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CARE DURING PREGNANCY, CHILDBIRTH, POSTPARTUM, AND HUMAN MILK FEEDING for Individuals Who Identify as LGBTQ+

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Abstract

The growing number of families that include members of sexual and/or gender minority (SGM) groups requires perinatal nurses to know how to provide respectful and affirming care to all people, including this population. Approximately 19% of adults who are members of SGM groups are raising 3 million children, with many hoping to become pregnant, foster, use surrogacy, or adopt in the future. Based on current literature, many nurses are not prepared to meet the clinical needs of patients who are members of SGM groups in the maternity setting. Likewise, patients and families of SGM groups often perceive that nurses are uncomfortable with providing care and are not always satisfied with their care. To meet these needs, it is important that nurses use strategies focused on promoting respectful, affirming care, reducing negative experiences, and eliminating marginalizing language and practices. Nurses must incorporate a holistic care focus for patients who are members of SGM minority groups that includes standardized strategic education; development of Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, or Plus (LGBTQ+) affirming and inclusive policies, practices, and language; flexibility, personal reflection of self-bias; and creating an environment of individualized compassionate care.

Key words: Birth; Breastfeeding; Co-mothers; Gender minority; LGBT families; LGBTQ+; Nursing competence; Pregnancy; SGM; Sexual minorities.

Nurses must be prepared to provide respectful perinatal care to all families, including the growing number of nontraditional families who are experiencing childbirth and parenting. Currently, more than 11 million people or 4.5% of the U.S. population self-identify as Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, or Plus (LGBTQ+), and an increasing number of members of sexual minority and/or gender minority (SGM) groups are starting families (Newport, 2018). The number of individuals who identify as transgender in the United States is unknown, recently estimated at between 0.39% and 0.6% of the total population with more transgender men than transgender women, and a trend toward younger adults (Flores et al., 2016; Meerwijk & Sevelius, 2017). These data are likely underreported (Garcia-Acosta et al., 2020). A list of common definitions for sexual orientation and gender identity is provided in Table 1. Some individuals may use other terms.

Approximately 19% of adults who are members of SGM groups are raising 3 million children, with many of those who want to become pregnant, foster, use surrogacy, or adopt in the future (The Williams Institute, 2015). According to a report by the National LGBTQ+ Health Education Center (2016), changes in same-sex marriage laws across the United States have encouraged many who may have been uncertain about parenthood to begin a family. The importance of human milk for infant health makes it critical for nurses to be familiar with feeding options available for parents who are members of SGM groups (Juntereal & Spatz, 2019; MacDonald et al., 2016; Spatz, 2020). Nurses are well positioned to provide respectful perinatal care to all families including nontraditional families who identify as LGBTQ+ during pregnancy, at birth, in the postpartum period, and with human milk feeding.

The purpose of this article is to discuss required nursing competence to meet the holistic perinatal needs of individuals and families who are members of an SGM group. We offer a review of health care inequities and risk factors, holistic caring measures, culturally competent education during pregnancy, human milk feeding options, and providing an inclusive culture of respectful and affirming caring.

Background

Members of the sexual and/or gender minority (SGM) population are often grouped together under the umbrella term LGBTQ+; however, each of these groups represents individuals with unique and specific health care needs (Institute of Medicine [IOM], 2011). People who are Lesbian, Gay, Bisexual, or Transgender come from all walks of life, include all races and ethnicities, all ages, all socioeconomic statuses, and live in various parts of the United States (Centers for Disease Control and Prevention [CDC], 2014, 2018). Their health needs are unique because as a group they tend to disproportionately suffer from social inequality, poorer health outcomes, and risk for illnesses and disease when compared with those who are not members of an SGM group, in part due to structural inequities, such as the stigma and discrimination that LGBTQ+ populations experience (CDC, 2014). Reproductive health needs of members of SGM groups include hormone therapy effects on fertility, contraception, natural or medically assisted reproductive options, gender dysphoria, breastfeeding, milk sharing, and chestfeeding (Dickey et al., 2016; IOM, 2011). Families with parents who are members of SGM groups are more likely to adopt since 13% of their children came to the home through adoption, and more SGM couples are adopting or using reproductive technologies such as artificial insemination and surrogacy (Gates, 2015; The Williams Institute, 2015).


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The growing number of families who are members of sexual and/or gender minority groups requires nurses in the perinatal setting to know how to provide respectful and affirming care to all people, including this population.

Many who identify as a member of an SGM group have experienced feelings of discrimination, perceived negative stigma, toxic stress, and disparate outcomes related to interactions with nurses and other providers in the perinatal care setting (Baptiste-Roberts et al., 2017; IOM, 2011). Individuals have reported perceiving a lack of cultural competence from nurses and other providers including images and language inclusive of only cisgender and heterosexual couples or families as well as lack of information and availability of research on SGM perinatal health (Farrow, 2015).

With evolving care needs in the perinatal setting, it is important nurses understand how to decrease perceived

TABLE 1. DEFINITIONS COMMONLY USED FOR SEXUAL ORIENTATION AND GENDER IDENTITY

Term	Definition
LGBTQ+	A term for lesbian (L), gay (G), bisexual (B), transgender (T), queer (Q), and/or questioning (Q) individuals.
Lesbian	A sexual orientation describing a woman who is emotionally, romantically, or sexually attracted to other women.
Gay	A sexual orientation that describes a person who is emotionally, romantically, or sexually attracted to some members of the same gender. Often used to describe men.
Bisexual	A sexual orientation that describes a person who is emotionally, romantically, or sexually attracted to people of more than one sex, gender expression, or gender identity.
Transgender	Describes persons whose gender identity and/or gender expression differs from the sex they were assigned at birth. Being transgender does not imply any specific sexual orientation; transgender people may identify as straight, gay, lesbian, bisexual, etc.
Heterosexual	A sexual orientation describing a person who is emotionally, romantically, or sexually attracted to people of a different gender.
Queer	An umbrella term describing persons who identify themselves with a flexible and inclusive view of gender and/or sexuality. Historically it has been used as a negative term for LGBTQ people. Some people still find the term offensive, whereas some embrace the term as an identity.
Sexual and Gender Minority	Encompasses individuals who identify as LGBTQ+. Individuals with same-sex or -gender attractions or behaviors and those with a difference in sex development are also included, as well as those who do not self-identify with one of these terms but whose sexual orientation, gender identity or expression, or reproductive development is characterized by nonbinary constructs of sexual orientation, gender, and/or sex.
Gender Identity	One's sense of being male, female, some of both, or neither. One's gender identity can be the same as or different from their sex assigned at birth.
Gender Expansive	An individual who does not conform to gender stereotypes, and can identify as both masculine and feminine.
Gender Spectrum	The idea that gender exists on a continuum rather than as a binary, male or female identity.
Cisgender	Gender identity and sex assigned at birth are aligned.
Nonbinary	An individual who does not identify with a specific gender.
Sexual Orientation	Describes a person's emotional, romantic, or sexual attraction to other people. Some examples of sexual orientations are gay, lesbian, bisexual, asexual, or pansexual.
Heteronormative	The assumption of heterosexuality as the given or default sexual orientation instead of one of many possibilities, and that the preferred or default relationship is between people of different genders.

Note. Adapted from Ferri et al. (2020), Trans Student Educational Resources (n.d.), and Wisner (2018).

barriers of negative experiences, and refrain from using language that marginalizes couples who are members of SGM groups (Sabin et al., 2015; Wojnar & Katzenmeyer, 2014). Sexual difference and gender expression require communication and an understanding that sexual difference and gender expression can be dynamic and fluid, remaining open to transformations without being reduced to literal meanings (Lee, 2018). Providing an environment of compassionate, affirmative, and individualized holistic care will serve to support a successful journey to parenthood (Table 2).

Review of the Literature

A literature search was conducted using The Cumulative Index to Nursing and Allied Health Literature, Cochrane Library, Pubmed, and Ovid databases, and focused on a variety of common themes. These themes included: nursing perceptions and attitudes, sexual and/or gender minority (SGM) perinatal care, competence, holistic care, patient education, parent/co-parent perspectives of care, and finally methods of breastfeeding education on specific needs during pregnancy, childbirth, and the postpartum period of those who identify as LGBTQ+.

Health Care Inequities and Risk Factors

It is critical to create a trusting environment of safety that is judgment-free for families and incorporates affirming, compassionate, and respectful open communication and care (Martos et al., 2019). Members of SGM groups often have increased risks of adverse mental and physical

health outcomes (IOM, 2011). However, these risks are not due to their identity, but rather their repeated exposure to stigma and discrimination embedded in our society such as homophobia, transphobia, lack of acceptance, and disrespect (CDC, 2014; IOM).

Members of SGM groups may face barriers in accessing mental health services by providers who are sensitive to their concerns, and competent to recognize the holistic needs of LGBTQ+ individuals during pregnancy, birth, and the postpartum period (Baptiste-Roberts et al., 2017; Plöderl & Tremblay, 2015). Access to mental health care is vital because multiple studies confirm that members of SGM groups disproportionately experience substance abuse, anxiety and depression, suicide and suicidal ideations, lack of acceptance and social support, social isolation, feelings of not being normal, and guilt and shame, when compared with heterosexual and cisgender people (de Vries, 2014; Frost et al., 2019; IOM, 2011; Pachankis et al., 2015; Zelle & Arms, 2015). In a recent study, lesbian and bisexual pregnant women were more likely to have depression, unmet health care needs, chronic health conditions, activity restrictions, and risky lifestyle behaviors (Gonzales et al., 2019).

Women within the SGM population who are also members of an ethnic or racial minority group may be at greater risk for being marginalized or having co-morbid risk factors (IOM, 2011). A longitudinal study by Everette et al. (2016) revealed that minority women who identified as lesbian and bisexual were at a greater risk for unintended pregnancies (24%), hazardous drinking (2%), and increased depressive symptoms (6%). These findings suggest additional emphasis on holistic psychosocial dimensions of "inequality, access to care, family unit, and socioeconomic status to help prevent adverse parental outcomes is needed" (Everett et al., 2016, p. 908).

Inequities During Pregnancy and Outcomes

It is essential for nurses to be familiar with potential disproportionate adverse pregnancy outcomes (both maternal and neonatal) for parents who are members of an SGM group as compared with mothers who are heterosexual and/or cisgender. However, the literature on exclusive care needs and outcomes assessment for individuals who are members of an SGM group during pregnancy is scarce; as most research centers on SGM and sexual risk behaviors (Gonzales et al., 2019). Recent studies focused on pregnancy outcomes found these individuals are more likely to experience lack of comprehensive pregnancy and prenatal care, decreased medical care, health disparities, and contrasting adverse pregnancy outcomes

TABLE 2. CARE FOR INDIVIDUALS WHO ARE MEMBERS OF A SEXUAL AND/OR GENDER MINORITY GROUP DURING PREGNANCY, BIRTH, POSTPARTUM, AND HUMAN MILK FEEDING

- Examine ones' personal awareness of views, implicit bias, competence, and stereotypes of pregnant or partnered patients who are members of an SGM group
  - Practice self-reflection
  - Understand personal barriers to care, fear, and how to eliminate discrimination
- Provide respectful, compassionate, affirming, supportive nursing care
- Treat all patients as you would like to be treated and as you would treat a loved one
- Be aware of body language and "microaggressions" that communicate a stereotype or antagonistic message about patients who are members of an SGM group
  - Microaggressions can be defined as the subtle, every day, commonplace, and intentional (or unintentional often times) interactions and/or behaviors that communicate some sort of bias toward any group, particularly culturally marginalized groups.
- Do not devalue fears or perceived experiences by families who are members of an SGM group
- Provide holistic (whole-person) care focused on the entire birth experience as opposed to "traditional" expectations
- Agencies should develop strategic provider and community education to create safe places of care
  - Create policies at all levels to support care and wellbeing of individuals who are members of an SGM group
- Become familiar with community resources and agencies to support families throughout the birth and postpartum process; offer information and referrals as appropriate
- Include and involve co-parents and same-sex partners in discussion about care
- Promote skin-to-skin for both parents to facilitate bonding
- Implement inclusive, personalized care—allow families to define their own success
- Avoid assumptions about gender identity from outward appearances
  - Use gender-inclusive language
  - Ask about their names and pronouns and use them (he/his/him, she/her/hers, they/theirs)
- Do not assume patient's gender status is known to others
- Do not expect patient to always teach you; listen, learn, and educate yourself
- If a mistake such as misgendering is made, apologize and do better
- Become aware of national, state, and local policy related to advocacy and laws for members of an SGM group

Note. Adapted from National LGBTQAI+ Health Education Center (2018), American Nurses Association Position Statement (2018), and Wolfe-Roubatis & Spatz, 2015.

as compared with heterosexual and/or cisgender women (Everett et al., 2019; Gonzales et al.). Results from both studies reported risk factors and disproportionate adverse outcomes including use of artificial reproductive technologies, lack of medical insurance or insurance with pregnancy care coverage, difficulty finding an obstetrical provider skilled in affirmative SGM care, psychological stress before, during, and after pregnancy, structural and interpersonal discrimination among care providers, depression and anxiety, miscarriage, preterm birth, increased alcohol consumption, and cigarette smoking (Everett et al., 2019; Gonzales et al.).

Holistic Caring

Sexuality is a unique and individualized phenomenon that begins in infancy. It is influenced by physical and emotional responses, as well as cultural, spiritual, ethical, and moral concerns that are present throughout the cycle of life (Sexuality Information and Education Council of the United States, 2018). Members of SGM groups have health risks beginning in childhood that can later manifest in adulthood (IOM, 2011). In a recent study, lesbian and bisexual pregnant women were more likely to have depression, unmet health care needs, chronic health conditions, activity restrictions, and risky lifestyle behaviors (Gonzales et al., 2019). Those who identify as LGBTQ+ are at greater risk for economic, health, and personal disparities (Emlet, 2016) due to societal stigma and discrimination, further complicating pregnancy, birth, neonatal, and postpartum health.

Nurses must perform an intrinsic self-assessment of personal beliefs, values, and implicit biases toward caring for marginalized groups including members of SGM groups. A large-scale needs analysis by Goldhammer et al. (2018) surveyed clinicians in 18 health care organizations. Findings revealed 19.4% of clinicians did not feel prepared to meet the clinical needs of patients who were Lesbian, Gay, or Bisexual and 31.8% did not feel prepared to meet the clinical needs of patients who were Transgender. Narrative survey responses on clinical care of the SGM population included participant statements such as: "this is not relevant to the care I provide," "making the patient [feel] uncomfortable or offended," "unsure of the appropriate language to use," a "lack of experience with knowledge in health issues specific to sexual orientation/gender identity," and uncertainty related to "personal cultural or moral beliefs" (Goldhammer et al., 2018, p. 3).

Provision of holistic care for members of SGM groups across the lifespan is an integral part of maternal and fetal health care. For the first time, the Healthy People 2020 initiative has included the welfare, health, and safety of members of SGM groups as a primary goal (Healthy People.gov, 2019). Sexual and/or gender minority group members are a disparate health group across many life circumstances. Their holistic care needs are similar but individualized and unique. A multimodal approach to the provision of holistic comfort must be considered to provide optimal care.


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Nurses are well positioned to accurately and respectfully address complexities in perinatal care to families who are members of sexual and/or gender minority groups during pregnancy, at birth, in the postpartum period, and with infant feeding.

Incorporating Care of Members of Sexual and/or Gender Minority Groups in Nursing Curriculum

Strategic education for nurses about caring for members of SGM groups is limited. In one study of 268 nurses in the San Francisco Bay area, 80% of nurses reported having no education on the care needs of those who identify as LGBTQ+ (Carabez et al., 2015). However, a recent systematic review highlights importance of LGBTQ+ education in undergraduate nursing curricula as well as professional development programs in nursing practice (McCann & Brown, 2018).

Creating a culture of holistic and nonbiased care for SGM populations should be incorporated into the curriculum throughout nursing school. Lim and Hsu (2016) explored attitudes of nursing students toward LGBTQ populations. They found that though more positive attitudes toward patients who identify as LGBTQ were increasing, many students still felt uncomfortable or uncertain about providing culturally competent care. The qualitative work by Echezona-Johnson (2017) supports the idea that an intentional focus should be placed on care of patients who are members of SGM groups. This should begin with early nursing education and continue into the agency setting. Interview sessions revealed that nursing faculty were reluctant to educate students about health of members of SGM groups in the birth setting, and that both faculty and students described talking about care for pregnant patients who identify as LGBT as "taboo" and "secret" (Echezona-Johnson, 2017, p. 142). Encouraging students to explore new ideas and expand their intellect about compassionate and inclusive care of patients who are members of SGM groups in the

Nurses and other health care providers should conduct an "inventory" of personal perceptions to professionally support and provide respectful, affirming, nonbiased, culturally competent care to patients who are members of sexual and/or gender minority groups.

perinatal setting should establish a framework to reduce disparity and engage open conversations.

Education about respectful affirming care for members of SGM groups for nurses in school and in clinical practice can contribute to the improvement of maternal and fetal health outcomes for women of childbearing age. According to nurse-theorist Kolcaba, holistic comfort care exists in four main contexts: (1) *physical*, referring to bodily sensations, (2) *psychospiritual*, pertaining to the internal consciousness of self, (3) *sociocultural*, involving interpersonal relationships, family, religious and societal affairs, and (4) *environmental*, referring to the external surroundings (Kolcaba, 2013), thereby defining human comfort experience as multifaceted and holistic from birth to end-of-life.

It is significant to note that literature, evidence, and governing body positions related to specific and individualized care of members of sexual and gender minority groups have only been recently evolving. It is likely that discussions focused on sexual and gender minority care were not addressed in nursing education until recently. Curriculum content about health care needs of the population of SGM group members is not federally mandated (Maley & Gross, 2019). The solution to the silence dilemma for nursing students and expert nurses is that nurse educators must incorporate content on care of members of SGM groups in all nursing programs and nurse administrators must integrate institutional professional development programs focused on bedside care of patients who identify as a member of a sexual or gender minority group.

Childbirth Education

Childbirth education classes are often focused on a family unit that consists of a man and a woman in traditional roles. Understanding how to provide competent affirming care to couples who are members of an SGM group during the antepartum period includes many important factors such as creating a welcoming environment using neutral terms such as "partner" or "support person," using inclusionary activities that do not single out gender roles, ensuring ethics and respect to all peoples, and incorporating diverse educational course materials (Malmquist et al., 2019).

Although many physiological aspects of pregnancy and birth for a transgender male are similar to those of a cisgender female, personal, family, and social aspects vary considerably. There is a gap in the literature on experiences of transgender men attending traditional childbirth classes. Several participants in a qualitative study reported that pregnancy and parenting support organizations for gay, lesbian, and bisexual people were "ill-equipped to support transgender parents," leading them to seek information and support from a transgender birthing and breastfeeding Facebook group (Hoffkling et al., 2017, p. 10).

In an effort to increase quality care, Pharris et al. (2016) explored importance of using proper terms and current practice standards to support and promote inclusion of pregnant lesbian couples in childbirth classes. The authors prescribed that getting to know couples from a "holistic" perspective, along with asking questions about preferred terminology, labels, and proper words served to provide comprehensive care. Supporting an all-encompassing approach to couples who identify as LGBTQ+ from a place of respect, trust, and open communication should promote an environment of inclusivity (Malmquist et al., 2019; Pharris et al.).

Co-Parent Needs

Experiences within the health care system of couples and their partners who are members of an SGM group play a significant role in overall perceptions of satisfaction with pregnancy and birth (Bowling et al., 2018; Cherguit et al., 2013). Nurses must consider and address the perinatal needs of parents who identify as LGBTQ+ as co-parents, as they are equals and seek to have collaborative interactions with nurses in the birth setting (Cherguit et al.). The theme of inclusion was supported by Erlandsson et al. (2010), who conducted an open-ended narrative analysis to learn more about shared stories from co-partners about pregnancy, and specific individualized maternal health needs. Findings supported an overall theme that same-sex partners need to be seen, included, and verbally addressed to as a co-parent (Erlandsson et al., 2010).

Labor and Birth

Although it is likely that many labor nurses have cared for a Lesbian, Gay, or Bisexual person during labor and birth, because the transgender population is much smaller, caring for a childbearing transgender man will occur less frequently. As for all patients, nursing care during labor and birth should be focused on meeting the needs of the birthing person and their partner (National Academies of Sciences, Engineering, and Medicine [NASEM], 2020).

Asking the person what pronouns they use (rather than what they prefer) and what terms they use to identify their body parts and then making sure to use them is important (Garcia-Acosta et al., 2020). In one study of 41 trangender men who gave birth, they overwhelmingly told health care providers to use he (n = 32) or they (n = 8) as their pronouns (Light et al., 2014). If an inadvertent mistake such as misgendering (e.g., calling the patient who is a transgender man a mother or woman) is made, quickly apologize (Wolfe-Roubatis & Spatz, 2015). As for all patients, consent for procedures and touching, privacy, and support for their choices during labor and birth are vital aspects of respectful and affirming care (NASEM). If a birth plan has been developed, be sure to discuss it with the birthing couple and let them know what can and will be done based on their individual clinical situation, fetal status, and facility limitations. Outcomes of pregnancies, labors, and births of transgender men are similar to cisgender women and do not seem to be affected by testosterone use prior to the pregnancy (Light et al.).

Options for Parents to Provide Human Milk to their Infant

As a result of the broad scope of identity diversity within the SGM community, there is variation how families choose to feed their babies. Breastfeeding that is carried out by individuals who were not socially assigned the identity of female at birth challenges how we understand the relationship between breastfeeding and sexual differences (Lee, 2018). Although all lactation involves cultivation of the body, a more deliberate example is "induced lactation to start the production of milk in the absence of a pregnancy" (Ferri et al., 2020, p.287). Some example scenarios include: a transgender man who carries and births his own baby may be able to chestfeed; a transgender woman may induce lactation and breastfeed her baby; and same-sex female couples can co-nurse their baby. These are situations that require sensitivity, awareness, and individualized care (Juntereal & Spatz, 2019; Wolfe-Roubatis & Spatz, 2015). Emphasizing both the nonnutritive and nutritional benefits of human milk will help parents navigate the variable rates of milk production inherent in alternative methods of lactation (Wilson et al., 2015). Use of gender-inclusive language when discussing infant feeding with parents lets them know nurses are respectful and affirming of their identity. For example, using human milk rather than breast milk or mother's milk and parents rather than mother is part of inclusionary care (Spatz, 2020).

Induced Lactation

Historically, breastfeeding has been associated with the mammary glands of postpartum women. However, inducing lactation is possible for adoptive parents, transgender persons, lesbian women, and individuals assigned male at birth (Lee, 2018). Induced lactation is the process of stimulating milk production in an individual who has not recently given birth. The interpretation of success and acceptance can vary widely depending on geographic area, cultural norms, and influences. The process to induce lactation includes hormone therapy, nipple stimulation, and dietary supplements or prescription drugs to increase milk supply (Wilson et al., 2015). Protocols require the introduction of birth control pills for up to 6 months to mimic pregnancy; abrupt withdrawal of birth control pills several weeks before the anticipated breastfeeding experience mimics the hormonal changes related to birth (Lee). Nipple stimulation following the withdrawal of birth control pills simulates the baby's suckling to induce milk production (Lee). Induced lactation may or may not result in a full milk supply and may require supplementation with donor human milk or formula. Individuals who have previously lactated have a better chance of producing enough milk to exclusively breastfeed (Wilson et al.).

Induced lactation, also known as nonpuerperal lactation, requires considerable time and effort, beginning the process months prior to the need for human milk. Induced lactation should not be contrasted with so-called "natural" or "normal" breastfeeding, as all lactation requires skill, time, and effort, and many cis-women (women assigned female at birth and identifying as women) who have recently given birth have physiological, as well as emotional and sociocultural-produced, difficulties lactating and producing sufficient milk for their children (Lee, 2018). Inducing lactation can be overwhelming and require additional sources of nutrition such as supplemental feedings, additional nipple stimulation. It is important to note the use of herbal enhancements or prescription drugs may have side effects for the parent and child. Providers should be mindful of these challenges when caring for families who are members of SGM groups to assist them in meeting their specific feeding goals.

Breastfeeding or Chestfeeding

Individuals who are unable to establish a full milk supply can still experience the benefits of breastfeeding or chestfeeding. Women, transgender men, and gender nonconforming persons with less than a full milk supply may consider the use of galactagogues or a supplemental nutrition system (SNS). Galactagogues are herbal or pharmaceutical substances that increase milk supply. An SNS assists in providing nourishment for babies at the breast or chest, and consists of a container of supplemental milk (formula, expressed milk, or donor milk) that is attached to a long (small French) tube. Implementation of feeding with an SNS includes placement of the distal end of the tube next to the nipple to allow the baby to ingest supplemental milk and the parent's milk simultaneously as the baby suckles at the breast. Although research of SNSs as an alternative feeding method for SGM families is scarce, use of these devices supports the Baby Friendly Hospital Initiative's policy to maintain baby's breastfeeding or chestfeeding capabilities by avoiding introduction of bottle-feeding with artificial teats (Penny et al., 2018). This type of feeding system ensures adequate intake for the baby, enables the parent to provide their baby with the milk they produce, allows for the emotional expe-

As nurses are now more aware of the varied nature of families in our society, our understanding of the individuals who form a family unit must be thorough and the basis of respectful and affirming care.

rience of doing so, and preserves the breastfeeding or chestfeeding relationship.

In addition to concerns about milk supply, transgender men may also experience challenges with latching the infant if the chest is very flat and taut after surgery. Sandwiching breast tissue or using a nipple shield may be effective measures to promote latch when this problem is encountered (MacDonald, 2019). Another frequent occurrence for transgender men who are lactating is gender dysphoria (Light et al., 2014). Gender dysphoria is a sense of distress "caused by incongruity between a person's felt gender and their physicality" (MacDonald, p. 224). Pumping, feeding in private, chest binding, and wearing masculine clothes that allow easy access to the chest are methods that have been effective in reducing gender dysphoria for transgender men (MacDonald). In one study of 41 transgender men who gave birth, 51% were able to chestfeed their infants (Light et al.). Possible complications of chest binding include reduced milk supply and increased risk for mastitis. To decrease these risks, individuals should postpone chest binding until the milk supply is well established, ensure binding is not excessively tight, and consider binding for short periods of time (MacDonald).

Colactation

Colactation is the shared breastfeeding of one infant among two or more persons (Ferri et al., 2020). Most instances of colactation typically requires induced lactation for at least one individual. Examples and variations include birth parent may choose to exclusively pump human milk, whereas the nonbirth parent may choose to induce lactation and use an SNS and the birth parent may choose not to provide human milk, whereas the nonbirth parent chooses to induce lactation and share breastfeeding with a lactating friend or family member (Ferri et al.). If parents are interested in inducing lactation and co-nursing, "discussions about expectations and goals should be initiated beginning in the perinatal period (when possible) so that lactation induction can be started" (Ferri et al., p. 288).

Given the division of time spent feeding the infant with a colactating couple, there is reduced nipple stimulation and milk removal for both individuals, which may in turn diminish milk supply (Wilson et al., 2015). Nurses can support individuals who choose colactating by emphasizing the nutritive benefits of human milk and by suggesting interventions to maintain milk supply, such as use of a breast pump. Referring these families to a lactation professional can help them in forming a plan to meet their goals.

Although colactation is an option, not all women who identify as cisgender lesbians choose to exercise this option. Some nonpregnant partners may consider nonnutritive suckling for the bonding experience as an alternative to induced lactation; others may forego any attempt to put the infant to breast, preferring to experience parenting in other ways.

Juntereal and Spatz (2019) explored decisions of nonpregnant partners on lactation induction and found reasons for not inducing lactation were partner preferred the support role, birth parent was able to breastfeed so it didn't seem necessary, gender identity conflict, and just not interested. One same-sex mother reported that she and her partner were not informed that induced lactation or nonnutritive suckling was an option until the third trimester of the pregnancy, therefore, if her partner had been interested the opportunity would have been missed (Juntereal & Spatz, 2019).

Nurses should not assume that they know the preference of the nonpregnant partner on induced lactation or nonnutritive suckling (Juntereal & Spatz, 2019). Nurses should provide information and resources on induced lactation and nonnutritive suckling in a timely manner using sensitive and nonjudgmental communication.

Milk Sharing and Cross-Nursing

Milk sharing is use of donor milk not provided by a certified milk bank, and therefore, not processed and stored according to standardized guidelines (McNally & Spatz, 2020). Cross-nursing is a form of milk sharing in which the infant is fed directly from the breast of a nonbiological parent. Because milk banks primarily distribute donor breast milk to sick or premature infants, parents of healthy, full-term infants who are unable to produce enough milk must rely on other sources for breast milk (Paynter & Goldberg, 2018). Milk sharing and cross-nursing are practices that enable some SGM parents to provide optimal nutrition to their biological or adoptive infants (MacDonald et al., 2016).

Although milk sharing and cross-nursing can provide health benefits to infants, there are also possible risks.

The Academy of Breastfeeding Medicine recognizes both the benefits and risks of informal milk sharing and therefore provides guidance for safety measures relating to this practice, such as medical screening of breast milk donors and recommendations for safe storage and handling of breast milk (Ferri et al., 2020). Perinatal nurses must understand the sociocultural reasons for milk sharing and can use the Academy of Breastfeeding guidelines to offer support to SGM parents who wish to engage in this practice.

Inclusive and Affirmative Caring

The concept of family unit is evolving as evidenced by couples who are members of an SGM group have the ability to create families through various avenues including birthing, adoption, artificial insemination, and surrogate carriers. Nurses and other health care providers must conduct an "inventory" of personal perceptions to professionally support and provide nonbiased, affirming, respectful, culturally competent care to perinatal patients who are members of SGM groups. Including co-parents in communication is imperative to support the needs to be involved, seen, and addressed as an equal parent. There is limited information on nurses' perceptions of resources and support on providing safe care in the birth setting. Nurses must incorporate evolving evidence on individualized care needs for members of SGM groups to support quality care outcomes.

Clinical Implications

Increasing cultural competence and nursing knowledge of some of the unique aspects of caring for patients who identify as part of the SGM population has important implications for nursing practice. As the nature of what is considered a family is changing in our society, so must our understanding of the individuals who form a family unit. Individuals who are members of SGM groups seeking perinatal care have often experienced discrimination in their health care encounters, either in an overt or covert manner (Hayman et al., 2013; NASEM, 2020). Patients report that most health care providers are not knowledgeable about their unique needs and their desire to receive care that is affirming of their identity (Garcia-Acosta et al., 2020; Light et al., 2014). Nurses should practice self-reflection, examination of personal views, knowledge, competence, implicit bias, and stereotypes of pregnant or partnered patients who identify as a member of an SGM group to enhance perinatal and family health. Implementing these personal practices may facilitate creation of open relationships and a strong rapport between the patient, partners, and the nurse.

Incorporating a holistic comfort care approach, providing early and continual nursing education on culturally competent care for those who are members of SGM populations, may develop integral relational pathways. These pathways can enable nurses to assist patients with the entire birth experience as opposed to holding onto "traditional" expectations. Standardized strategic education must be developed and focus on creating policies, at all levels, to support the acute, long-term, and health maintenance care of individuals who are members of SGM groups. Nurses are frontline advocates, care givers, and change agents, well positioned to increase patient satisfaction, decrease patient fear, provide competent care, and help reduce health disparities, all of which are integral to improving patient outcomes. ✣

SUGGESTED CLINICAL IMPLICATIONS

- An essential aspect of nursing care of members of minority populations such as those who identify as LGBTQ+ is respectful, affirming maternity care.
- Implementing the practice of self-reflection to examine personal views may facilitate creation of open relationships and a strong rapport between the patient, partners, and the nurse.
- Offering care in a holistic (whole-person) manner is vital to assessing and understanding the unique care needs of sexual and gender minority patients. Nurses conducting a comprehensive holistic patient assessment may help to develop individualized care plans to meet the care needs of LGBTQ+ patients and their spouse, co-parent, or partner.
- Pregnant or lactating patients who identify as LGBTQ+ often report that care providers lack knowledge or are reluctant about their care needs. To better address this gap in knowledge, nurses should consider participating in educational courses focused on pregnancy, birth, and postpartum care of sexual and gender minority patients.
- There are multiple options for LGBTQ+ families for newborn feeding preferences. It is important that nurses discuss detailed feeding options and provide education to families about human milk feeding methods. Inclusion of the co-parent, same-sex partner or spouse may enhance the shared parental experiences of human milk feeding, skin-to-skin bonding, and inclusive personalized care centered on the families success.
- Knowledge gaps exist across both academic and clinical settings because of limited or nonexistent education concentrated on LGBTQ+ maternity and postpartum care needs. Incorporating sexual and gender minority education throughout the academic and clinical setting can increase knowledge when communicating and assessing for unique aspects of care, decrease personal biases, improve clinical competence, support inclusive communication, and improve the patient experience.

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