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Male-Partnered Sexual Minority Women: Sexual Identity Disclosure to Health Care Providers During the Perinatal Period

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Abstract

Male-partnered sexual minority women (SMW) have received little research attention, despite the fact that they represent a large proportion of SMW – particularly child-bearing SMW. Male-partnered SMW are less "out" than female-partnered SMW and will likely be "read" as heterosexual by perinatal providers. Given this, and evidence that pregnant women have unique mental health care needs, the current study focuses on male-partnered SMW (n = 28) during the perinatal period, recruited from Toronto, Canada and Massachusetts, USA, in an effort to understand disclosure and concealment processes in general and to perinatal heath care providers specifically. Women generally reported that they did not disclose (but made no effort to conceal) their sexual identities and histories in new or unfamiliar relationships, largely because the topic rarely came up, although some women highlighted bisexual invisibility and fear of biphobia as reasons for non-disclosure. Despite overall positive experiences with perinatal providers, less than one-quarter of the sample (n = 6) had disclosed their sexual identities and histories to them. Most women felt that this information was generally not relevant to their health care, and particularly their reproductive/obstetric care, although some believed that disclosure would be appropriate under conditions of sexual health risk (n = 8). Others noted that although they did not feel the need to disclose, they did prefer an LGBQ-affirming provider (n = 7). Findings provide insight into male-partnered SMW's views and patterns of disclosure during the perinatal period, and have implications for providers, organizations, and scholars who interface with SMW.

Pregnant sexual minority women with male partners are often assumed to be heterosexual, raising questions about whether and when these women disclose their sexual minority status in the perinatal context. This qualitative study of 28 women found that most participants did not share their sexual identity or sexual histories with their perinatal health care providers because this information was perceived as not relevant to their care, although some women nevertheless valued having LGBTQ friendly providers.

Keywords

Bisexual; disclosure; health care provider; nonmonosexual; perinatal; sexual minority

Disclosing one's sexual identity or sexual history to health care providers can be stressful for sexual minorities due to fears of discrimination, and limited access to lesbian, gay, bisexual, and queer (LGBQ)-competent providers and services (Koh, Kang, & Usherwood, 2014; Quinn et al., 2015). LGBQ people may experience anxiety related to sexual identity disclosure in health care settings, in that they weigh the potential costs of disclosing (vulnerability to mistreatment; denial of care) with the potential benefits (forming a good relationship with a provider; receiving a thorough health evaluation and appropriate services; Sherman, Kauth, Shipherd, & Street, 2014).

Following the lead of Schrimshaw and colleagues (2013), we differentiate non-disclosure (not sharing one's sexual identity) from concealment (efforts to hide it), which have different meanings and implications for psychosocial functioning (Jackson & Mohr, 2016; Schrimshaw et al., 2013). Among behaviorally bisexual men, greater concealment of same-sex sexual behavior has been linked to poorer mental health whereas nondisclosure per se was unrelated to well-being (Schrimshaw et al., 2013). And, in a sample of LGB persons, concealment of sexual orientation was linked to difficulties with mental health and minority stress, but non-disclosure predicted positive views of one's sexual orientation (Jackson & Mohr, 2016). Despite such findings, most studies have examined disclosure only, and underlying this work is often the suggestion that disclosure is inherently positive and non-disclosure is inherently negative. The "disclosure imperative" suggests that everyone should be "out," ignoring the potential risks of disclosure and the fact that for individuals who are single or partnered with someone of a different gender, disclosure of a non-heterosexual identity may feel irrelevant or uncomfortable (McLean, 2007).

This study focuses on the disclosure practices and beliefs of sexual minority women (SMW) partnered with men (i.e., women who identify as non-heterosexual or have sexual histories involving women, who have sometimes been referred to as "behaviorally bisexual") during the perinatal period. Bisexual women show elevated risk for difficulties in the domains of mental health (Ross, Siegel, Dobinson, Epstein, & Steele, 2012), behavioral health (e.g., substance abuse; Emory, Kim, Buchting, Hang, & Emery, 2016) and physical health (e.g., sexually transmitted infections [STIs]; Bostwick, Hughes, & Everett, 2015). Notably, we could identify only one study that distinguished between male- and female-partnered bisexual women in examining these health disparities. Dyar, Feinstein, and London (2014) found that bisexual women with different-sex partners had higher depression levels than bisexual women with same-sex partners, a difference that was explained by the greater levels of binegative exclusion and rejection by lesbians/gay men that were experienced by bisexual women with different-sex partners. The health disparities that have been associated with bisexuality may have severe consequences in the perinatal period, in that perinatal depression, substance use, and untreated STIs pose threats to maternal and child health (Burnett, Loucks, & Lindsay, 2015; Yedid, Harley, Weintraub, Sergienko, & Sheiner, 2016). Health disparities have been attributed to bisexual women's unique exposure to bisexual

stigma (e.g., stereotypes about bisexual people; Bostwick, 2012) and bisexual invisibility (e.g., being "read" as heterosexual or lesbian; Ross et al., 2012); yet, little work has examined how stigma and invisibility are experienced in the perinatal period (Ross et al., 2012).

Given the health disparities associated with bisexuality and the consequences of health problems for maternal and child well-being, together with the limited existing research on health among childbearing bisexual women, this population requires further study. Existing literature suggests a strong possibility that pregnant sexual minority women who are partnered with men will not disclose their sexual identities or histories to providers, and also suggests potential health implications of non-disclosure. As such, it is important to understand male-partnered SMW's disclosure to and experiences with providers during the perinatal period. Women are especially likely to interface with the health care system during pregnancy and postpartum (Loureiro et al., 2009) but are also vulnerable to unmet health care needs (Megnin-Viggars, Symington, Howard, & Pilling, 2015). Within supportive environments, patient disclosure of sexual history/identity could be beneficial – e.g., by enabling a holistic picture of patients' sexual history, romantic lives, and sexual identity, and informing appropriate testing (e.g., for STIs) and related interventions. Disclosure may also enhance rapport with providers, thus facilitating appropriate psychosocial assessment and care (Austin, 2004). Yet it also possible that women may perceive disclosure as unnecessary in the perinatal health care setting, as important only under certain conditions, or as dangerous – and in turn, may be motivated to conceal aspects of their sexual identity or history.

Sexual Identity Disclosure Among Sexual Minority Women

Within the larger category of SMW, bisexual women tend to be less "out" than lesbians (Colledge, Hickson, Reid, & Weatherburn, 2015; Dyar, Feinstein, & London, 2015). Bisexual women may not disclose their sexual orientation because of fears of encountering biphobia (Eady, Dobinson, & Ross, 2011; Ross et al., 2012) and discrimination (Koh et al., 2014; Sherman et al., 2014). They may also choose not to disclose as a result of lower salience and centrality of their sexual identity (Dyar et al., 2015), which may be especially relevant if they are have a different gender partner (Mohr, Jackson, & Sheets, 2016; Schrimshaw et al., 2013). Bisexual identities are typically invisible, since sexual identity is often presumed according to one's partner's gender, whereby male-partnered women are assumed to be heterosexual and female-partnered women are assumed to be lesbian. As a result, some women who self-identify as bisexual may present themselves as heterosexual or lesbian (Mohr et al., 2016), likely because correction of outsiders' presumptions is experienced as burdensome. Perceptions of irrelevance may also drive non-disclosure of sexual identity for bisexual people. Research on bisexual women (Wandrey, Mosack, & Moore, 2015) and men (Schrimshaw, Downing, Cohn, & Siegel, 2014) suggests that believing that others have no reason to know often underlies non-disclosure of sexual identity and behaviors.

Bisexual women are less likely than lesbians to disclose their sexual orientation/history to health care providers specifically (Mor et al., 2015; Quinn et al., 2015), with Durso and

Meyer (2013) reporting non-disclosure rates of 32.6% and 12.9% respectively, to general medical providers. Providers are likely to avoid asking patients about sexual orientation/history for a range of reasons (e.g., to avoid offending heterosexual patients, or to conceal lack of competence), thus placing the responsibility for disclosure solely on SMW women (McNair, Hegarty, & Taft, 2012). In this way, non-disclosure may reflect bisexual invisibility (Ross et al., 2012). Non-disclosure to providers may also reflect the belief that one's sexual identity/history is not relevant in a particular health care setting (Wandrey et al., 2015)—a belief that is likely to be especially common among people whose relationships conform to heteronormative expectations, such as male-partnered SMW (Schrimshaw et al., 2014). Such individuals may feel that the default care provided in the context of heteronormative expectations is sufficient for their needs, and so do not feel the same necessity to disclose as those for whom this default care is not relevant or sufficient.

Significantly, women who do not disclose their sexual identity/history to providers are not necessarily seeking to conceal it (Jackson & Mohr, 2016), and, by extension, the threat of negative consequences of nondisclosure (e.g., poor rapport, inadequate service use) would appear to be low. In contrast, some women may feel that it is important for providers to know about their sexual histories but do not feel comfortable sharing; others may actively conceal this information (e.g., because they worry about judgment of sexual practices; McNair et al., 2012). In these contexts, nondisclosure could constitute a barrier to rapport-building and health care use.

Thus, SMW who are partnered with men may be especially unlikely to disclose their sexual orientation/history to providers, who generally presume heterosexuality and seem unlikely to ask about patients' sexual orientation (McNair et al, 2012). This may be particularly true during the perinatal period, in light of heteronormative assumptions surrounding pregnancy, partnership, and childrearing (Ross & Goldberg, 2016) such that women who are visibly pregnant and possibly present with their male partner may often be presumed heterosexual. Little research has examined bisexual (or male-partnered SM) women's disclosure experiences with providers in the perinatal period, with one exception. In a study of bisexual women who were trying to conceive, were pregnant, or were new parents, Ross and colleagues (2012) noted briefly that women who were partnered with men were less likely to have disclosed their sexual orientation to family, friends, and health providers, relative to other women in the sample. Some women described conflicting feelings about ways in which their heterosexual privilege (i.e., the social benefits of being partnered with a man) had contributed to invisibility of their bisexual identity—an experience that troubled them in that it isolated them from a potential source of community. In an analysis of quantitative data from the same study, Steele and colleagues (2008) found that women who had conceived with a man were more likely to report unmet need for mental health services than SMW who conceived via other means. Thus, the limited data suggest that bisexual women partnered with men may experience invisibility and possibly unmet health care needs in the perinatal period.

The Current Study

There is a lack of research on male-partnered SMW's health care experiences, and during the perinatal period specifically – although there is some suggestion that perinatal health care providers (e.g., midwives, OB/GYNs[1]) may tend to "read" male-partnered SMW as heterosexual (in terms of identity and behavior), and women themselves may not disclose their sexual identities or histories. Given that the perinatal period is a time of both elevated invisibility of sexual minority identity and increased health service use for male-partnered SMW, it offers an ideal context in which to examine women's choices and feelings about disclosure to providers. Such work is particularly important in that male-partnered SMW, by virtue of their sexual relationships with men, likely make up a large proportion of SMW, and, specifically, childbearing SMW (Moegelin, Nilsson, & Helström, 2010), as evidenced by the fact that bisexual women are more likely to have children than lesbians (Goldberg, Gartrell, & Gates, 2014).

This study explored male-partnered SMW's views of and experiences with disclosure to health care providers during the perinatal period. We provide data on their sexual identities (e.g., preferred labels) and perspectives on disclosure in general (i.e., with people that they do not know well), before presenting data on their choices and feelings about disclosure in relation to providers. Of interest is the extent to which these women engage in active disclosure (i.e., volunteering the information), passive disclosure (responding to a provider's inquiries), nondisclosure, or concealment (McNair et al., 2012). Also of interest are their feelings about and reasons for (non)disclosure and their perceptions of the consequences of (non)disclosure on the effectiveness of their care. We place these disclosure-related concerns in the context of broader relationship with providers by providing data on their experiences more generally with prenatal care.

Method

Participants

Included in the study are data from 28 SMW partnered with men, who were interviewed during the perinatal period. In our pilot work (*author citation*), we found that sexual behavior in interaction with partner gender was significantly associated with women's mental health. As such, we used a broad definition of "sexual minority" in this study, which was based on not only self-identity but also sexual history (i.e., having had at least one female partner in the past five years).

A description of the sample appears in Table 1. Twenty-four of the women were pregnant at the time of the interview; in four cases, women were interviewed 1-2 weeks after the birth of their baby. Most women were first-time parents, White, and had at least a Bachelor's Degree. Women were between 22 and 44 years (M = 31.39, SD = 4.97). About half were employed full-time; the remainder were working part-time, were students, or were not employed. About half of the sample reported 1-2 sexual partners in the past five years, and

[1]A doctor who deals with the birth of children and with diseases that affect the female reproductive system. OB is short for obstetrics or for an obstetrician, a physician who delivers babies. GYN is short for gynecology or for a gynecologist.

about half reported three or more partners during that time period. Most women reported that their sexual relationships during the past five years were either with men and women about equally, or mostly with men. Regarding the length of their current relationships, most reported a relationship duration of over two years.

Most women (n = 20) identified as bisexual (although a few of them stated that they sometimes identified as queer, depending on the context), two identified as primarily heterosexual but open to future relationships with women, and one each identified as queer, bicurious, bi/pansexual, heterosexual, heteroflexible, and unlabeled. Two-thirds (n = 19) described at least one serious or long-term sexual and romantic relationships with women. The remainder (n = 9) described primarily sexual encounters with women.

Procedures

The current study was approved by the human subjects committees at [*blinded*]. Women were recruited through consecutive sampling from selected midwifery clinics and OB/GYNs (including hospital-based and stand-alone practices) during presentation for prenatal care, in and around the city of Toronto, Canada, and cities and towns in Western and Central Massachusetts, USA (Worcester, Northampton, Holyoke, Greenfield, and Westfield). A multi-region, multi-site design was necessary as perinatal SMW are a relatively small population. The two specific regions were chosen because of the high density of SMW in these areas. Within these regions, recruitment sites (n = 11) were located in a variety of different geographic locations, rural and urban, serving low-, middle-, and high-income women. Women attending a prenatal care visit at 25-32 weeks gestation were asked to complete a brief questionnaire including: a) sexual orientation, b) gender of sexual partners in the past five years, and c) current partner status. This pre-screen enabled us to obtain a systematic sample of “invisible sexual minority women”: women who were currently partnered with a man but reported having had a least one female sexual partner in the past 5 years and/or identified with a non-heterosexual identification (e.g., bisexual, queer). To be eligible for participation, all women also had to be pregnant, at least 18 years old, and speak English fluently.

Potentially eligible participants were contacted by research staff to invite participation in an internet-based survey. Of the eligible consecutively recruited participants who were contacted (75% of attempted contacts), 89% (n = 31) consented. Of these 31 women, 29 consented to also participate in in-depth prenatal interviews. One of these women was partnered with a transgender woman. We included her in the original sample given our interest in her experience as an “invisible” sexual minority. Given that she was not male-partnered, we did not include her in the current study. Thus, we include data from the 28 male-partnered women only in this analysis.

Most women were interviewed prenatally; in four cases, women were interviewed 1-2 weeks after delivery due either to early delivery of the baby or scheduling difficulties. Most interviews took place in person; five were telephone interviews. Interviews were conducted by one of the two principal investigators of the study or trained graduate or postgraduate students. Interviewers were diverse in terms of age, sexual orientation, and parental status. The interviews ranged from 1-2 hours, and were mostly conducted at the participants’

homes, although some women preferred the interview to be conducted at the investigator's office or a restaurant.

Interviews followed a semi-structured interview guide which probed areas such as feelings about the pregnancy/parenting; support/non-support from partner, family, friends, LGBTQ community, and health care workers; and sexual history. Relevant to this particular study were questions that addressed how women saw their sexual identities and histories as impacting their experience of pregnancy, their openness about their sexual identities/histories, their experiences seeking out and interacting with health care providers during pregnancy, whether providers were aware of their sexual history or identity, and the perceived importance of sharing this information.

Data Analysis

Participants' responses were transcribed and examined using thematic analysis (Bogdan & Biklen, 2007). The thematic analysis focused on parents' descriptions of their sexual identities and histories, their general openness and patterns of disclosure, and their experiences with health care providers. The analysis was informed by the literatures on bisexual and non-monosexual identities, health care experiences of sexual minorities, and concealment and disclosure.

To develop themes, the first author, a professor of psychology, initiated the coding process with open coding. She engaged in line-by-line analysis to generate initial theoretical categories (Charmaz, 2006). For example, she generated the initial codes "does/does not disclose sexual history to providers" to describe women's general stance on disclosure. As she moved to focused coding, she refined these codes; for example; discloses to providers was replaced by two codes: (a) discloses in response to explicit questioning about sexual identity (passive); and (b) discloses spontaneously (active). Further, she developed subcodes to denote reasons for and conditions of non-disclosure (e.g., perceptions of irrelevance). These focused codes, which are more conceptual and selective, became the basis for the "themes" developed in the analysis (Patton, 2002).

The third author, a doctoral student in psychology and a graduate research assistant on the project, coded a select number of transcripts (Miles, Huberman, & Saldana, 2013) in order to serve as an outside perspective on the emerging categories and to provide a reliability check. This coder independently coded the data. Subsequently, the two coders examined their level of agreement upon codes. Intercoder agreement ranged from 85-94% (number of agreements/number of agreements + disagreements), indicating good reliability. Coding disagreements were discussed; these discussions led to minor refinement of the scheme. The final scheme was established once both coders had verified agreement among all the independently coded data.

Results

To provide context for the findings regarding women's disclosure to providers, we first discuss the degree to which they tended to share information about their sexual histories and identities in new or relatively unfamiliar relationships in general. Then we briefly discuss

their experiences with providers, which provides context for talking about their disclosure practices and explanations for these practices in the perinatal health care setting. (See Table 2 for key themes.)

Approaches to and Perspectives on Disclosure in Everyday Life

All 28 women asserted that their male partners (all of whom reportedly identified as heterosexual) were aware of their sexual identities and histories. In general, however, women reported that they did not tend to disclose information about their sexual identities and histories to people outside of their friend/family network – although notably, not a single woman said that they specifically sought to conceal this information, and some ($n = 8$) specifically noted that they did *not* attempt to hide it. Brigitte,[2] a bisexual woman, reflected, "I guess it's on a need-to-know basis. Right, like I wouldn't say that I hide it, but I don't go around and talk to people about what I do for sex" [*laugh*]. Meredith, also bisexual, asserted, "For women like me, [with a husband], nobody knows that you're bi unless you tell them. I'm not gonna like, meet someone and be like '. . .and I'm bisexual.' But I'm definitely not one of those people that make a point to hide."

In explaining their general lack of disclosure, most women ($n = 20$) noted that this information did not organically or regularly "come up in daily conversation." Common statements were "it's typically not relevant" and "it doesn't come up." Maxine, a bisexual woman, stated, "As normal parts of conversation…it's not like things come up where I feel like I need to catalogue my sexual history with someone." Sharon, also bisexual, said, "By and large it doesn't come up because talking about sexuality or relationships beyond day to day gripes about living with your husband or wife; they're not conversations that typically come up." In turn, women generally did not "avoid telling people" but also did not "go out of [their] way" to make the information known.

Although this lack of disclosure was largely discussed in terms of the fact that the topic "rarely came up," some of the women ($n = 8$) directly or indirectly hinted at bisexual invisibility as a reason for the absence of situations or conversations during which it would seem natural to "come out" about their sexual identities or histories. They noted that they were consistently "read" as heterosexual because of their relational configuration and gender presentation (i.e., feminine): "I'm a fairly feminine woman and he's a fairly masculine guy so that doesn't challenge people's notions of us being straight" (Sheila, bisexual). Carrie, a bisexual woman, shared, "There's not this need to come out about it, which is why I think so many bisexual people are closeted. If I'm in a heterosexual relationship…[it's like], why do I need to be out?…It's easy to get by being a bisexual person and not having to be out about it, 'cause I'm with a man."

"Passing" as heterosexual meant that women had access to heterosexual privilege – which they did not necessarily want: "I do struggle a little bit with… some guilt around my ability to. . .fluidly move into places of privilege" (Stacy, bisexual). Yet to correct assumptions of heterosexuality could potentially "create an awkward situation; I don't like to offend people." On the other hand, a few women who acknowledged that people generally assumed

[2]All names are pseudonyms.

that they were heterosexual noted a lack of discomfort with these assumptions: "It doesn't weigh on me."

In addition to highlighting the role of bisexual invisibility in non-disclosure, a few women (*n* = 3) acknowledged that concerns about biphobia also affected their lack of disclosure. Carrie, bisexual, stated: "There's a lot of taboos that go along with being bisexual, so it's not something that I think I'm that out about. I feel like it makes people uncomfortable, and they somehow associate it with being kinky or dirty." Alicia, also bisexual, was aware that some people think that bisexual "means that you need to be with a man *and* a woman, or that monogamy will be hard for you or that you're somehow confused or something…so [bisexual] is not an easy label because of the baggage that comes with it, [and] people's misconceptions." In turn, she felt that it was easier "not to talk about it." A few women (*n* = 3) who were in open relationships described feeling that the stigmas surrounding non-monogamy were even greater than the stigmas surrounding bisexuality. In turn, concerns about encountering discrimination based on their non-monogamous identities prevented them from disclosing about their sexual identities, since it seemed impossible to be open about one without being open about the other. Stacy, bisexual, explained:

> I actually think it's way more easier to be in a same-sex relationships and [be open about] that with straight colleagues than it is to explain about polyamory or talk about having more than one partner, or bringing those partners to events. So I actually found that at my last job, even though I would say close to half the staff was in same sex relationships, that I never talked about my dating life. And that was really more about the poly stuff.

General Experiences with Perinatal Health Care Providers

Before describing women's experiences of disclosure with perinatal providers, it is necessary to contextualize these data by briefly describing their general experiences with providers. As described in the section that follows, despite their positive experiences with providers, women were unlikely to disclose their sexual identities, regardless of provider type.

Most women (*n* = 15) were cared for by midwives only, of which seven reported being seen by more than one midwife. Seven women were seen at practices (hospital and community-based) with both OB/GYNs and midwives, of which four reported being seen by more than one midwife. Finally, six women reported being cared for by OB/GYNs only. Given that most of the women saw midwives, it is not surprising that women frequently highlighted the positive qualities of midwives, often contrasting them with "traditional" providers (e.g., OB/GYNs). One perceived advantage of midwives was their tendency to embrace *holistic and natural approaches* to pregnancy and birth, whereby they minimized the need for interventions, especially during birth; promoted natural childbirth and home birth; and were generally "attuned" to not only women's physical experience of pregnancy and birth but their emotional experience of it (*n* = 13). Another theme was the perception of midwives as more *available, responsive, and hands-on* (*n* = 9), whereby they booked "longer appointment times" and spent time "creating good rapport." A respectful, collaborative, and "non-dogmatic" style was named by a few women as typical of midwives (*n* = 4), such that

discussions regarding their care and birth plan were a "conversation, [not] an instruction." Two women perceived *a less heteronormative stance* and greater openness to queerness as more likely amongst midwives (i.e., it was consistent with their "philosophy"). Terry, bisexual, chose a midwife because she "[wanted] somebody who wouldn't make assumptions of who I've had sex with in my life or who I want to have sex with or how I have sex actually."

Some women ($n = 7$) described having switched providers during the prenatal period. Women's reasons for changing providers centered on *continuity and intimacy of care* (e.g., they wanted to see the same provider at every appointment; $n = 4$); *philosophy* (i.e., they wanted a provider who shared their views on vaccinations, breastfeeding, and natural childbirth; $n = 4$); and *accessibility* (i.e., they wanted a provider that was closer to where they lived; $n = 2$).

Disclosure to Perinatal Health Care Providers

Only one woman, Stacy, reported that she had been asked about her sexual history and/or identity – either in person or via paperwork – by a health care provider during the prenatal period. Stacy said that she "ticked" a box on the paperwork to indicate that she was bisexual/queer; yet despite this, and the fact that she was "there with [her] male partner," her midwife had not followed up on or initiated a conversation about this information. In two cases, women disclosed in response to a related but not direct question about sexual history by their providers. Terry, bisexual, tried to recall exactly how the conversation had unfolded:

> I feel like [provider] does know. I felt like one of the questions that she had to ask, health-wise, was about that and I think one of them was like, you know, how long has it been since you had sex, and…I said "We've been monogamous; but I had sex with men and women before that" or something.

Finally, three women said that despite no direct or indirect inquiry regarding their sexual history or identity, they had indeed volunteered this information to their providers. Notably, all three recalled that their providers seemed to have taken the information in stride and had had little reaction. For example, Liza noted that her midwife "seem[ed] fine," in response to her disclosure that she was bisexual and had a history of relationships with both men and women.

In contrast to these exceptions, most women ($n = 22$) noted that their providers had "assumed that they were straight" and/or had not inquired about any alternative identifications or a sexual history with women, and, in turn, they had not disclosed their sexual history or identity. Arielle, who was bisexual, said, "They didn't ask on any forms that I can remember…Providers or nurses or whatever, they assume that I'm married to a man. I know that based on their language …you know, 'What does your husband do?' when I've never said I have a husband." Sophie, who was pansexual, said that in the health care setting, she typically encountered "the usual assumption of, you know, they see me with my fiancé…and think, oh, hetero couple…I feel like, you know, the appearance is, guy, girl, baby…clearly they did something to [get pregnant]."

Many participants (n = 12) explicitly described feeling that it was not important or relevant to disclose their sexual history or identity to their perinatal providers. They stated unequivocally that their sexual history had not only not come up, but also, they did not see it as relevant to disclose – although three provided the caveat that they felt that it was important to disclose to providers "on the behavioral health side of things" (i.e., therapists). Greta, who was bisexual, stated, "It never came up and did not feel particularly relevant to the current situation [pregnancy]. . .We're just sort of dealing with *this* right now."

Several of these women (n = 4) explicitly noted that although they didn't see how it was relevant, they would share the information if asked. Rose, who was bisexual, said, "If they needed to know for any reason, I wouldn't have any problem telling them. I [just] don't really offer stuff out of the way to people." Thus, at least some of these women did not perceive themselves as hiding their sexual history or identity; rather, they described themselves as open to providing the information if and when they were asked (despite not seeing it as relevant).

In some cases (n = 8), women noted that although they had not disclosed because it had not come up, they did believe that such information could be relevant under certain circumstances – namely those involving sexual risk, such as if they was seeking testing or treatment for STIs and/or if they were in an open relationship and having sex outside of their relationship with their primary male partner, such that they "may have been exposed to such and such a thing." Iris, bisexual, remarked, "It's interesting [that they never asked], because I feel like there's aspects of your sexual history that kind of come up in, you know, midwifery care, gynecological care."

Other women (n = 7) shared the perspective that although they did not feel compelled to disclose their sexual identities or histories to providers – and, likewise, it was not essential that providers inquire about it – they did prefer to see providers who were queer-affirming, and who did not make assumptions about their sexual orientation. They asserted that if they had a provider who was homophobic or biphobic, they "would not feel comfortable with that." Keira, bisexual, said, "If one of my providers said something to me that I thought was discriminatory towards gay people or something, I would be really offended and wouldn't want to see them again."

A few of these women (n = 3) explicitly noted that their providers had offered indications that they were queer-affirming, which put them at ease and perhaps made it seem less important to disclose (i.e., in order to figure out a provider's attitudes). Patty, who did not identify with any label, was aware that her OB/GYN was gay, had children, and served "many gay couples." Knowing these details made Patty feel like, "as a human being, she has a slightly different perspective. And I value that, that she has a different viewpoint. To me, she's an awesome, awesome doctor." Maxine, bisexual, described how the midwifery clinic she attended had

> posters up [of] different queer families, [like], "we're against discrimination in medical settings" and…like, "we support [all families]." It's just very open and out. So I didn't feel like I was on high alert…and just with my midwife, she was just so…open minded and just very relaxed that I didn't feel like I needed to push

> anything. Honestly, if I felt like a midwife was…not like that, I would probably request that I change midwives. Having prejudice or biases against queer people is like, totally unacceptable to me.

In contrast to the above women, one woman, Rayna, who was bisexual, said that she would not switch providers if she suspected that they were homophobic or biphobic, noting further that "I probably wouldn't say anything [about my sexual identity] just because I wouldn't want them to discriminate against me afterwards because of it…I would probably just keep my mouth shut."

Only one woman had strong feelings about the desirability of having perinatal providers ask explicitly about sexual identity/history. Sophie, who was pansexual, felt that "knowing that information will definitely help a medical professional connect…You want to make a connection with your patient. I as the patient…would want someone to actually care enough to [ask]." She went on to say that she would probably prefer a provider that was LGBQ-savvy, because "they may have a little bit better of an understanding…[of what] makes [me] unique."

Discussion

This study explored how male-partnered SMW, who represent a large proportion of childbearing SMW, experience disclosure of their sexual identities and histories to perinatal providers. Because the perinatal period is a time of both heightened invisibility of sexual minority identity, and increased health service use (between 80%-95% of American and Canadian women receive prenatal care; Child Trends, 2015; Public Health Agency of Canada, 2009), it offers an ideal context in which to explore women's choices and feelings about disclosure to providers.

Dominant discourses about sexual minority identity have historically positioned sexual identity disclosure as "good" (as it is seen as facilitating or reflecting healthy sexual identity development), whereas nondisclosure is positioned as "bad" (McLean, 2007). As such, there is a "disclosure imperative" attached to living as LGB. Yet as McLean (2007) argues, for bisexual people, perhaps especially those in different-gender relationships, coming out to others may be experienced as more complicated or less necessary (e.g., due to bisexual invisibility and stigma), thus challenging the notion of the disclosure imperative. Likewise, research suggests that bisexual individuals often explain nondisclosure of their sexual identity or behaviors by stating that others have no reason to know or the topic is too personal (Schrimshaw et al., 2014; Wandrey et al., 2015), highlighting how the perceived costs of disclosure may seem to outweigh the benefits.

The narratives of the participants extend and nuance such findings. When discussing disclosure to individuals that they did not know well, they tended to state that they did not perceive it as relevant – although some also invoked bisexual invisibility as contributing to their nondisclosure, as well as concerns about stigma related to their bisexual and/or non-monogamous identities (McLean, 2007). Likewise, with regard to perinatal providers, most women did not disclose their sexual identities/histories, typically because they did not see it as relevant; although, some women indicated that it would be important under certain

specific circumstances, such as if they were concerned about their sexual health, which echoes some prior work demonstrating that LGB individuals are more likely to disclose their sexual orientation to their physician if they have discussed sex or sexual health of any kind (Meckler, Elliott, Kanouse, Beals, & Schuster, 2006). Such non-disclosure is notable in light of women's generally positive experiences with providers. That these male-partnered SMW were unlikely to openly or voluntarily share their sexual identities/histories did not, in most cases, seem to stem from fear of marginalization. Instead, non-disclosure resulted from low perceived salience or relevance, and, perhaps, uncertainty about how to raise the issue amidst bisexual invisibility and lack of invitation to provide the information.

Indeed, some women said that they would be open to providing this information if directly asked: that is, they were *open* to *passive* disclosure, but did not *see the need* for *active* disclosure (McNair et al., 2012). Perhaps, in the presence of a neutral/positive provider-patient relationship, questions about sexual history or identity (e.g., in person or via paperwork) could be experienced as indicating openness to non-heterosexual behaviors and identities, which could foster greater openness on behalf of women and a more positive relationship between women and providers.

At the same time, some participants expressed their relative preference to have an LGBQ-savvy or affirming provider, and a few said that they would switch providers if they seemed to be homophobic or biphobic. These findings echo those of Quinn et al. (2015), who found that LGB respondents tended to feel more trust toward a health care setting that had the Human Rights Campaign (HRC) logo (i.e., a symbol of equality) than one that did not – although bisexual men and women were less likely to notice the symbol than lesbians. Thus, while a queer-affirming atmosphere was named as desirable by some women, it may not be as salient for them as it might be for female-partnered pregnant women. And yet explicit indications of acceptance of *bisexuality* may be particularly important to some women who have sexual histories with women. Several women did note that their providers had assumed they were heterosexual, and some articulated an attunement to bisexual stigma (Bostwick, 2012), which may have contributed to their general reluctance to share information about their sexual history with their perinatal providers.

Given women's elevated risk for mental health challenges during the perinatal period, it is important for women to establish good relationships with providers, who can serve as sources of support and resources should women encounter emotional challenges in the postpartum period. Significantly, women generally described positive relationships with providers, with many noting the benefits of seeing midwives specifically. It is possible that these relationships could be further enhanced by explicit environmental cues that communicate inclusion and acceptance of diverse families, relationships, and sexualities. This was, after all, identified as more important by some women than explicitly asking about sexual history/identity. Perhaps, in the presence of such cues, women might feel more comfortable about mentioning their sexual history, and/or may feel encouraged to talk about this topic *if and when* it feels relevant to do so (Koh et al., 2014).

Given that women generally indicated that they did not try to conceal their sexual histories, interventions that focus on disclosure to providers may be misplaced, in light of work

suggesting that it is concealment (which may be motivated by internalized homophobia) that has the most negative effects on well-being (Dyar et al., 2015; Jackson & Mohr, 2016). And yet, efforts to facilitate disclosure (e.g., via affirming environmental cues) may be beneficial, in that providers are better equipped to offer appropriate referrals if they know patients' sexual histories. Indeed, if a provider knows that her patient is bisexual, she can refer her to a bi-affirmative therapist for the treatment of postpartum depression, or recommend a bi-inclusive support group for new parents.

Recommendations

Based on our findings, it seems important that providers – particularly those of perinatal care – avoid assuming that their patients are heterosexual on the basis of current male partnership. Explicit awareness of the tendency to assume a heteronormative lens may encourage providers to approach their patients with greater openness and sensitivity (e.g., in terms of their language and assessment tools). By working to acknowledge their own heteronormative value systems, and how these may frame their assumptions and interactions, providers can become more skilled in their approach to LGBTQ patients.

Insomuch as some women indicated that they would disclose if they felt that they were in a "safe space" and/or if they were asked, providers should seek to communicate an LGBTQ affirming stance and to consider whether to ask about patient sexual identity and history. Providers can communicate affirmation of diverse sexual identities, families, and relationships via visual cues, medical forms, and resource lists (e.g., that contain LGBTQ community resources). Ensuring that these lists are made available to *all* patients is important, given the potential invisibility of patients' sexual identities. Providers should develop relationships with community LGBTQ organizations to ensure that their resource recommendations are well-informed, and to highlight their own investment in providing sensitive perinatal care to members of the LGBTQ community.

Providers who choose to assess aspects of patient sexuality should, in considering questions for medical forms, be aware that sexual history, sexual identity, and partner gender represent different components of sexuality, and should evaluate whether it makes sense to ask about any or all of these; in turn, they should not request data about one component and use it to make conclusions about others (Bauer & Brennan, 2013). In talking with patients (e.g., about sexual identity), providers should use their language, and, if in doubt, ask what terms they prefer. Providers should also respond non-judgmentally to patients' language choices, and to disclosures of sexual histories and behaviors more generally (Eady et al., 2011).

In sum, providers' ability to communicate awareness of sexual orientation diversity in a non-prejudicial manner may enhance LGBTQ patients' comfort and willingness to disclose details of their sexual history, possibly facilitating improved care and better health outcomes. Ultimately, though, while it appears important for providers to anticipate and accept sexual diversity amongst patients, it is also necessary that providers understand that "when it comes to issues of disclosing sexual orientation, this may or may not be uppermost in the patient's mind" (Seeman, 2015, p. 312). Given that, as we saw in our findings, the meaning and salience of sexual history may vary significantly, it necessary that providers avoid making

assumptions about meaning and salience based on one piece of data (e.g., a client has a prior history of same-sex relationships).

Limitations & Conclusions

Although our sampling technique has many strengths, including identifying women who are less identified with or "out" about their sexual minority status, we may have underrepresented SMW who underutilize health care by virtue of drawing on women who were being seen by perinatal providers. Research suggests that racial minorities are disproportionately represented among women who do not seek prenatal care; and, reasons for not seeking prenatal care often include substance abuse and financial problems (Child Trends, 2015; Friedman, Heneghan, & Rosenthal, 2009). Thus, women who do not seek prenatal care and are also sexual minorities may possess multiple risk factors that could impact their transition to parenthood. In addition, the geographic regions from which we drew participants likely had implications for their disclosure experiences. The experiences of pregnant SMW partnered with men might be very different in politically conservative and religious regions. Also, although there was variability within the sample with regard to educational and financial status, most women were college-educated, which inevitably had implications for their constructions of their sexual identity, health care choices, and decision-making regarding disclosure. Our findings may not generalize to women of diverse backgrounds. Finally, we cannot generalize these findings to non-pregnant male-partnered SMW, nor to this population's disclosure experiences with other types of health providers. Indeed, the literature is consistent in showing that individuals' reasons for disclosure and nondisclosure of their sexual histories/identities vary considerably across different types of "targets" (Schrimshaw et al., 2013). As such, reasons for and rates of (non)disclosure to midwives or OB/GYNs may be different from those in relation to mental health or infectious disease providers, for example.

A strength of our study is that it reveals the diversity of sexual orientations and identities within the larger category of SMW partnered with men. However, the variability of our sample is also a limitation, insomuch as a sizable minority of women endorsed self-identifications other than bisexual, including, most notably, heterosexual. Had we gathered data from a larger number of heterosexual-identified women with a recent history of sexual relationships with women, for example, it may have been possible to explore in greater depth how experiences of disclosure vary according to self-identification. Future work should seek to explore how sexual identification and its salience shape disclosure for diverse SMW, particularly those who are pregnant and on the cusp of entering "parenthood culture," which is largely heteronormative (Goldberg et al., 2014). Also, we also only interviewed SMW partnered with men; we did not include nonmonosexual (e.g., bisexual) women partnered with women. Thus, we do not know how our participants' disclosure experiences may compare to those of women who have a history of relationships with men but are partnered with women – and thus presumed lesbian by their health care providers.

Despite these limitations, our study makes a contribution to the literature by expanding our understanding of how male-partnered SMW think about and navigate disclosure in the health care setting, and during the perinatal period specifically. The diversity in these

women's identities and perspectives highlights the unique concerns and considerations of a group that is often invisible in society, in health care, and in research. Future work should aim to build on these findings to probe even more deeply into the lived experiences of male-partnered SMW as they navigate partnership and parenthood.

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Table 1

Selected Demographic Characteristics of Participants (N = 28)

Demographic Variable	*n (%)*
First time parents	18 (64.3)
Race	
White	23 (82.1)
Of color[a]	5 (17.9)
Education	
High school or less	4 (14.3)
Some college or technical certificate	3 (10.7)
Associate or bachelor's degree	10 (35.7)
Higher degree	11 (39.3)
Employment	
Full-time	15 (53.6)
Other	13 (46.4)
Household Income	
<$30,000	8 (28.6)
$30,000-$59,999	5 (17.8)
$60,000-$99,999	7 (25.0)
$100,000+	8 (28.6)
Number of Past Partners (in past 5 years)	
1	6 (21.4)
2	7 (25.0)
3+	15 (53.6)
Gender of Past Partners	
Mostly women	2 (7.1)
Women and men equally	8 (28.6)
Mostly men	11 (39.3)
Exclusively men	7 (25.0)
Marital status	
Married	18 (64.3)
Unmarried[b]	10 (35.7)
Relationship Duration of Current Relationship	
<2 years	8 (28)
2-10 ears	14 (50)
>10 years	6 (21)
Consensual Non-Monogamy	
Yes[c]	9 (32.1)
No	19 (67.9)
	Mean (SD)
Age	31.39 (4.97)

[a]This category includes four Latina participants and one East Indian/South Asian participant.

[b]One participant was engaged to her partner.

[c]Classification of consensual non-monogamy (including threesomes, swinging, open relationships, and polyamory) was based upon our interpretation of participants' interview data.

Table 2

Key Themes Regarding Disclosure of Sexual Identity/History and Provider Experiences

Major Codes and Subcodes	*n*
Reasons for Non-Disclosure[a]	
Lack of relevance	20
Bisexual invisibility	8
Concerns about biphobia	3
Stigmas around non-monogamy	3
Types of Health Care Providers	
Midwives (alone or with OB/GYNs)	22
OB/GYNs only	6
Benefits of Midwives as Providers[a]	
Holistic and natural approach	13
Responsive and hands-on	9
Respectful and non-dogmatic style	4
Less heteronormative stance	2
Reasons for Switching Providers[a] **(*n* = 7)**	
Continuity/intimacy of care	4
Provider philosophy	4
Accessibility	2
Disclosure to Health Care Providers	
Disclosed in response to direct provider inquiry	1
Disclosed in response to indirect inquiry	2
Initiated disclosure (provider did not ask)	3
Did not disclose	22
Perceptions of Importance of Disclosure to Providers	
Not relevant, in general	12
Relevant under conditions of potential sexual risk	8
Not relevant, but prefer an LGBTQ affirming provider	7
Important for providers to ask	1

[a]Categories are not mutually exclusive (respondents sometimes cited multiple factors)