are nonetheless important because they document the viability of the lesbian-headed family unit in a cultural climate that stigmatizes them.

Another emerging strand of research has studied lesbian usage of donor insemination. Traditional donor options for lesbians have included using an unknown donor, i.e., an 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 such as a male friend or relative of the social mother. There has been much controversy over the anonymity of unknown, frozen sperm donors regarding the effects on recipient couples and the consequences for the child (Brewaeyns,

Ponjaert-Kristoffersen, Van Steirteghem, & Devroey, 1993). Historically, three stances have vied with each other: (a) complete anonymity; (b) anonymity with non-identifying information; and (c) registration of donor identity. Until recently, there has been little research on the long-term effects of donor anonymity due to the cloud of secrecy imposed by heterosexual DI recipient couples and their corresponding reluctance to participate in research. In contrast, LDI (*lesbian donor insemination*) parents have been willing participants in studies assessing experiences with third party assisted reproduction. Research on LDI parents has studied parental and child attitudes towards donor anonymity (Brewaey, Devroey, Helmerhorst, Van Hall, & Ponjaert, 1995; Vanfraussen, Ponjaert-Kristoffersen, & Brewaey, 2001), attitudes towards donor identity releases (Scheib, Riordan, & Rubin, 2003), parental choice of anonymous or identity-release donor (Brewaey, de Bruyn, Louwe, & Helmerhorst, 2005; Scheib, Riordan, & Shaver, 2000) and why some children want to know more about their donor (Vanfraussen, Ponjaert-Kristoffersen, & Brewaey, 2003). Since insemination with a known donor usually skirts medical intervention due to self-insemination, the effects of this choice on the lesbian-headed family are not documented in the scientific literature.

Investigations of the factors that influence gay and lesbian (GL) couples' inclinations to make parenthood part of their lives are limited. Results of the studies by Siegenthaler and Bigner (2000) and Bos, van Balen, & van den Boom (2003) lend support to the idea that lesbian and heterosexual couples pursue parenthood for similar reasons such as expected happiness and fulfillment that parenthood would provide. However, prospective lesbian parents are less motivated by social expectations or generativity, and they generally spend more time contemplating parenthood than their heterosexual counterparts. These differences are explained in terms of differences in the social context in which decisions to parent as a heterosexual couple versus a lesbian couple occurs. Lesbian parents make parenting choices in a more hostile environment and have to go to greater lengths to achieve a pregnancy than fertile heterosexual couples. What these studies do not address are the aspects of parenting the lesbian couple considers during the reflection period.

Research on the family building process of lesbian-headed families is limited to The National Lesbian Family Study by Gartrell and colleagues (Gartrell et al., 1996, 1999, 2000, 2005). This study has thus far provided longitudinal, descriptive data on a sample of 84 LDI two- and single-parent families residing in the United States. Results of these studies showed that nearly one-third of the couples had separated by the

time the child was five years old, but almost all of this segment continued shared parenting. The continuous couples reported that the child involved was equally bonded to both mothers. The children did not differ in the prevalence of developmental disorders and were comparable in their psychosocial development to children from heterosexual families. In contrast, the prevalence of physical and sexual abuse in the lesbian families was much lower than national rates. The psychological functioning of the children did not differ on the basis of whether or not they knew their donor.

In recent years, lesbians in Germany have also begun starting families. The existence of lesbian-headed families in Germany is poorly documented, and there is a corresponding lack of information about them. Generally, these families are not legally or socially recognized despite there being an estimated two million lesbians residing in Germany—approximately 650,000 of whom are lesbian mothers (Krüger-Lebus & Rauchfleisch, 1999). According to the Federal Statistical Office of Germany, one in eight same-sex relationships involve children (*Statistisches Bundesamt*, cited in Dworek & Ferchau, 2006). The majority of these children were conceived in the context of a heterosexual relationship (Berger, Reisbeck & Schwer, 2000). It can be assumed that, based on the Swedish experience of a baby boom after legal reforms for homosexuals, lesbian-headed families in Germany may increase rapidly in up-coming years.

This study focuses on the family building process of lesbians who choose to become parents by conception via donor insemination of themselves (*birthmother*) or their partner (*social mother*) and will be referred to as *lesbian donor insemination (LDI) families*. Common usage amongst the study population refers to the birthing mother of a child as the *birthmother* or *biological mother*. The terminology used for the non-birthing mother is more diverse and somewhat controversial. Terms such as *co-parent* (Scheib et al., 2000, 2003), *co-mother* (Gartrell et al., 1999; Muzio, 1993; Wilson, 2000), *non-biological mother* (Nelson, 1999; Patterson, 1996; Pies, 1988), *social mother* (Bos et al., 2004; Brewaeys et al., 1997; Vanfraussen et al., 2001), *psychological mother*, *nonlegal mother*, and *other mother* (McClellan, 2001) have been used to distinguish this parenting role. *Co-mother* is an established term in the United States. In practice, however, this term is ambiguous because it refers to any woman who is partnered with the lesbian biological mother irrespective of her definitional role in the family. The researchers hold the view that since the prefix “co-” means with, *co-mother* is better suited for designating a woman occupying the role of *lesbian stepmother*. It is

important to avoid defining the non-birthing mother role in a primary lesbian family in a manner implying that she is deficient in some manner. It is our 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, although the authors acknowledge the shortcoming that it may be understood to imply that the birthmother is not a social mother.

LESBIAN FAMILY FORMATION

The process of family building via DI for lesbians is conceptualized chronologically in the present study: coming-out, committed lesbian relationship, Kinderwunsch-planning, Kinderwunsch-insemination, pregnancy and birth, transition to parenthood, children attending kindergarten (ages 3-6/7), children attending elementary school (grades 1-4), and children attending secondary schools (grades 5 and up).

A prerequisite of lesbian parenting is the acquisition of a lesbian identity, also known as coming-out. The term *coming-out* describes the process by which a person acquires gay male or lesbian sexual orientation and identity. Secondly, it describes the act of disclosing this personal information to others. This act of disclosure is necessary since gay men and lesbians are presumed to be or are treated as if they were heterosexual. The other prerequisite of lesbian parenting includes lesbian couple formation if parenting is pursued as a couple.

These phases are followed by the Kinderwunsch-planning and Kinderwunsch-insemination phases. Directly translated, Kinderwunsch (German) means *child wish* and entails the combined meaning of wishing to become a parent and wanting to have a child. What constitutes the beginning of the planning phase is unclear. Its end, however, is marked by the beginning of the insemination phase. If conception proves difficult or the couple is not satisfied with their insemination procedure or donor choice or if the insemination phase is disrupted in some other way, they may return to the decision-making phase before proceeding with inseminations.

The uniqueness of LDI family formation in comparison to family building for heterosexual couples lies in the coming-out, the conscious and active decision-making process, and the insemination phase in order to achieve a normal pregnancy. Once pregnancy is achieved, the lesbian couple is absorbed by the same series of events dictated by biology

and subsequent development of their children as heterosexual parents. However, the phases of pregnancy, childbirth, transition to parenthood, and child development pose additional challenges for lesbian parents and their children. Navigating the heterosexual world with its heterosexism and homophobia, and, possibly, also the absence or the presence of a father/donor pose additional challenges for lesbian-headed families. Lesbian parents re-engage in the unique phases of decision-making and insemination for subsequent children which may include a role switch between partners.

Legal Situation

The legal situation in a particular country also shapes the creation of LDI families. Laws impact families 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. In August 2001, the German parliament instituted Registered Life Partnerships (*Eingetragene Lebenspartnerschaft*) for gay and lesbian couples in Germany. The life partnership law [*Lebenspartnerschaftsgesetz* (LPartG)] began in 2001 as a compromise and offers minimal rights and all of the responsibilities of marriage to those who choose it. It offers the gay and lesbian couple a first degree relationship status, e.g., in case of hospitalization or death, the opportunity of the life partners to be covered by each other's medical insurance, and the choice to carry one of the two people's last names. Critique has focused on the financial disadvantage it imposes on the couple since their income is considered combined as regards social law but separate for tax purposes. Thus, these couples are denied access to the tax advantages that 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, after data collection for this study was concluded, the life partnership law was extended [*Lebenspartnerschaftsergänzungsgesetz* (LPartGErgG)] to include equal access to social security benefits, extension of name changes to biological children, and stepparent adoption of biological children of the life partner. As it currently stands, the LPartGErgG entitles lesbian and gay couples to all of the rights of legal marriage with the exception of the tax related laws (*Steuerrecht*) and the right to jointly adopt children (*Adoptionsrecht*).

The legal situation negatively impacts lesbian access to reproductive medicine in Germany. Insemination with donor sperm 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 (Thorn, 2003). The National Embryo Protection Act of 1991 does not regulate access to assisted conception services. However, guidelines for medical professionals, which reserve DI for married heterosexual couples only, do apply. 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 or imported frozen sperm. Interestingly, the treatment of DI for single or lesbian women is entangled with a contradiction in German DI usage. On the one hand, a court decision in 1994 upheld a child's right to knowledge of its descent, 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).

This study endeavors to contribute to the knowledge about: (1) the process by which German lesbian women become parents through donor insemination by systematically describing the early family formation phases of coming-out, lesbian relationship, and decision-making for these families; (2) the roles of biological and social mother in the initial lesbian family planning stages; and (3) the cognitions and processes that result in lesbian couples' donor choice.

METHOD

Sample

A non-random, volunteer sample ($N = 105$) consisting of predominantly German citizens (89%) from middle or upper middle class was used for this study. Of the 105 lesbian DI mothers, 55 were *birth mothers* (M age = 37.1 years, $SD = 5.2$ years), and 50 participants were classified as *social mothers* (M age = 39.0 years, $SD = 6.1$ years). Classification was based on the mother role with respect to the first-born DI child. The 50 social mothers were partnered with 50 of the 55 participating birth mothers (in 5 families only the birthmother participated). The

official family status of the majority of participants was single (60%), while the remaining had entered same-sex registered life partnerships.

The women in this study chose different donor types in planning DI: anonymous donors (42%, $n = 42$), identity-release donors (18%, $n = 22$), known donors (38%, $n = 39$) and unknown fresh sperm donor (2%, $n = 2$) to conceive their first-born child.

Twenty participants were in a pre-parenthood stage of family building in which either they or their partner was currently inseminating ($n = 12$) or pregnant ($n = 8$). Thirty-two women had index children who were 0-3 years old ($n = 32$). Thirty-five mothers' first-born DI child was of kindergarten age (3-6 years old, $n = 35$), and 18 mothers' first-born DI child was school aged (6/7 years or older, $n = 18$).

The participants were mothers to a total of 47 first-born children (M age = 4.2 years, $SD = 2.0$ years) conceived via DI of whom 43% were female and 57% were male. There were also a total of 16 younger sibling children (6 born to the birth mother, 8 born to the social mother, 1 born to a new partner, and 1 foster child). Participants primarily lived in a two mom/one child family (92%). All children were planned for and born before the stepparent adoption option was introduced for registered lesbian couples. Two social mothers were birth mothers to 4 adult children conceived and raised during a heterosexual life phase.

Procedure and Instruments

Participation in the study was open to: (a) lesbians with a desire to become parents who had completed or their partner had completed at least one insemination cycle; or (b) lesbians whose first-born child was conceived via DI (they should have no previous children). The sample was recruited through an extensive search of various channels. The first author accessed informal networks of lesbian mothers by installing a Web site on the Internet, placing advertisements in LG magazines and on the German national LG organization (*LSVD e.V.*) Web site as well as by approaching the LG counseling centers in Cologne and Berlin and all (feminist) women's health centers in Germany. A total of 67 questionnaires were mailed between June 2004 and January 2005; the response rate was 84%.

LDI Family Formation Questionnaire. The LDI Family Formation Questionnaire is a self-constructed, structured questionnaire which assesses demographics and information pertaining to the respondents' sexual history, coming-out, lesbian relationship, family constructs, and decision-making. Closed questions and answer probes were developed

based on an extensive investigation of the literature on LDI families. Questions that were truly exploratory in nature were left open-ended. Two questions asking participants to list advantages and special concerns about raising children in a lesbian home and four items assessing social support were adopted from kindly shared questionnaires constructed by Johnson and O'Connor (2002) and Shelley-Sireci & Ciano-Boyce (1999), respectively.

The Kinderwunsch section was divided into two parts. The first part aimed at gaining general insight into the aspects involved in the lesbian decision to parent using donor insemination. The items address topics such as the trigger of the desire to parent, the length of time the couple deliberated parenthood before coming to a decision, the issues that were pondered, deciding who will give birth, attitudes of social mothers regarding their role, methods of becoming parents that were considered, and considerations regarding men in children's lives. The second part of the Kinderwunsch section was divided up into four sections with questions assessing choice of donor type. Subjects only filled out the section that corresponded to the donor they were currently inseminating with or had conceived with. Data regarding aspects of donor choice such as availability of different donor types, positive and negative aspects of the chosen donor type, procedure for inseminating, knowledge and internal image of donor, and plans and/or desires to meet donor were collected.

Lesbian Internalized Homophobia Scale (LIHS). The LIHS is a 52 item scale for assessing levels of internalized homophobia in lesbian women (Szymanski & Chung, 2001a). It provides a global score and 5 subscale scores representing 5 dimensions of internalized homophobia: (1) Connection With the Lesbian Community; (2) Public Identification as a Lesbian; (3) Personal Feelings About Being a Lesbian; (4) Moral and Religious Attitudes Towards Lesbianism; and (5) Attitudes Towards Other Lesbians. Each item is rated on a 7-point Likert scale from Strongly Disagree to Strongly Agree. Average subscale and total scores are computed with higher scores indicating higher levels of internalized homophobia. Recent studies showed that the LIHS has good psychometric properties and construct validity (Szymanski & Chung, 2001a, b; Szymanski, Chung, & Balsam, 2001).

Dyadic Adjustment Scale (DAS). Participants' satisfaction in their couple relationship was measured using the German version of the *Dyadic Adjustment Scale* (Spanier, 1976), the *Fragebogen zur Beurteilung der Zweierbeziehung* by König-Kuske (1977), adjusted by Krüger-Lebus (1996) for lesbian respondents. The DAS is a 32 item scale for assessing the quality of dyadic relationships. It provides a global score

and four subscale scores: (1) Dyadic Satisfaction; (2) Dyadic Cohesion; (3) Dyadic Consensus; and (4) Dyadic Affectional Expression. The DAS is the most commonly used method of assessing dyadic adjustment. It possesses significant psychometric properties and construct validity in studies using various samples (Hahlweg, Klann, & Hank, 1992). It has also been used in studies with lesbian samples in the United States, Germany, and Switzerland (Flaks et al., 1995; Kruger-Lebus & Rauchfleisch, 1999).

Data Analyses

Group comparisons were conducted by maternal role (birthmother vs. social mother), sperm type (fresh vs. frozen) and donor type (anonymous vs. identity-release vs. known donor) to identify answering patterns particular to a group, and Chi-Square analyses were calculated. Qualitative data analyses of answers to open-ended questions were conducted, and quotes are used in the following section to illustrate prototypical responses.

RESULTS

Coming-Out

The majority of respondents (93%) described themselves as lesbian and experienced their coming-out during young adulthood ($M = 21.5$ years, $SD = 5.7$ years); all respondents were satisfied with their sexual orientation and sexual identity. The mean age for entering the first lesbian relationship was 23.5 years ($SD = 5.0$ years). Respondents had experienced a mean of 2.4 ($SD = 1.4$) lesbian relationships. The mean duration of the longest one was 9.7 years ($SD = 3.9$ years), which was, in general, the current parental relationship. Seventy-five percent of participants had had heterosexual relationships in the past.

Overall, the coming-out process only had a moderate impact on women's life plans. The expectation to marry a man was the most impacted. Initially women were evenly divided in their expectations to marry (32%), not marry (38%), and being unsure (33%). After coming-out, lesbians almost unanimously expected not to marry a man (93%). In contrast, participants' expectations regarding having children were not affected by the coming-out process. Similar proportions of lesbians intended to have children (before 63 and after 57%), not have children (before 20 and after 27%), or were unsure (before 16 and after 20%).

Despite changes in participants' expectations of marriage, coming-out had only a mild impact on their expectations of financial independence. Fifty-eight percent of the women expected to provide their own living. Over one third (38%) had already been earning their own living before their coming-out. Only 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 (before 19 and after 31%) while the number of participants who gave money no thought decreased slightly (before 14 and after 8%).

In general, participants indicated being currently out to all or most of their friends (96%), family of origin (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%). Most of the lesbians (91%) reported that they decided on a case by case basis whether or not they wanted to come out to others. A few stated that they always make their lesbian identity very clear to the other person.

Table 1 shows that respondents demonstrated low levels of internalized homophobia ($M = 1.9$, $SD = .4$) on the LIHS. This result corresponds with the high levels of self-reported outing behavior indicating a strong lesbian identity in the sample population.

Lesbian Relationship

Thirty-nine percent of the lesbians in this study were registered life partners. Of the non-registered life partners, the majority cited disagreement

TABLE 1. Mean Scores of Biological and Social Mothers on the Lesbian Internalized Homophobia Scale ($N = 105$)¹

Dimension	All mothers	Birth-mothers	Social mothers
Connection with the Lesbian Community	2.1 (.7)	2.1 (.6)	2.1 (.7)
Public Identification as a Lesbian	1.9 (.6)	1.8 (.6)	2.0 (.7)
Personal Feelings about Being a Lesbian	1.6 (.5)	1.5 (.4)	1.6 (.6)
Moral and Religious Attitudes Towards Lesbianism	1.4 (.5)	1.4 (.5)	1.3 (.4)
Attitudes Towards Other Lesbians	2.1 (.8)	2.0 (.8)	2.2 (.8)
All Dimensions (mean score)	1.9 (.4)	1.8 (.4)	1.9 (.4)

¹ Standard deviation shown in brackets.

with the *Lebenpartnerschaftsgesetz* (LPartG) in its form from August 1, 2001 as their reason for not entering a life partnership. The mean numbers of years the women had lived in the relationship in which they had planned to become a parent or had been parenting was 9.2 years ($SD = 4.1$). Ninety-three percent of respondents were still living in this relationship while the remaining group had since separated from the person they had planned their child with.

Respondents reported numerous forms of outward signs of commitment to their partner citing one or more of the following: 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 such as weddings or anniversary celebrations (74%), and using the same last name (28%). Most women also had made provisions for their partner in the event of their death (78%).

All of the women cohabitated with the female partner they were parenting with or were planning to parent with. The mean duration of relationship length before cohabitating was 2.0 years ($SD = 1.9$ years). More than half of the lesbian couples entered into the lesbian relationship in which they were parenting or planning to parent with the topic of parenthood being an issue for one or both of the women from the start (57%). The large majority of respondents reported exclusively monogamous relationships (84%). The remainder all stated that they had reached an agreement with their partner regarding monogamy and consistently emphasized the more monogamous nature of their relationship, but either said that affairs were theoretically allowed or that these would not cause the end of the relationship.

Mothers indicated high levels of couple satisfaction in the Dyadic Adjustment Scale (see Table 2). The total score as well as the subscale scores were similar to those participants who rated their couple relationship as happy in Hank et al. (1990).

Birth mothers experienced an increase in their sense of well-being due to the decision to parent (64%). Some social mothers (17%), however, experienced a decrease in their sense of well-being. As for the relationship to her partner, the decision-making and planning process was perceived as having had either a positive effect (59%) or no effect (42%). During the planning phase, partnership satisfaction was rated very high [$M = 3.7$ (scale from 1 to 4)] while intimacy and conflict frequency was not impacted [$M = 3.2$ and 2.9, respectively (range from 1 to 5)] by the decision-making process.

TABLE 2. Mean Scores of Biological and Social Mothers on the Dyadic Adjustment Scale ($N = 105$)¹

Subscale	Point range	Hank et al. (1990)		German sample		
		Couples in counseling	"Happy" couples	All moms	Birth mothers	Social mothers
Consensus	0-65	43 (10)	50 (6)	50.2 (5.8)	49.8 (5.7)	50.5 (6.0)
Satisfaction	0-44	31 (8)	41 (5)	39.3 (4.9)	39.2 (4.4)	39.3 (5.4)
Cohesion	0-20	13 (4)	16 (3)	15.8 (3.7)	16.1 (3.9)	15.4 (3.5)
Affectional expression	0-12	6 (2)	9 (2)	8.0 (1.9)	7.9 (1.8)	8.0 (1.9)
Total	0-147	93 (23)	115 (12)	113.2 (13.6)	113.0 (13.2)	113.3 (14.0)

¹ Standard deviation shown in brackets.

Kinderwunsch Planning

Trigger. Twenty-seven percent of the women were unable to identify a single trigger event or factor as their desire to have a child had felt like it had always been with them. Birth mothers reported this factor more often than social mothers. Some participants said their *Kinderwunsch* was triggered by their partner's desire to have a child (23%). More social mothers gave this response than birthmothers [$\chi^2(1) = 5.0, p = .03$]. Further triggers for contemplating parenthood included pleasure when interacting with other people's children (19%), the relationship to the partner (19%), a desire for family life (11%), discovering the possibility of lesbians having children by meeting other lesbian moms or hearing of their existence (9%), and age (3%).

Renate, social mother: *My Kinderwunsch was always there, but I thought that, as a lesbian, you had to choose between having a female partner and having children.*

Birgit, birth mother: *I have long carried the desire to experience pregnancy in me. The desire to have a joint child arose out of our love for one another.*

Elke, social mother: *My partner's desire.*

Most commonly, birth and social mothers reported that the prospective birth mother of their first DI child had experienced the desire to parent

before her partner did (46%) or that both mothers experienced the desire to parent simultaneously (37%). Only 17% said that the prospective social mother was the first to experience the desire to parent.

Issues in the Decision-Making Process. The mean time between starting discussions about parenthood and the first insemination was 2.1 years [$SD = 1.7$ years (range from 0.2 to 9.0 years)]. During this time, they discussed a multitude of general and lesbian-specific aspects of parenthood which included the following topics: plans for childcare (85%), parenting styles (77%), the issue of bonding for the social mother (77%), plans for child custody should the couple break-up (75%), the power imbalance between the birth and social mother roles (61%), and the potential effect of family background on prospective parenting (56%).

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. Fifty-four percent expected both mothers to be equally involved in child rearing as well as housework and gainful employment. If the childcare plan included the birth mother taking maternity leave, this led to plans for a temporary traditional division of labor (homemaker/bread winner) during this time.

Helma, birth mother: *Joint parenting.*

Pia, social mother: *We both wanted to look after our child and continue to work.*

The majority of participants (75%) also discussed how they would handle the situation if their couple relationship ended. Although at the time of their decision-making, all participants were living under German legislation that gave birth mothers sole legal custody of the child(ren), all participants indicated that both mothers would continue parenting their child(ren) should their relationship terminate. One set of participants indicated internal plans for joint custody (28%). Other participants indicated custody agreements common to heterosexual divorce (64%), i.e., the child would live with the birth mother and social mother would have visitation rights, contribute to child support, and continue to be involved in major decisions regarding the child. Almost half of these private agreements were written, often notarized, agreements (42%).

Martina, social mother: *Bio-mama has custody, legally; we agreed on child care payments and that our child*

would live 10 years in our house with a caring mother—but not which one.

Fransiska, birth mother: *That we both continue to share custody and that we will always consider the child's needs.*

Concerns Related to Parenting. Concerns of lesbian mothers during the decision-making process included: fears of discrimination, that a child might experience (76%), concerns regarding the fatherlessness (70%) or regarding financial resources (66%), potential lack of support from immediate family (37%), friends (30%), or work environments (19%). Social mothers worried about the continuity of contact with their child if their couple relationship were to end (72%).

Model of Family and Parenting. Just over one third of lesbian mothers had to make decisions pertaining to lesbian parenthood in the absence of any role models (28%). These women were more likely to have school aged children at the time of the study [$\chi^2(1) = 12.2, p < .001$]. The remaining lesbian mothers, who predominantly had children of kindergarten age or below, knew other lesbian-headed families personally (57%) or at least knew of them through others (18%) and/or the media/Internet (36%). Most participants (80%) aspired to the two mom-child nuclear family model including equal parenting. There was willingness for extended family networks to include people who were not blood relatives of either mother along with kin.

Advantages of Lesbian Parenting for Children. Respondents listed numerous advantages for their children of being raised in a lesbian family. First, all children conceived by lesbian couples are wanted since their parents chose parenthood after much deliberation and planning (24%). As a result, these children can look forward to much parental attention and love from both parents (14%).

Lotte, social mother: *They are Wunschkinder, who are planned for and really wanted.*

Tina, birth mother: *The most important thing for children is that they are loved and are raised without prejudice.*

Two thirds of mothers felt their children would profit from growing up with egalitarian role models, more democratic family systems, and enjoying 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.

Ulrike, social mother: *(The children) will grow up more sensitive, tolerant, and with strong female role models.*

Being raised in a lesbian household was expected by three quarters of mothers to benefit children greatly in the areas of personality identity and social competence. They felt that their children would be more exposed to diverse types of families, partnerships, ways of life, and sexual identities. As a result, their children would be more tolerant, creative, empathetic and sensitive towards others, and not assume heterosexuality for self or others.

Christine, birth mother: *Hopefully they will grow up to be more tolerant, freer to design their own lives, also with respect to their choice of [same/opposite sex] partner.*

Perceived Disadvantages of Lesbian Parenting for Children. The disadvantages mentioned by the lesbian mothers were concerns they had for their children in the future. Interestingly, none of these had to do with the parents' lesbianism *per se* but rather society's homophobia and heterosexist stance on family. Thirty-two percent of participants voiced concerns regarding society's non-acceptance of their families and the possible discrimination their children may face as a result (41%).

Sabine, birth mother, anonymous donor: *(I was worried) whether (our child) would be confronted with intolerant/sick people, that would tease (our child), want to 'solve its problem' . . . and (our child) isn't yet able to cope with it.*

The other significant concern the participants voiced had to do with the issue of the missing father/male identification figure (23%), i.e., how the child would feel about this one day and what effects this may have on them in the long run.

Antje, birthmother, identity-release donor: *. . . that the child feels like an outsider, that (child) misses having a father as an identification figure.*

Finally, some respondent (9%) did not see any potential problems for their children as long as they were raised in a loving, caring environment.

Gisela, social mother, . . . *little, when there's love and affection*
 identity-release donor: *(in a family).*

Participants also considered coping mechanisms that could aid their children in managing societal homophobia and discrimination. Five coping strategies were identified from one or more responses per person: (1) valuing diversity (93%) which comprised responses such as talking about different family forms, emphasizing that all families are valuable and that its good to be different; (2) open communication with the child (91%); (3) instilling pride (81%) by, for example, taking part in GL activities, celebrations, and the community; (4) normalizing (79%) which comprised of actions such as having contact with other LG families, being open about discussing family form with others, and defining family based on love; and (5) buffering (47%), which included talking about the different opinions people hold of gays and lesbians and role playing responses to homophobic or heterosexist encounters.

Deciding Who Will Become Pregnant. Participants reported several aspects that were influential in the decision regarding 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 would become pregnant (first). Other factors which played an influential role in this decision included the age of the women (56%), financial considerations (51%), and job related reasons (51%). For a small minority of couples, the most decisive factor was a logistical reason: foreigner status of one member of the couple (4%, $n = 4$), the donor was a relative of one member of the couple (5%, $n = 5$), they simply let chance decide (simultaneous insemination, 7%, $n = 7$), or the women had switched roles because one partner had not become pregnant (4%, $n = 4$).

When a second child was planned, in more than half of the cases the birth mother was expected to bear the next child (57%). Most mothers had no gender preference for their child (62%) but if a preference was specified it was more often for a girl (32%) than a boy (5%). Mothers had no sexual orientation preference for their children (98% girl and 96% boy). All unanimously agreed that they intended to support their child no matter what sexual orientation their child manifested.

Expectations of Social Mother Role. The majority of social mothers expected their mother role to be a primary/shared caregiver similar to an adoptive mother (64%). They identified numerous positive aspects of their maternal role such as a sense of joy of simply being a mother (without giving birth). A common theme was emphasis on the equality

of the social mother and birthmother roles especially through the eyes of the joint child:

Angela: *Everything, because I consider myself a fully-fledged parent and (our) child is also my Wunschkind.*

Pia: *(I) don't see any difference between the parental roles.*

Miriam: *It is totally normal for our children to have two mothers . . . We are both important attachment figures for our kids.*

Social mothers also looked forward to experiences that being a mother would open them up to a close bond or to see the world through other eyes. One mother summed up her experiences:

Ulrike: *I have learned to be amazed at and enjoy observing how much positive energy such a small being can radiate.*

Lack of legal standing and social recognition headed the list of negative aspects of the social mother role. They felt they did not have any legal standing, i.e., they were not on the birth certificate, and they feared losing their child if their relationship with the birthmother ended through divorce or her death since, legally, they were a biological stranger to the child.

Helga, known donor: *. . . societal/state recognition of (the social mother) role is missing. I don't exist for the state, and the children only have second class citizen rights.*

Social mothers felt they had to explain their role or prove themselves as mothers.

Mira, anonymous donor: *. . . always having to justify my role as parent in society, having to fight for recognition as an equal parent.*

Monika, anonymous donor: *. . . the feeling of also having to prove myself as second mama (for example, in the family or extended family).*

Some were concerned with experiencing jealousy or feared competition with the birth mother or the known, involved donor father or felt they might be by-passed in decisions regarding their joint child.

- Sabine, identity-release donor: *(I was concerned) whether I would be able to deal with not being the birth mother.*
- Hannah, known donor: *. . . that (the child) rejects me.*
- Vera, known donor: *The biological father also plays a big role. I was afraid that I would be passed over in decisions concerning the child in this constellation.*

The other major negative aspect mentioned by social mothers included 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 birthmother and whether the social mother would feel left out.

- Jutta, anonymous donor: *(I was worried) whether our child would consider me as much her mother as her birth mother.*

Another issue noted by the social mothers was concern about how the child and family would fare during his or her adolescence and at puberty and whether they would be able to support their child through this developmental period.

- Charlotte, identity-release donor: *I think that when our son is in puberty, he may have problems accepting me as his mother.*

Two mothers felt there were no negative aspects or problems inherent to the social mother role.

- Lisa, anonymous donor: *(I) saw only outside problems, everything else we can handle.*

Terminology/Issue of What to Call the Mothers

The lesbian mothers in this sample had given a lot of thought to the terminology they would use to denote their roles or what they would like their child to call them by. This was particularly the case for social mothers. Respondents indicated that the name for each mother should firstly differentiate between them, and secondly reflect the respective roles. Most respondents felt it was important to have names that reflected both women's roles as mother, and terms were chosen to signal equality

of the maternal roles both within the family and particularly to the outside world. All names, with the exception of first name and nickname usage, make the mother status of each mother role transparent.

Popular combinations of names for the two mothers were *Mama/Mami*. More mothers using anonymous donors most often chose the combination *Mama* for the birth mother and *Mami* for the social mother. More mothers using identity-release donors chose the reverse combination than mothers using the other donor types. Mothers using known donors most often chose to name the birth mother *Mama* but there was no clear pattern for the name of the social mother.

THOUGHTS REGARDING METHODS OF BECOMING A PARENT

The method of becoming a parent via conception was primarily chosen due to a desire to experience pregnancy and childbirth (76%) as well as to raise a newborn baby (64%). Thirty-eight mothers also saw a lack of adoption alternatives for themselves. Of all the alternative methods to becoming a parent, participants in this study only pursued conception via DI with sperm from a sperm bank (67%) or known donor (60%) very actively. Interestingly, 80% of women who inseminated with known donors did not actively look into the option of inseminating with frozen donor sperm before deciding against it. In contrast, women who eventually opted for a frozen sperm donor also pursued the known donor option actively (39%). Insemination with a go-between was least common (8%).

Adoption (8%) received little consideration though respondents may have shied away from this option due to a perceived or real lack of adoptive alternatives and concerns over multiple oppressions for the child. Sexual contact (2%) and foster parenting (6%) received little to almost 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 did not 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 participants found helpful in planning to become a parent were: books/journals/media (86%), other lesbian parents and parenting groups (61%), sperm banks/clinics (53%), organizations

lobbying for GLBT 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. Compared to others, mothers whose first child was of school age or older more often reported not having had lesbian mother role models [61% vs. 21%, $\chi^2(1) = 12.2, p < .001$].

Obstacles

There were numerous obstacles to be overcome in the women's plans to become a parent. The most commonly anticipated difficulties had to do with DI and donor type. Mothers using anonymous donors expected problems finding a physician/clinic that would inseminate lesbian identified women (75%), gaining access to sperm banks (48%), and the cost (of sperm and insemination, 45%). 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 (88%).

Social Support

More than half of the mothers (55%) perceived support for their plans to become parents via DI. Mothers of school-aged children (28%) perceived the least amount of social support for their plans to parent while the group of prospective mothers (70%) experienced the most social support [$\chi^2(3) = 7.5, p = .02$]. Mothers identified friends (98%) and their community (94%) as significant sources of support. Notably, 82% of the mothers' families of origin were seen as supportive in this phase of family development.

Overall, respondents described themselves as relatively inactive in the GL scene (81%) and lesbian mother groups (56%). More mothers of school and kindergarten aged children (61%) reported being active in groups for lesbian mothers than inseminating/pregnant women or mothers with small children [61% vs. 27%, $\chi^2(1) = 11.5, p < .001$]. 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, most participants would have liked more contact

with other lesbian-headed families (72%). Only a minority felt they had satisfactory contact with others (28%).

Kinderwunsch: Choosing a Donor

Donor Characteristics. Overall, the only donor attributes considered important were education level (74%), skin tone (67%), and ethnicity (48%). One third of respondents 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). The remainder was interested in additional information about their donor such as health history, allergies, the donor's motivation, and the donor's facial appearance/ (childhood) picture.

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 both men and women. They felt it is important to include men in children's lives because:

Nina, social mother, anonymous donor:	<i>Men are a part of life and our child should know and like both (men and women).</i>
Hannah, birth mother, known: donor:	<i>. . . my child will grow up to be a man. . . .</i>

Many respondents reported having plans for particular men to play a special role in their child's life (58%). Mothers using known donors had been able concretize this by planning for the donor to have contact to the child (88%). 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. These plans, however, were rated either as hopes or implicit expectations (68% and 67%, respectively). They planned to include men in their family by asking a close male friend to be the child's godparent, a person who is morally responsible for the child if the parents die. In cases where the mothers had made no special plans for male involvement, it was because, since men are part of everyday life, these women felt that their children would have sufficient contact with them (7%, $n = 7$).

Attitudes Towards Father. Almost all mothers (95%) agreed that establishing paternity is not the only criteria a man has to fulfill in order to be considered a father. 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, i.e., it is not imperative that the biological father be the male role model (99%).

Compared to mothers using anonymous donors, more mothers using known or identity-release donors reported: (1) agreeing that a child has right to know the biological father [67% vs. 90% vs. 95%, $\chi^2(3) = 10.8$, $p < .01$]; (2) agreeing with the idea that not knowing the donor is damaging to the child [2% vs. 63% vs. 43%, $\chi^2(3) = 34.0$, $p < .001$]; and (3) agreeing less with the belief that it is acceptable to bring children into the world when they will not know the donor [90% vs. 74% vs. 62%, $\chi^2(3) = 7.4$, $p = .03$]. Mothers using known donors agreed more often than others that the desire to know one's biological father is a true biological desire rather than a result of social pressure [54% vs. 36%, $\chi^2(2) = 6.0$, $p < .05$]. In contrast, mothers using anonymous donors felt less strongly about children's right to know their biological father (67%), and disagreed the most with the idea that not knowing him could be damaging to the child (98%). They clearly indicated that it is acceptable to bring children into the world when they will not know the biological father.

Unknown Frozen Sperm Donor: Anonymous Donor. Mothers who used anonymous donors only had access to this type of donor (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 about the child never being able to know 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%).

More women with kindergarten or school aged children received sperm via the medical professional/clinic where the insemination was performed than inseminating/pregnant women or mothers with children 0-3 years [53% vs. 17%, $\chi^2(1) = 8.5$, $p = .004$]. The other sperm source was sperm banks in the Netherlands and, more recently, Denmark; both

countries have non-discriminatory policies towards inseminating lesbian women. Respondents who got their sperm directly from the sperm bank either had it sent by courier to them at home (39%), to a doctor's office (39%), or picked it up personally (33%). 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 (88%). Fewer women with anonymous donors self-inseminated (23%).

Most women using anonymous donors had no input regarding their donor (79%). Primarily, the medical personnel at the clinic performing the insemination (47%) or the sperm bank (23%) 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 non-identifying information (59%) or no information (41%) 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, only 33% of mothers who used anonymous donors wanted non-identifying information about their donor.

Most women who used anonymous donors said they had no internal image of their donor (51%). The remainder did so, 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: tall, handsome, athletic, and nice.

Most women were content not to have met the sperm donor of their child (88%). A few would have liked to meet him (12%) either before the insemination (40%), during pregnancy (20%), or within a year of delivery (20%). Nonetheless, most women wished their child could meet his/her sperm donor, if the child wished to do so (88%). Significant aspects of the donor choice are summarized in Table 3.

Unknown Frozen Sperm Donor: Identity-Release Donor. Mothers who chose identity-release donors could choose freely between anonymous and this type of donors (91%). 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

TABLE 3. Apects of Donor Choice (N = 105)

Aspects	Anonymous Donor	Identity-release Donor	Known Donor
Choose freely between anonymous/identity-release donor	5%	91%	NA
Major Positive Points	Safety of frozen sperm (95%) Protection of family boundaries (79%)	Safety of frozen sperm (91%) Child access to donor identity (86%)	Child can know donor (94%) Children can have same donor (64%)
Major Drawbacks	Child can never know identity of donor (71%) Concerns over lower pregnancy rate—frozen sperm (41%)	Concerns over lower pregnancy rate—frozen sperm (41%) Whether identity release will work (36%)	Concerns over regulating donor's (non-) involvement (76%) Donor could sue for custody (53%)
Clinical Insemination	88%	68%	(0)
Self-insemination	23%	50%	(100%)
Who selected donor?	Clinic	Sperm bank	mothers
Had information about donor	21%	64%	NA
Had no internal image of donor	51%	60%	NA
Wished to meet donor	12%	36%	(100%)
Wished child could meet donor	88%	80%	(100%)
Identity-release	no	adulthood	any time
Custody of child	birthmother	birthmother	birthmother
Child's last name	birthmother	birthmother	birthmother
What to call donor	—	—	First name
Plans for recipient—child—donor contact	none	Possibly, after identity-release	No contact until child wishes

Note. Singly participating respondents weighted double for donor type comparisons. NA = non-applicable. () = presumably, but not measured directly.

that might shatter when meeting the real person (38%). Mothers using identity-release donors worried less about raising their child in father absence (24%) than mothers using anonymous donors (71%) although the every day situation for both families was the same until the child reaches adulthood [$\chi^2(1) = 13.8, p = .001$]. The donor's identity will be

released to the child only (91%) when the child has reached a specified age, usually 18 years but in some cases 16 years or younger.

In about half the cases, the mothers were certain they would have access to the donor's identity in any case (55%). Some 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 have 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 (68%) or from the United States (27%). Mothers who used identity-release donors got their sperm directly from the sperm bank (95%). A few had it sent to them or a doctor's office (36%), but over half picked it up personally (59%). Sperm was stored at the women's home (45%) or at a doctor's office (41%) but also at the sperm bank that inseminated (27%).

Lesbians using identity-release donors reported one or more insemination methods: clinical insemination (68%) and self-insemination (50%). Mothers using anonymous donors (90%) reported planning a clinical insemination more often than mothers using identity-release donors (68%). Conversely, fewer mothers using anonymous donors (22%) reported self-insemination than mothers using identity-release donors (50%).

Most participants using identity-release donors had no input regarding the donor (71%); he was selected by someone at the sperm bank (52%), or the medical professional at the clinic (19%). 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.

The majority of participants (60%) who used identity-release donors said they had no internal image of their donor. The internal images of those women who did included socially desirable characteristics in men such as tall (20%), nice, and friendly (15%) and images based on knowledge of where the donor is from (10%). 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 meet the donor (36%) to say, "Thank you." Most of the mothers wished their child could meet his/her donor if the child wished to do so (80%).

Fresh Sperm Donor-Known Donor. The major incentive for mothers to choose a known donor to conceive their child was that the child might know its biological father prior to adulthood (92%). Other positive aspects which were considered important included the idea that sibling

children might have the same biological father (64%), the donor might be potentially involved in the child's life (56%), the parents could 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 free (51%). They did, however, perceive risks for their family with a known donor. Most women endorsed concerns that the donor might 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 called 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. 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%) or specialized organizations (5%). 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 specialized organizations (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 communicated via a go-between (6%). The key criteria for 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 his 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%). Recipient-donor compatibility stood at the forefront of the known donor selection.

Heike, birth mother: *It was important that I like him and think he's nice. Besides . . . we can imagine being in contact with him for the rest of our lives (which we apparently will be . . .).*

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%).

Anke, social mother: *It was a perfect opportunity as a gay man to have children . . .*

Some donor's motivation was perceived to be a desire to help the lesbian couple fulfill their wish to become parents (14%) or express solidarity with lesbians (9%).

Monika, birth mother: *Solidarity with lesbians and faith in us as a couple and as future parents.*

Barbara, social mother: *Because he wants to help.*

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, in a few instances, mothers indicated that the donor's name will appear on the birth certificate (18%, $n = 7$), and in one case was it planned that the child carry the donor's last name.

The family concept of women who conceived via known donors included the birth mother and the social mother as designated parents where as the donor was less commonly considered a parent (18%, $n = 7$). 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%, $n = 7$) while others 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 participation (36%) or being a family friend (28%), uncle (25%) and social father/Papa (25%). 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 with the donor unless or until the child requested it (43%). One-third of the sample had plans for occasional contact (32%), i.e., one to two times a year or via phone or postcards while a minority of mothers planned for the donor to have regular contact (19%, $n = 7$), defined as meeting one or more times a month.

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

The issue of what information the lesbian family and the donor were free to reveal to others was left to each other's discretion (64% and 62%, respectively). Those that had specific agreements regarding this issue (15% and 22%, respectively) agreed to reveal little or no information, anything but their names, or only that the donor was the biological father.

Most mothers generally reported needing little negotiation to define the donor's role (64%). Others indicated that it required a lot (26%) or that they were still negotiating and conceptualized 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.

DISCUSSION

This retrospective self-report study aims to describe family planning of lesbian parent via DI in Germany. Only one fifth of the participants were recently in the planning stage as they or their partner were either currently inseminating or pregnant. For the remaining women, the planning phase was several years past, and their responses may have been influenced by their memories or attitudes that they developed due to experience over the years (selective memory). Interpretation of the data is based on qualitative descriptive analysis, and correlation or casual conclusions can not be drawn.

We assessed the issues pertinent to each mother's role and those involved in donor type choice. Three different types of donors are represented: anonymous, identity-release, and known donors as well as 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. In particular, it was possible to collect information about planning involved in self-insemination with known donors, an aspect which is seldom included in research. One of the strengths of this study is that it focuses on the decision-making phase and does not confuse issues at various stages of the family building process or family functioning with family planning.

Our sample, although not representative and based on recruitment through snowball technique, shared several demographic characteristics with planned lesbian mother populations in studies conducted in other countries such as the United States, Canada, United Kingdom, New Zealand, The Netherlands, and Belgium. Strikingly similar is their high socio-economic status, division of childcare/gainful employment, strong lesbian identity, duration of committed relationship, and their tendency towards urbanization (Bos et al., 2003; Brewaeyts et al., 1993; Brewaeyts et al., 1997; Jacob et al., 1999; Scheib et al., 2000; Scheib et al., 2003; Vanfraussen et al., 2001; Wendland et al., 1996). The sample was also similar with respect to the high participation rate of 84%.

Participants in this study demonstrated a strong lesbian identity and were in committed relationships while they deliberated general and lesbian parenting issues at length. Although most 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 heterosexual couples (Hank et al., 1990). Their relationships were characterized by high levels of perceived commitment and outward signs of commitment to their partner. The partners felt they had found the person they wanted to be with and have a family with. Convergent with other studies, the decision to parent together and the first cycle of insemination often took years to complete (Baetens, 2002; Jacob, 1997; Jacob et al., 1999; Wendland et al., 1996).

Lesbian Family Planning and Parenting

The process of planning a lesbian-headed family is, in many ways, unique to this family form. First of all, each woman had 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, 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 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. Conversely, 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.

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 (Brewaeyts et al., 1997; Baetens & Brewaeyts, 2001; Jacob, 1995; Kershaw, 2000).

Lesbian mothers voiced concerns regarding society's (non-)acceptance of their families and how this would affect their children. Convergent with other studies, participants worried about their children experiencing teasing and discrimination themselves and the potential impact this may have on their child's (emotional) well-being. (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 valuing diversity, i.e., stressing values such as tolerance and acceptance of difference, maintaining open communication with their child, instilling pride, that is, supporting positive interpretations of their family, normalizing, that is, interacting with other rainbow families and buffering such as role playing responses to homophobic encounters. These are all very proactive responses. Other coping strategies that have been reported included: (1) conscious, informed parenting (Jiles, 1999) such as 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 being active in the child's school environment (Mercier, 1999; Steeno, 1997); 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 a missing father/male identification figure. This is also a consistently reported concern of lesbian parents (Johnson & O'Connor, 2002; Leiblum et al., 1995). The idea that a father could be missing, however, reflects a heterosexist view of family since it implies that a (whole) family consists of mother, father, and child. 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 (1997) 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 sexual orientation of their child. Almost all mothers reported plans to be supportive of the child irrespective of its future sexual orientation. This result is consistent with other literature (Gartrell et al., 1999, 2000; Jiles, 1999). In fact, this openness towards sexual orientation of the child is interpreted by the authors as an advantage of lesbian parenting.

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. Others 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 (Jacob, 1995; Johnson & O'Connor, 2002; Thompson, 2002). 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 positive effects on children's adjustment have also been reported (Patterson, 1995).

Legal Aspects

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 birth mother for both the social mother and the child. They provide for these situations by discussing them during the planning phase and by composing (other) legal documents to document their original intent since the social mother would

have no legal recourse in those cases. In contrast to heterosexual couples planning children, most lesbian couples discussed plans should their relationship end (Curry, 1999; Dundas & Kaufmann, 2000; McCandlish, 1987; Wendland et al., 1996). This is a necessary step for lesbian couples whose break up would be outside of any kind of regulating system, e.g., the judicial system.

Also, the availability of some form of second parent adoption for LDI children is 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 on the social mother's sense of security is well documented (Gartrell et al., 1999, 2000; McClellan, 2001), and it has been found to increase the likelihood of shared custody after a break up (Gartrell et al., 2000). Nearly two-thirds of mothers in our study indicated that they intended for the birthmother to have custody and the social mother to have visitation rights in the event of relationship dissolution.

Maternal Roles

The second aim of this study was to assess issues pertinent to each mother role. The lesbian parents in this sample aspired to equal parenting of the birth and social mother in decision-making power and involvement in 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, whose role is virtually culturally non-existent, 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.

Based on the presented data, the mother roles in the LDI family do not differ significantly during this stage of family building. Both women consider their *Kinderwunsch*, and they work out if and how they want to become parents. Usually one woman in the couple had a stronger desire to experience pregnancy and childbirth than the other. Convergent with other studies, we found that age, job, and financial reasons were important decision factors for who was designated as birth mother (Baetens et al., 2002; Chabot, 1998; Martin, 1993; Mohler & Frazer, 2002; Pies, 1990; Wendland et al., 1996). In general, the women planned to have a second child together when planning the first. The couples were equally

divided as to whether the women planned a mother role switch, i.e., the social mother of the first child becomes birth mother to the next child or if the same woman was intended to become birth mother to both children.

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 birth mother and social mother roles seems to be that the former anticipates entering the "Mommy's club" (see Nelson, 2007) while the latter anticipates invisibility outside her family. Most mothers said the decision-making process enhanced their well-being whereas 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.

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 among our sample 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*. 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 (for an exception see Baetens et al., 2002; Brewaeys et al., 1993; McCandlish, 1987).

Types of Donor Choice

Lesbian women must decide on the method by which they want to become parents. In accordance with other studies, mothers in our sample preferred DI over heterosexual contact because they did not want to break the fidelity of their relationship nor did they want to have traditional heterosexual intercourse with a man (Harvey et al., 1989; Jacob, 1995; Jacob et al., 1999; Wendland et al., 1996). Women using known donors had difficulties finding a man who shared ideas about his role in the LDI family. Mothers using unknown donors had problems gaining access to reproductive medicine and handling the costs of involved. Kenney and Tash (1992) also reported these problems. Women intending to use frozen sperm donors in this sample had the difficulty that they must look internationally for reproductive services due to German regulation of DI.

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).

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 effect will be the primary bearer of the consequences without being to know what these will be; (b) raise a child in a societal climate predicting that positive child development is only possible when raised by the biological mother and father; while (c) regulating the lesbian couple or family unit boundaries' that are vulnerable to outside intrusion.

Anonymous Donor Choice. Mothers who chose anonymous donors held the opinion that gender of parents was not an important factor and that children can be raised without knowledge of the identity of biological father. They also felt that 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 aspects of this choice included safety (sperm that were tested for HIV, STDs), having a clear family situation (birth mother-social mother-child) in which particularly the social mother-child bond was best protected from outside intrusion in absence of legal provisions (such as same-sex marriage and second parent adoption) and would be emotionally uncomplicated. The women who chose this donor type were very aware of the consequences of this decision for the child and were concerned that the child might one day resent them for making it. 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 the wish that their child might one day meet the donor if he or she so wishes.

Known Donor Choice. Women participating in this study who chose known donors held the opinion that it would be damaging for a child to be brought into the world without the child being able to know its other genetic parent. They also felt that 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, and it allowed for creative combinations of family constellations, i.e., having two, three, and even four

parental figures. Usually, however, the birth and social mother were intended to be the child's 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/ "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 LDI family over the long term.

Lesbian mothers using a known donor 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, only secondly, 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 had legal and financial ramifications nor was he endowed with financial responsibilities, decision-making power, or childcare responsibilities. Overall, arrangements with known donors appeared 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. With a known donor, women had the greatest degree of self-determination of all the donor types, i.e., input in the donor selection process and being most likely to self-inseminate.

Identity-Release Donor Choice. Women in this study who chose identity-release donors held opinions similar to women who chose known donors but less strongly. They were looking for the safety of using tested sperm and raising a child without a father who could become over-involved but still allowing for the child to have access to the donor's identity (in adulthood) should it become important to him/her. A major drawback to this donor type has been availability since most sperm donors prefer to remain anonymous, identity-release donors are in very short supply, and concern about the child building up expectations regarding the donor that may not be able to be met in reality in the future. 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 the 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. This may explain the lower pregnancy rates of self-insemination with frozen sperm (Carroll & Palmer, 2001; Ferrara, Balet, & Grudzinskas, 2000). 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 having no internal image of the donor nor an interest in meeting him although most endorsed their children meeting him if s/he so wished in the future.

All Donor Choices. The 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 the 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 in the future. 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. 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 that is more consistent with heteronormative mores and less likely to necessitate explanation.

Our consideration of three different types of donor insemination does not necessarily imply that lesbian women have a choice in methods of achieving parenthood. Choice is only the case if one may choose freely and is not restricted due to finances, sexual orientation, and availability. For some lesbian 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 chose 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, if any, is modified by availability. Nonetheless, all women were able to identify aspects of their donor that were so positive they chose it even though they still saw potential problems regarding their donor type choice. In conclusion, there is no blanket solution for everyone 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 isolation. Although 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 choice of donor type.

In this study, women using known donors 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 planned 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 was 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 could 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 the donor's identity 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. The results suggest that mothers with school-aged children may have less access to resources than mothers with younger children. Contemporary prospective lesbian parents have profited from the wide spread use of the Internet, the organization of lesbians with *Kinderwunsch* or children, 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 birth mothers' families of origins than those of social mothers. It is a common finding in the LDI family literature that social mothers 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. The women in this study reported almost as high levels of perceived support from social mother's families as from birthmothers' families. This could be due, in part, to the retrospective nature of this study with many of the social mothers already having had children and, from the literature, we know that families often come around over time (Gartrell et al., 2000).

Future Research

This study lends itself well to future research of the subsequent phases of early LDI family formation: insemination phase, pregnancy phase and childbirth experiences, transition to parenthood and kindergarten experiences as well as to family functioning. At the time data were collected for the planning stage of family building, participants also filled out questionnaires for the above phases of family building that they had already or were currently experiencing as well as information on family functioning. Future studies will evaluate the progression of these women through the various stages and how the birth and social mother roles develop as well as the evolving of the known donor role in these families.

Longitudinal studies that follow family development over time or cross-sectional studies that analyze the phases of family building individually are important for LDI families to understand themselves as

well as for clinical and non-clinical experts. A major research interest is the impact of donor type choice on the development of children, the couple and parental relationship, and the 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 evidence-based information without knowing what the future may bring and how attitudes, opinions, and values will change. This is a very intimidating situation since the actual long-term impact of a donor type may vary greatly from expected impact. Future research will enable lesbian couples to make informed decisions regarding family planning, donor type choice, organization of parental roles and its repercussions on family development.

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