PHN-PREP
Public Health Nursing Practice, Research & Education Program

Professional Resource

2SLGBTQIA+ families: Unique perinatal mental health concerns

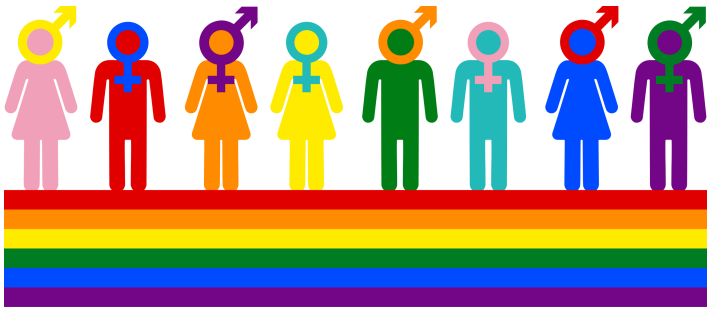
This resource provides evidence-informed guidance for providers of perinatal care for Two-Spirit, lesbian, gay, bisexual, trans, queer, intersex, and asexual 2SLGBTQIA+ individuals. The purpose of this document is to provide an overview of the prevalence of perinatal mental health concerns (PMHC) and risk factors among 2SLGBTQIA+ communities, including non-birthing partners. We then provide recommendations for perinatal care providers and discuss considerations for trauma-informed care and gender affirming care towards addressing PMHC in this population.

Brief Note: We consider the acronym 2SLGBTQIA+ to be the most contemporary and inclusive acronym for sexual and gender minority communities. Nevertheless, language is dynamic and shifts over time. For a glossary related to 2SLGBTQIA+ identities, see: https://www.lgbtqhealth.ca/_files/ugd/1332d5_b6d5c2e0b13d4891b2b3b2d1ed0d8740.pdf

PREVALENCE OF PMHC

Studies that estimate the prevalence of 2SLGBTQIA+ PMHC are still scarce, and most are focused on lesbian and bisexual women. The most recent studies have found that compared to heterosexual women, sexual minority women (i.e., lesbian, bisexual and other non-heterosexual women) have an elevated risk of adverse mental health and increased antidepressant use, increased stress during pregnancy, and elevated risk of depression[1,2].

Consistently across studies, bisexual women appear to be at higher risk for PMHC compared to lesbians[1,2,3]. Also, postpartum sexual minority women are less likely to use antidepressants until their symptom severity is critical[1]. Thus, a key takeaway for perinatal care providers is that repeated mental health screening is recommended in this population[1].



To date, no studies have explored PMHC among transgender and non-binary people. However, recent review articles suggest they may experience increased vulnerability given higher rates of mental health challenges outside of the perinatal period[4,5]. It is estimated that the lifetime prevalence of depression among transgender and gender non-conforming individuals is as high as 50% to 67%, largely attributed to experiencing discrimination and lack of social support[6,7,8].

Similarly, no studies have yet examined the prevalence of PMHC among Two-Spirit people. However, like trans individuals, Two-Spirit people may experience increased vulnerability to PMHC due to higher rates of mental health challenges outside of the perinatal period – impacts of the ongoing effects of colonization together with sexual- and gender-minority based discrimination. A survey by Trans PULSE Canada, a community-based survey of the health and well-being of trans and non-binary people, found

that one out of two Two-Spirit people had unmet healthcare needs in the past year and identified themselves as psychiatric survivors or persons with mental health concerns[9]. Additionally, almost one out of five Two-Spirit people did not have a primary health care provider[9]. This lack of healthcare access can affect timely detection, treatment, and follow-up of PMHC.

RISK FACTORS FOR PMHC

Besides the usual stressors that the general population faces, 2SLGBTQIA+ individuals also deal with discrimination, prejudice, homophobia, biphobia, and transphobia, which increases their risk for PMHC[5,10]. Discrimination can both cause trauma and be a form of trauma. These challenges result in persistently high stress levels for many 2SLGBTQIA+ individuals.

Risk factors for PMHC among sexual minority women have been identified at multiple levels. These risk factors can contribute to chronic high levels of stress, depressive symptomatology, and anxiety, among other mental health care concerns[2,11,12,13]. In the following table, we summarize those different risk factors.

	Societal level	Interpersonal level	Individual level
Sexual minority women (i.e., bisexual, and lesbian women)	• Experience different types of discrimination (e.g., social stigma, homo- and biphobia, and heterosexism) at various systemic levels (e.g., governmental, institutional, or family) • Barriers from the legal system • Lack of acknowledgement of the co-parent	• Experience invisibility of their sexual identity • Lack of social support from their peers or families of origin • Negative or harmful experiences with healthcare providers	• Past mental health history • Experience social isolation due to different factors

Compared to lesbians, bisexual women are more likely to report lack of partner and family support[2]. Bisexual and sexual minority women may face a higher risk of discrimination based on their sexual orientation when they are presumed to be heterosexual while attending care with a male partner[2]. This invisibility can elevate their risk for depression[13].

Within gender minority groups, the limited available research suggests that transgender and nonbinary individuals face similar PMHC risk factors as sexual minorities, with added complexities. A small number of studies have examined perinatal experiences of transgender men or transmasculine people. Transgender individuals are more susceptible to traumatic birth experiences and PMHC compared to cisgender women due to:

1. Provision of health care that does not consider the needs of transgender people (e.g., lack of inclusive and affirmative perinatal care and support in the context of perinatal loss, fertility treatment, labour and delivery, and the postnatal period);
2. Social isolation, exclusion, invisibility, and lack of social support; and
3. Gender dysphoria[5,14,15,16].

We also want to highlight that experiencing discrimination, and a lack of affirmative care often involves more than just a lack of inclusive care from a single provider; it also includes structural and systemic practices at various levels. There are multiple barriers to affirmative care for 2SLGBTQIA+ individuals, including systemic cisheteronormativity— a system of regulartion and normalization that ascribes power, privilege, and normative status to cisgender and heterosexual identities. An example of systemic cisheteronormativity in healthcare settings is how, in many hospitals, the recovery space for birthing parents is called the "mother and baby unit," which excludes and renders invisible birthing parents who do not identify with the term “mother.”

Gender Dysphoria

This is a term used to describe feelings of distress that result from a disconnect between one’s desired and actual experience of one’s body or gender presentation. Gender dysphoria does not look the same for every transgender person, and not all trans individuals experience gender dysphoria[17,18].

What can trigger gender dysphoria during the perinatal period?

- Bodily changes due to pregnancy, childbirth, postpartum, and/or nursing/chest-feeding,
- Direct experience of birthing a baby through the vagina, exposure of genitals, health care providers’ assumptions about the reproductive organs as ‘female’,
- Use of incorrect pronouns or other acts of misgendering.

Care providers’ assumptions about sex, gender, and sexual orientation; incorrect clinical documentation, misgendering, transphobia, parent(s) loss of choice during birth, and the refusal of services for transgender patients, all contribute to transgender individuals’ negative, and even harmful, experiences of care[5,14,19]. Negative or harmful experiences, whether real or anticipated, pose a risk factor for PMHC in transgender individuals. This can culminate in traumatic care and birth trauma experiences, which can lead to post-traumatic stress symptoms, postpartum depression, gender dysphoria, isolation, and intense distress[5,14].

Although the transgender umbrella usually includes nonbinary individuals, nonbinary identities can be distinct from transgender identities, as nonbinary people often do not conform to one end of the gender binary. Compared to their transgender counterparts (i.e., transgender men or transgender women), nonbinary individuals in the general population experience:

- Higher rates of discrimination and chronic stress due to experiences of invisibility.
- Greater risk for negative mental health outcomes including higher risk of suicidality, psychological distress, anxiety, and depression[20].

Regarding Two-Spirit individuals, there is minimal information. A study found that Two-Spirit participants highlighted the lack of support and available resources for them, which might contribute to additional risk factors for PMHC[3].

PROTECTIVE FACTORS FOR PMHC

2SLGBTQIA+ people also benefit from protective factors for PMHC, both those common to the general population and those specific to their experiences as 2SLGBTQIA+ people. Key among these is social support from families of origin and chosen family, other 2SLGBTQIA+ parents, and the 2SLGBTQIA+ community[10,21]. Protective factors for gender minority people centre on inclusive and affirming perinatal care experiences, for example inclusive and affirming birth experiences, including language used by healthcare providers towards the birth parent and partner(s)[15,16].

Reminder

It is important to ask about the preferences for addressing each family member or support person. This includes asking for pronouns, names, or any other terms that might be important to the person.

PMHC IMPACT ON PARTNER

Parents who are expecting a child but are not biologically involved in the conception or birth are often called non-birthing, nonbiological, or co-parents [22,23]. Since non-birthing 2SLGBTQIA+ parents have parenting experiences that are distinctive, it is also important to consider the factors that might impact their mental health [11,13,22]. Limited research has mainly focused on the experiences of lesbian, bisexual, and queer (LBQ) non-birthing parents. LBQ non-birthing parents could be affected by concerns about their absence of biological ties, struggles with infertility for those seeking to conceive, discrimination, and being socially overlooked as a parent from family, strangers, and institutions[22,24], lack of services for non-birth parents, legal issues (e.g., donors changing their minds and desiring a parenting role), and lack of legal recognition (e.g., birth certificates)[22].

In Canada, birth registration is regulated by province or territory. 2SLGBTQIA+ parents and their children will have varying legal protections depending on the province/territory where the birth is registered. In some provinces/territories, non-birthing parents are only legally recognized after second-parent adoption. Also, being a legally married partner does not ensure that birth registration includes the non-birthing or non-biological parent as a legal parent of their child

Why is legal recognition important? Legal parent status enables parents to make critical decisions about medical care, education, and upbringing impacting the child's health and wellness. In contrast, the absence of legal parental status prevents parents from making medical decisions for their child during emergencies or from visiting their child in a hospital[25]. Also, only some provinces/territories include gender-neutral parenting terms, which can then force trans and non-binary parents to identify themselves in ways that are incongruent with their gender identity, potentially leading to PMHC.

Reminder

Making space for a general discussion about infant feeding and supporting both parents is important. Sometimes, the partner who is not nursing or feeding the baby can feel disconnected from their child or experience PMHC related to it. One way to address this could be by asking, "Is this what you expected parenting/infant feeding to be like?" or "Is there anything you would like to talk about regarding how this makes you feel?"

Parents who are not feeding their baby can be encouraged to participate in other bonding activities, such as diaper changing, bathing the child, and other forms of caregiving.

APPROACHES TO TREATMENT AND CARE

One out of two perinatal women in the general population experiencing anxiety and depression are either undiagnosed or, if diagnosed, do not receive appropriate treatment[26]. The limited available evidence suggests that this is likely also true for 2SLGBTQIA+ people: a study found that one-third of LGB perinatal women had used some mental health services during the past year, but another third of their participants perceived an unmet need for mental health services[27]. PMHC treatment for 2SLGBTQIA+ individuals will generally adhere to similar standards as those for heterosexual, cisgender patients. Nevertheless, given the pervasive societal discrimination and related risk factors, service providers need to pay specific attention to this population's needs.

Two approaches to address this are *trauma-informed care* and *gender affirming care*.

2SLGBTQIA+ COMPETENT TRAUMA-INFORMED CARE	GENDER-AFFIRMING CARE
2SLGBTQIA+ competent trauma-informed care (TIC) adopts a comprehensive approach that acknowledges the prevalence of trauma histories and the diverse impacts of trauma frequently encountered by this community[28,29]. Expanding upon the principles of TIC, this approach represents a shift towards a strengths-based perspective, moving away from asking "*What is wrong with you?*" to "*What happened to you?*" This broader understanding of "what happened" encompasses ongoing experiences of oppression, discrimination, and violence faced by 2SLGBTQIA+ individuals[28]. Hence, 2SLGBTQIA+ competent TIC aims to address care obstacles and prevent re-traumatization during service provision. Some TIC practices that could be integrated into perinatal care include: • Recognizing that individuals may be afraid to disclose their PMHC but making space for those disclosures when patients/clients are comfortable, • Reflecting on one's own assumptions and examining stereotypical beliefs about sexual orientation, gender identities and mental health concerns, • Not assuming a person's sexual orientation, gender, or trauma history based on their appearance or the perceived gender of their partner(s).	A crucial part of PMHC support for trans, Two-Spirit and gender diverse parents is providing gender-affirming care. Gender-affirming care represents both a care model and an approach to individuals and their families that actively validates their gender identity[30]. It aims to support patients and their families in expressing their true, authentic selves both physically and emotionally[30]. Research indicates that gender-affirming care has protective effects, leading to improvements in symptoms of depression, anxiety, and stress[31]. Moreover, these protective effects tend to strengthen over time: the more frequently individuals receive gender-affirming care, the more positive their mental health outcomes tend to be[31]. Thus, providing gender-affirming care is important to reduce PMHC and includes, among other practices, using gender affirming language and images on forms, intakes, clinical notes, e-mail communication, social media, and posters of clinic spaces. Finally, another key component of gender affirming care is checking more than once during care to ask about pronouns and sexual or gender identity, since these are fluid and can change.

REFERRAL TO 2SLGBTQIA+ COMMUNITY SUPPORT & INTERSECTING IDENTITIES

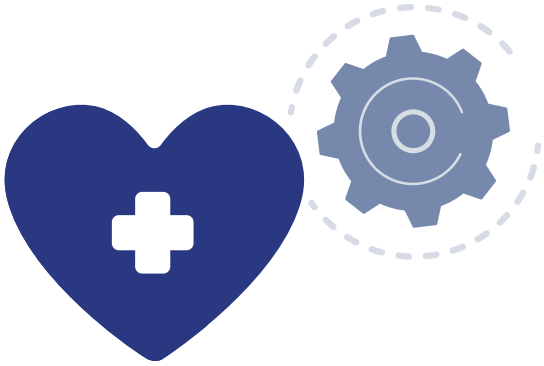
It is important to understand that certain individuals within the 2SLGBTQIA+ community may distrust a biomedical approach to mental health concerns due to historical harm and trauma caused by psychiatric pathologization of sexual orientation and gender identity. Consequently, non-medical and/or community support will be an important component of PMHC for many 2SLGBTQIA+ people. Given the role of social support in reducing the risk for perinatal mental health concerns in 2SLGBTQIA+ people [11,21,32,33], referral to 2SLGBTQIA+ community support groups, including parenting-specific supports if available in the local community, is warranted. In-person community support groups may not be available in all regions; therefore, online groups and resources can be a valuable complement[32].

Furthermore, 2SLGBTQIA+ people with intersecting identities (e.g., racialized 2SLGBTQIA+ immigrants, undocumented or precarious status) might face additional levels of violence, discrimination, racism[34], social isolation[35], harassment, housing insecurity, and mental health concerns.

Therefore, it is essential to consider these factors when approaching the treatment and care of PMHC. Racialized 2SLGBTQIA+ parents might also benefit from community support groups either in-person or online.

KEY TAKE-AWAYS

- Care providers' assumptions about sex, gender, and sexual orientation; incorrect clinical documentation, misgendering, transphobia, parent(s) loss of choice during birth, and the refusal of services for transgender patients, all contribute to transgender individuals' negative, and even harmful, experiences of care that are risk factors for PMHC.
- A key action that healthcare providers can do to avoid retraumatizing patients is providing trauma-informed care and gender-affirming practices.
- Protective factors for gender minority people centre on inclusive and affirming perinatal care experiences, for example inclusive and affirming language used by healthcare providers towards the birth parent and partner(s).



- It is essential to acknowledge the historical harm and trauma that psychiatry has caused to the 2SLGBTQIA+ community. As a result, some individuals may not immediately embrace a biomedical model for addressing mental health concerns.
- Given the role of social support in reducing the risk for PMHC in 2SLGBTQIA+ people, referral to 2SLGBTQIA+ community support groups, including parenting-specific supports if available in the local community, whether in-person or online, would be valuable.

RESOURCES

- Facebook-based group in Toronto and the GTA - LGBTQ+ Pregnant & Parenting GTA: https://www.facebook.com/groups/632997236848715
- Maternal Mental Health Now (2024). Queer and Trans Perinatal Mental Health Toolkit. Retrieved May 2024, from: https://www.maternalmentalhealthnow.org/wp-content/uploads/2022/08/MMHN-QueerTrans-PMH-Toolkit-2.pdf
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