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Paths to Parenthood Among Self-Identified Bisexual Individuals in the United States

Jessamyn Bowling[1] · **Brian Dodge**[2] · **Elizabeth Bartelt**[2] · **Megan Simmons**[3] · **J. Dennis Fortenberry**[4]

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Abstract Bisexual parents have been notably absent from prior research on parenting, despite comprising the largest proportion of parents among "lesbian, gay, and bisexual" (LGB) individuals. Indeed, recent national probability data indicate that young bisexual women are more likely than their heterosexual counterparts to report having at least one child. Intentions to have children, patterns of family planning and contraception use, and related issues have important implications for health and healthcare-related decisions and priorities among bisexual parents. We conducted in-depth interviews with a sample of 33 bisexual parents from across the U.S. who reported having at least one child (genetic, adopted, step or foster child, guardian, and/or warden of the state). In cases of intentional pregnancies, participants considered relationship and financial stability, job security and their ideal family size. Unintentional pregnancies, as well as pregnancy terminations, were often reframed as positive experiences. After deciding not to have more children, participants reported using contraceptive methods, including sterilization or long-acting reversible contraceptive methods (e.g., intrauterine devices). Instances of deception, in which partners deceived participants with false beliefs regarding their contraceptive use, were recalled negatively for the relatively small number of participants who reported such experiences. Overall, our findings point to a diversity in the intentions and ways bisexual individuals become parents, similar to parents of other sexual identities. Acknowledgements of the diverse experiences and concerns faced by bisexual parents may be beneficial in improving efforts related to providing appropriate and relevant health- and healthcare-related services.

Keywords Bisexual · Parenting · Pregnancy intention · Assisted reproductive technology (ART) · Contraception

Introduction

Paths to parenthood are diverse (Power et al., 2012), including conception through sexual encounters, assisted reproductive technologies (ART) (e.g., in vitro fertilization, surrogacy, donor insemination), adoption, fostering, and raising stepchildren. This diversity is particularly prominent among same-sex parents (Gates, 2013). Findings from the 2002 National Survey for Family Growth demonstrated that bisexual men and women were more likely than gay- and lesbian-identified individuals to report a desire to have children (Gates, Badgett, Macomber, & Chambers, 2007). More recently, 37% of lesbian, gay, and bisexual (LGB) individuals reported being the parent of at least one child (Gates, 2013); the proportion for bisexual individuals was much higher (59% for women and 32% for men, compared to 31% of lesbian women and 16% of gay men) (Pew Research, 2013).

The 2012 *National Survey of Sexual Health & Behavior* (NSSHB), a nationally representative probability survey of adults (18 years and older) including an oversample of self-identified LGB individuals, provided baseline rates of parenthood among bisexual individuals in the general population of the U.S. (Bowling, Dodge, & Bartelt, 2017; Herbenick et al., 2012). In bisexual

✉ Jessamyn Bowling
jessamyn.bowling@uncc.edu

[1] Department of Public Health Sciences, University of North Carolina at Charlotte, 9201 University Circle Dr., College of Health and Human Services, 428C, Charlotte, NC 28223, USA

[2] Center for Sexual Health Promotion, Indiana University, Bloomington, IN, USA

[3] Center for Human Sexuality Studies, Widener University, Chester, PA, USA

[4] School of Medicine, Indiana University, Indianapolis, IN, USA

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adults under the age of 60 years, 24% of men and 49% of women lived with at least one child under the age of 18 years. Further, the proportion of bisexual women with a child under the age of 5 years old in their household was *higher* than that of heterosexual women. These findings provide evidence that parenting among bisexual individuals is very common.

The experiences of parenthood among bisexual persons (including motivations, intentions, and family planning practices) have been relatively understudied. One early study on LGB individuals' preferred paths to parenthood indicated that intercourse with a man was preferred for bisexual women, while lesbian women were more likely to prefer adoption or donor insemination (Johnson, Smith, & Guenther, 1987). The majority of bisexual individuals report having genetically related children rather than children from adoption, stepchildren, foster children, or other methods (Goldberg, Gartrell, & Gates, 2014). This may be reflective of a societal ideal of having genetically related children within a two-parent, different-gendered, monogamous household (Clarke, 2002; Crabb & Augoustinos, 2008).

Sexual Minority Parenting and Health

Prior research has examined the impact of sexual identity on pregnancy and parenting. Numerous studies have examined unintended pregnancy among LGB youth (Saewyc, Bearinger, Blum, & Resnick, 1999; Tornello, Riskind, & Patterson, 2014). Adult sexual minority (i.e., non-heterosexual) women have been found to have a higher risk than heterosexual women for unintended pregnancy, with an even higher risk among those with discordant identities (defined as individuals whose attraction did not correspond to their identity) (Hartnett, Walsemann, & Lindley, 2015). Genetic reproduction includes intentional as well as unintentional pregnancies, which may be further classified as mistimed or unwanted (D'Angelo, Gilbert, Rochat, Santelli, & Herold, 2004). Unintended pregnancies have been linked to negative health outcomes for both the baby (Shah et al., 2011) and the mother (Logan, Holcombe, Manlove, & Ryan, 2007; Maxson & Miranda, 2011).

Research on family formation indicates that there may also be underlying social–ecological factors that influence desired timing for and motivations to parent, including personal, economic, interpersonal/relational factors, and other contextual factors, such as goal achievement, partners' desires, financial stability, and relationship satisfaction (Kendall et al., 2005; Santelli, Lindberg, Orr, Finer, & Speizer, 2009; Stanford, Hobbs, Jameson, DeWitt, & Fischer, 2000). These complex social factors are further complicated by healthcare disparities in service and access for sexual minority individuals. There are disparities between heterosexual individuals and sexual minority individuals in discrimination from providers (Stern, Cramer, Garrod, & Green, 2002), a lack of formal medical education for providers on LGB healthcare (Amato & Morton, 2002; Obedin-Maliver et al., 2011), fertility education through fertility-center Web sites (Jin & Dasgupta, 2016), and use of fertility services by sexual minority women (linked to insurance access disparities) (Blanchfield & Patterson, 2015). However, we do not know how these factors influence bisexual individuals' reproductive and parenting plans, nor how the factors influencing bisexual individuals' motivations for parenting compare to those of heterosexual or lesbian/gay individuals.

Bisexual Parenting Concerns

As Ross and Dobinson (2013) argued, research discussions on parenting have almost exclusively focused on monosexual (e.g., exclusively heterosexual or gay/lesbian) individuals, which erases the experiences of bisexual individuals. As such, prior research focus does not allow for nuanced examination of sexual identity and parenting as it relates to the formation of families. One aspect that may be unique to the bisexual experience is the influence of dominant heteronormative family frameworks, including prioritization of genetic relation and monogamous dyadic relationships, and how that influences bisexual expression. Scholars have posited that heteronormative, genetically tied nuclear family frameworks are reinforced in part by social and scientific rhetoric emphasizing the need for both male and female role models in children's lives (Crabb & Augoustinos, 2008), as well as the prevalent notion that children must know their genetic heritage not only for medical purposes, but as part of identity formation (Folgero, 2008).

Studies of diverse groups of bisexual men have highlighted parenting-related concerns, which may impact mental health, including pressures to father children as fulfilling traditional expectations of "familism" and traditional masculinity (Dodge, Jeffries, & Sandfort, 2008; Dodge et al., 2013; Martinez et al., 2011; Munoz-Laboy, 2008; Munoz-Laboy et al., 2009). Significant health disparities have also been documented specifically among bisexual individuals (relative to both heterosexual and gay/lesbian individuals) not only in terms of psychosocial health issues—such as high levels of depression, anxiety, substance use, violence victimization, suicidality, and lower health-related quality of life ratings—but also specific sexual health-related concerns, including disproportionate rates of unprotected sex, higher number of sexual partners, frequent use of emergency contraception and pregnancy termination (Conron, Mimiaga, & Landers, 2010; Dodge et al., 2012, 2016; Dodge & Sandfort, 2007; Fredriksen-Goldsen, Kim, Barkan, Balsam, & Mincer, 2010; Friedman et al., 2011, 2014; Goodenow, Netherland, & Szalacha, 2002; Herrick, Kuhns, Kinsky, Johnson, & Garofalo, 2013; Kerr, Ding, & Thompson, 2013; Levin, Koopman, Aral, Holmes, & Foxman, 2009; Matthews et al., 2013; Pathela & Schillinger, 2010; Tornello et al., 2014; Walters, Chen, & Breiding, 2013).

Study Aims

Although previous studies illustrate that many bisexual men and women desire children and actively work toward achieving family goals, little is known about the circumstances under which they decide whether or when to parent. Additionally, the factors that influence bisexual individuals' decisions about timing of parenthood or how to achieve parenting goals have been under researched and this has potential implications for bisexual health. This dearth of research contributes to a lack of resources for clinicians and bisexual parents themselves. Exploring bisexual individuals' motivations to parent and paths to parenthood provides a more comprehensive understanding of parenting issues among diverse populations and may assist in identifying the specific concerns and needs of bisexual parents. This study aimed to answer the question: What are bisexual individuals' motivations and intentions for having (or not) children (including contraception use, timing, among others) and how are these reflected in their personal experiences and paths to parenthood?

This exploratory study sought to examine contextual factors related to parenting intentions using a multifaceted framework that not only seeks to understand the intendedness of pregnancy, but to also explore the multi-level factors that influence desired timing for and motivations to parent. Social–ecological approaches to understanding parenting motivations may benefit from qualitative research methods, as they allow for greater depth of understanding of individual's preferences (Dunlop, Logue, Miranda, & Narayan, 2010). Qualitative approaches assist with deeper understanding of the contexts in which individuals decide to become pregnant or parent, as intendedness of a pregnancy is highly correlated with positive mental and physical health outcomes for parents and children (Gipson, Koenig, & Hindin, 2008), and ambivalence about pregnancy is correlated with higher rates of contraceptive misuse and unintended pregnancy (Bartz, Shew, Ofner, & Fortenberry, 2007; Zabin, 1999).

Method

Participants

We conducted 34 in-depth interviews, via telephone, in order to reach parents who self-identified as bisexual across the U.S. Our final sample included 33 participants as one participant reported recently moving to the U.S. Participants were eligible if they were at least 18 years of age, self-identify as "bisexual," a parent of at least one child (genetic, step-, partner's children, adopted, foster children, guardian, and/or ward of the state), had phone or computer access, and were currently living in the U.S. For the purposes of this study, we focus on self-identified bisexual identity rather than "bisexual behavior" (i.e., having partners of different genders in a specified time period) as many bisexually identified parents may not be engaging in recent bisexual behavior; in addition, this focus allows us to examine the impact of bisexual identity on parenting. Due to the exploratory nature of this study, we included a diversity of pathways to parenthood in order to examine differences based on these. Participants were recruited via a range of LGBT—or parenting-focused social media groups (e.g., Facebook, Reddit, Twitter), word of mouth, and participant referral. Potential participants completed a demographic screening questionnaire in Qualtrics, and, if eligible, a research team member contacted them via email in order to schedule the interview. Participants selected their own pseudonyms, and repeat names were changed in spelling to differentiate. Participants received a $50 Visa gift card by mail or a $50 electronic Amazon gift card by email.

Measures

Interviewers were trained in standard qualitative interviewing techniques and had extensive experience working with diverse sexual and gender minority individuals and communities. Interview domains included *gender and sexuality* (including sexual and gender identities, sexual behaviors, contraception, and consent), *communication* (including communication about sexuality in participants' family of origin, topic areas of sexuality communication with children, ideals and memories of sexuality communication with their own children), and *parenting intentions* (reproductive life plans, parenting ideals, and contraception use). Each interview lasted approximately 60–90 min. After conducting the first three interviews, we refined the interview guide for flow and wording. Interviews were digitally recorded. Trained research assistants transcribed each audio file verbatim and deleted all potentially identifying information during this process. We used descriptive coding to categorize participants' demographic information; followed by topical coding to identify themes (Saldaña, 2016). Study team members created a preliminary codebook based on the interview guide (using a direct approach from the literature and the guide, see Higgins & Hirsch, [2008]), which was then augmented in initial analyses (using an open coding approach through axial coding) (Corbin & Strauss, 2008). Three coders established reliability using Dedoose online qualitative software (Dedoose, n.d.). At least two of the three coders analyzed each interview. We compared resulting themes based on participants' gender, age, and relationship to child. All study protocols were approved by the Institutional Review Board of Indiana University, Bloomington.

Results

We sought to interview equivalent numbers of male and female bisexual participants, with a smaller number of gender non-binary individuals, in order to examine possible influences of gen-

der in the parenting intentions and contraception (see Table 1 for participant demographics, including pseudonyms that we refer to throughout the paper). We aimed for balanced numbers of participants' age, both over and under 40 years of age. The average age for men was 43.5 years, for women was 37.6 years, and for gender non-binary individuals was 49.6 years.

The majority of participants were married to a different gender partner ($n = 21$) with an additional two in committed relationships; most of these partnerships were monogamous ($n = 13$). None of the participants were in committed relationships with partners of the same gender when their child was born. Only 12 participants reported that they were not in the same relationship as when they became parents of at least one of their children (e.g., their partner when they adopted a child or the other genetic parent). Participants reported having between one and six children who were related genetically, adopted, stepchildren, or their partners' children. Five participants used ART or adopted children, and an additional four participants considered using these methods to have children (Table 2).

Females over the age of 35 years have been considered advanced maternal age and at higher risk for health complications (Hansen, 1986), but technology has greatly improved outcomes (Jacobsson, Ladfors, & Milsom, 2004); advanced paternal age has been linked to some negative outcomes for the child as well (Bray, Gunnell, & Davey Smith, 2006). When they had their first child, 15.1% ($n = 5$) of participants were 36 years or older, including only one woman and the remainder were men. With their most recent child, 32% ($n = 6$) of those with more than one child were over 36 years of age. Age of children is tied to parental age of conception, and children's age may affect perceptions of past intention (based on recency of an unintended pregnancy or not) and future parenting intentions. In our sample, women had younger children (47%, $n = 7$) of women had a child under eight years of age compared to 27% ($n = 4$) of men and none ($n = 0$) of gender non-binary individuals. More men had adult children (40%, $n = 6$) of men compared to 20% ($n = 3$) of women and 67% of gender non-binary individuals ($n = 2$).

Intended Family-Building

Intended pregnancies included those that involved reproductive life plans, unassisted pregnancy, and pregnancy that utilized ART. Twenty-two participants reported at least one intentional pregnancy, each of these participants was either in a different gender relationship ($n = 21$) or was unpartnered and utilized ART ($n = 1$). Participants reported multiple motivations for having children when they did (or did not), including appropriate age, successful careers, stable relationships, and financial stability.

Individual Factors

Many factors influenced the decision to avoid the possibility of having subsequent children including health concerns, including reproductive health as well as general health issues. While these are not specific to bisexual individuals, it is noteworthy that bisexual parents prioritized these common factors. Age of the participant and/or their partner was a common reason for not having more children, either due to health or not wanting to raise a child later in life. Health issues were important beyond only age concerns; Jamie struggled with ovarian cysts and endometriosis, and referred to her child as a "miracle child." Jana was concerned with prevention of genetic health conditions in her children. John, who identifies as genderqueer, had started taking hormone replacement therapy in his gender transitioning and felt that this would likely reduce his fertility. Taylor felt she should not have more children for her mental health; she stayed at home with her three children, including two with special needs. "I do have major baby fever but I'm trying to stop myself because it's a bad idea, I'm overwhelmed as it is" (Taylor).

Although pregnancies were often planned, the process was not always smooth. Infertility was a problem for a few participants ($n = 4$). Gwen, after having infertility issues with her partner, discussed her top priority was adopting a healthy baby. She described doubts as to whether the birth parents were going to back out of the planned adoption. Max and Philippe both were looking into adoption when their partners became pregnant. "We got to the point that we were just dying to have children, it was either we were going to adopt a child or have a child but we needed a child by the end of the year" (Philippe).

Gender of children was occasionally a factor in participants' reproductive decisions. Mariah wanted more children because she was an only child and did not want that experience for her children, but she also wanted to have a daughter. Adam wanted to have a boy to carry on the family name. Participants commonly spoke about their ideal child's gender (e.g., dreams of having a daughter), but all reported that they were happy with their children. In some cases, they surprised themselves at how they bonded with their child or how much they enjoyed raising a child of a non-preferred gender. "I always thought I was gonna be a mom to a boy. It was a different experience, parenting a daughter. I love having girls. I can't imagine not having daughters now" (Sara).

Interpersonal Factors

The structure of participants' relationships influenced their paths to parenthood and timing of having children. Both of Amy's pregnancies were through insemination because she was not in a partnership with a man during conception (either dating a woman or single), using semen donated by a friend. Derik wanted one or two more children but was waiting for a committed relation-

Table 1 Self-identified bisexual participant ($N = 33$) demographic information

Pseudonym	Age	Gender[a]	No. of children	Method of parenthood	Age range at first child[b]	Age range at most recent child[b]	Race/ethnicity	Region of the U.S.
Mariah	22	Woman	1	Genetic	≤ 20	–	Non-Hispanic Black	South
Taylor	25	Woman	3	Genetic†	≤ 20	21–25	Non-Hispanic White	South
Jane	27	Woman	2	Genetic†	21–25	26–30	Hispanic Black, other	South
Kelly	28	Woman	1	Genetic†	≤ 20	–	Non-Hispanic White	Midwest
Shai	31	Woman	1**	Genetic†	26–30	–	Non-Hispanic White	Northeast
Anna	32	Woman	2	Genetic†	21–25	21–25	Non-Hispanic White	Northeast
Sara	36	Woman	4	Genetic†	21–25	26–30	Non-Hispanic White	South
Ann	36	Woman	2*	Genetic	26–30	26–30	Non-Hispanic White	West
Jamie	37	Woman	1	Genetic	21–25	–	Non-Hispanic White, Native	Midwest
Gwen	40	Woman	1**	Adopted†	31–36	–	Non-Hispanic White	Pacific Northwest
Amy	41	Woman	2**	Genetic	26–30	≥ 37	Non-Hispanic, Black, White	Northeast
Dana	43	Woman	2	Genetic	31–36	31–36	Non-Hispanic White	West
Elizabeth	44	Woman	3	Genetic†	26–30	31–36	Non-Hispanic White	Midwest
Jana	58	Woman	1	Genetic	26–30	–	Non-Hispanic White	West
Lynn	64	Woman	3	Genetic†	≤ 20	≥ 37	Non-Hispanic White	Midwest
Tom	29	Man	2	Genetic†	21–25	26–30	Non-Hispanic White	West
Adam	34	Man	2	Genetic	≤ 20	26–30	Non-Hispanic White, Black	South
Frank	36	Man	1*	Genetic†	≤ 20		Non-Hispanic White	Midwest
Anthony	37	Man	2	Genetic†	21–25	31–36	Non-Hispanic White	West
David	37	Man	1	Genetic	31–36	–	Non-Hispanic White	Northeast
Derik	37	Man	1	Genetic	21–25	–	Non-Hispanic Black	West
Max	41	Man	3**	Genetic†	31–36	≥ 37	Non-Hispanic White	Midwest
Timothy	44	Man	6*	Genetic, step-, partner's children†	21–25	31–36	Hispanic White	Pacific
Franque	44	Man	1	Genetic†	≥37	–	Non-Hispanic White	Pacific
Mike	46	Man	1	Genetic	21–25	31–36	Non-Hispanic White	Midwest
Boris	47	Man	1*	Genetic†	26–30	–	Non-Hispanic White	Midwest
Jon	50	Man	1	Genetic†	26–30	–	Non-Hispanic White	West
Philippe	53	Man	2**	Genetic†	≥ 37	≥ 37	Non-Hispanic White	Midwest
Al	53	Man	4	Genetic†	26–30	≥ 37	Non-Hispanic White	South
Carl	65	Man	2	Genetic†	≥ 37	≥ 37	Non-Hispanic White	Northeast
V	38	Genderqueer	1	Genetic	21–25	–	Non-Hispanic White, Native	Midwest
John	53	Genderqueer	2	Genetic†	31–36	≥ 37	Non-Hispanic White	Northeast
Lynette	58	Gender non-conforming	5	Genetic, stepchildren	≤ 20	26–30	Non-Hispanic White	Pacific Northwest

* Considered using assisted reproductive technology (e.g., in vitro fertilization) or adoption

** Utilized assisted reproductive technology (e.g., in vitro fertilization) or adoption

[a] "Woman" and "man" both refer to cisgender individuals in which their assigned sex at birth matches their gender identity

[b] Age ranges are calculated based on children's ages, stepchildren are excluded from analyses due to lack of information about initiation of parenting relationship

† In a relationship with the same partner as when they became a parent of at least one of their children (e.g., conceived the child with that partner, adopted a child while in a relationship with that partner)

Table 2 Themes and sub-themes reported by participants in response to interview questions

Themes	Sub-themes	Sample interview questions
Intentions	Assisted reproductive technology (ART)	Tell me about the moment that you realized that you were going to have a child for the first time?
	Infertility	
	Motivation for having children	
	Motivation for not having children	Can you tell me about the process of having children for you?
	Preferred child gender	
Contraception	Contraceptive types	Would you like to have more children? What factors shape that decision?
	Failed contraceptive	
	Sterilization	
	Deception	
Unintended	Semi-planned	Are you actively trying to avoid pregnancy?
	Not planned	
	Stress with unintended pregnancy	How does your partner feel about having more children?
	Abortion and miscarriage	(Not specifically probed)

ship, "I want to get married, that's kind of been what I'm looking for, so just finding the right woman" (Derik). Marriage was closely tied to having children for other participants. "We assumed… that as a married couple, we would have at least one child" (Franque).

Ideal family size was sometimes discussed as the motivation for having children, but also for not having more children. Unlike ideals of their children's gender, the number of children was often negotiated with a partner. "Until we had them, we didn't [know three was the right number]. We thought, 'We don't wanna rush into this. We don't want to have that regret.' But as soon as the third was born, we looked at each other and we knew it was perfect to us" (Max). These intentions sometimes started long before participants entered a partnership; "I felt like I'd spent most of my adult life trying to prepare to be a parent, because I always wanted to" (Carl). Participants' negotiated their individual family size ideals with those of their partner. Al and his partner originally planned to have two children, but after an unintentional third pregnancy his wife wanted to have an even number of four children. Jane and her partner both wanted two children, and they accounted for both concerns with the cost of children and her husband's age.

> My husband is older than me, and he didn't want to be an "old dad," he wanted two kids. I only wanted two kids for financial reasons. So we thought, "Our son is going to be one, so we should try and get pregnant again as soon as possible so we can have our other one and get it over with" (Jane).

Though some participants had previous ideals, Sara's goals were shaped by the realities of having infants. "You get to a point where you enjoy having kids versus babies. Babies are a lot of work, but kids are people. I enjoy the people they're becoming" (Sara).

Financial concerns were important in considering ideal family size, as Jane discussed. Shai had one child but planned to have a second because she had dreams of a larger family, in spite of numerous challenges (their apartment in an expensive city was small, health concerns with her aging partner, financial and emotional stress of another child, her lack of desire to be pregnant and raise a baby). Frank and his wife spent a year getting their finances in order before attempting to become pregnant.

Preventing Pregnancies

While parenting was important to many participants, most did not want to constantly have children or continuously be new parents. Contraception methods varied across participants (including intrauterine devices, condoms, subdermal implants, fertility charting, vaginal rings, and cervical caps), with the majority using sterilization to prevent future pregnancies ($n = 13$). One of the other more common long-term methods for participants or their partners was an intrauterine device (IUD) ($n = 4$). Mariah was uncomfortable with the idea of the IUD, so she had a subdermal implant in her arm (e.g., Implanon); her use of contraception was a means to having time to reflect on her bisexuality without the stress of an infant. Shai used fertility charting in order to get pregnant and used withdrawal to avoid it otherwise. These methods did not further impede sexual intercourse (e.g., through stopping to put on a condom), as her sex life was limited due to raising an infant in a small one-bedroom apartment.

Inconsistent or incorrect usage of contraception contributed to some unintended pregnancies. A few participants became pregnant while practicing lactation amenorrhea (i.e., breastfeeding that prevents menstruation) ($n = 3$). Ann had unintended pregnancies from inconsistent pill usage and another when she was using lactation to prevent pregnancy, but a gap in lactation led to an unintended pregnancy. Following her second pregnancy, she and her partner at the time decided a

vasectomy was the best plan to prevent subsequent pregnancies. Lactational amenorrhea also failed for Elizabeth; her pregnancy occurred due to her irregular menstrual cycles during lactation. While Sara did not use lactation alone, she did use it in conjunction with the pill. She described her pregnancy as, "a complete surprise…I had been taking the mini-pills so I was taking a birth control that was compatible with breast feeding but that failed. We were using birth control but we weren't using condoms or anything" (Sara).

Sterilization was a common method for participants ($n = 13$) who had decided their family had reached either an ideal size or the maximum number of children they were willing to have, and for some people this was not simply a parenting decision. Some participants underwent tubal ligation procedures ($n = 3$), either for health reasons or to prevent future pregnancies. Jamie was the only participant to report having a hysterectomy; she had initially not wanted to have a child but reported that having a child made her more intentional about role modeling, particularly in how to discuss sexuality and gender with her child. Vasectomy was a common method of birth control ($n = 10$) for those who knew they did not want to have more children, usually related to the participant's or their partner's health issues. Participants with vasectomies often described the conversations they had with their partner about that decision. Boris had a vasectomy because of his wife's prior pregnancy experience. "It was a very difficult pregnancy for [my wife]. She said, 'I don't ever want to do this again.'… She said if we change our mind, we'll adopt" (Boris). Similarly, Kelly's partner had a vasectomy because Kelly had adverse reactions to many of the forms of contraception she used. Timothy discussed the potential failure of his vasectomy with his partner.

> [My partner is] 28, she's in that phase of life where her friends are having babies. When she sees a baby she gets that "I want to have a baby thing" going on. So we discuss it, and I just try to be open to that for her because again, she knew going in that I wasn't going to be able to give her any. We've had really serious conversations about what happens if the vasectomy fails…It's not my preference, it's not what I was planning on, but it would just be something that happened (Timothy).

Poor partner communication and partners' deception regarding contraception also led to problems with pregnancy prevention among some bisexual parents ($n = 5$); "We usually used a condom and she was on birth control for a while. I guess she got off and she got pregnant as soon as she stopped her birth control" (Adam). Mike was unsure of whether the birth control failed or if his partner discontinued its use. "The birth control either didn't work, or I don't know if she wasn't taking it or what, so I was not expecting it." In some instances ($n = 3$), communication was more manipulative and participants discussed having children as a result of partner's deception. "She told me she was on birth control and she wasn't. This wasn't expected and I thought we were taking the appropriate precautions…I thought we had communicated about these things, and we hadn't" (Derik). David was having a relationship with a married woman who told him she had was using an IUD; later, she said that she purposely got pregnant by David in order to prevent him from leaving her. V described their partner making them believe he was putting a condom on and later admitting that he had not, this was particularly distressful as they had not wanted to be a parent. V further reported they thought perhaps their partner had done it to spite them for being bisexual. After engaging in sexual activity, Taylor found out her partner was breaking condoms on purpose.

Planning Pregnancies

Semi-planned Pregnancies

Some participants did not always plan the exact moment for pregnancy, but talked with their partner about having a child ($n = 5$), what Anna describes as "semi-planned." These pregnancies often coincided with a change in contraceptive practices, such as not taking birth control pills. "My wife and I had talked about it, we hadn't specifically said okay let's do it. But at that point it was if it happens, it happens, and we'll be fine with that" (Tom). After trying unsuccessfully, Jon and his partner were no longer actively planning to get pregnant. Dana's partner wanted two children and they both wanted the children close together in age. "We just decided that after my older daughter was born that we weren't going to try not to, and see what happens" (Dana). Timothy had a unique situation in which he found out he had a daughter when she was already a teenager. "That was pretty intense. It was simultaneously a feeling of having been let down and having been ineffective as a parent. Because the first thought that I had was she's had 14 years of her life and I have not been in it" (Timothy).

Unplanned Pregnancies

Other participants did not plan having a child at all, with 18 individuals reporting at least one child who was unplanned.

> The day I found out I was pregnant with my son, that was a very crazy day. Actually, I didn't think I was pregnant, because I hadn't gained weight and I didn't have any morning sickness. One night, I went to get Chinese food after work, and I couldn't stand the smell, and I love Chinese food…I went to get the pregnancy test, and it came back positive (Mariah).

Sara's second child was unplanned, but because her first child was 13 months old at the time, the spacing was acceptable. Taylor alludes to how difficult her first pregnancy was in describing her second and third pregnancies. "They were also unplanned but not exactly prevented. It was less of a shock,

less of a surprise, and less of a bad reaction…No thoughts of adoption, no thoughts of abortion, no thoughts of my life is over kind of thing" (Taylor). Lynette describes multiple unintended pregnancies at different stages in their life; these were in part due to various emotional distress she faced.

> The first one wasn't planned because I was 15. The second one I had just left the birth father, and found out a month later I was pregnant. The third one I had already been told I was probably not going to have children, and I had been married for eight years to the father and went through emotional trauma. I was kind of ignoring myself and realized after three months I was pregnant, so yes, they were all a surprise. A welcomed surprise (Lynette).

Jana described her unintended pregnancy, but also her agency in choosing to have the baby. "I didn't plan to have children. [My daughter] was an oops. She was a diaphragm baby, and I was freaked out when I found out I was pregnant, and then I was like, 'If I'm not ready to have a baby now, I don't know when I will be,' because I was 28. So I chose to have her" (Jana).

Unplanned pregnancies caused different amounts of stress among participants due to multiple issues, including financial challenges and relationship status.

> My third daughter was a surprise. [We] decided we were not going to have any more children, because we didn't have the money…So [my wife] was surprised, and with that it was a feeling of just dread. How are we going to handle another pregnancy? Another child? My wife at the time was not working, I was torn for money. I was very stressed out (Timothy).

The security of a committed relationship helped reduce the shock for some participants. "It was accidental. But we were married and it was, it was fine with us, it wasn't like a crisis or anything" (Anthony). Al originally planned for two children but was not stressed about his third pregnancy, which was unplanned, because his wife was staying at home to take care of children. Dana did not have that relationship security, but the idea of being a parent was surprisingly positive for her. "We weren't planning on having one, it was a surprise. My ex and I weren't particularly good at the time. I was really happy about it, which is interesting, because for years prior to that point I didn't think I'd have children at all" (Dana).

Pregnancies Not Carried to Term

Although we did not specifically ask participants about abortion or miscarriage, a few participants ($n = 8$) did discuss their experiences with not carrying pregnancies to term. Participants that reported abortions (their own or their partners') ($n = 2$) did not usually use the word "abortion" but emphasized their choice. Ann worried initially about her partner's reaction but was glad she could exercise her choice.

> We did discuss not completing the pregnancy, but when I told him ultimately that wasn't an option for me—I'm pro-choice, I believe that people should have that option. But as far as my own personal values based on the situation that I was at in that point in time, it wasn't a viable option for me. And he accepted that, he wasn't pushy or anything (Ann).

Participants that experienced miscarriage ($N = 6$) often highlighted the emotional difficulties inherent in miscarriages. "It's amazing how those miscarriages stay with you all your life" (Lynn). Lynn reflected that she was too young to have a child when she had a miscarriage. She wanted to gain more life experience before carrying a pregnancy to term. Philippe's partner, after using in vitro fertilization, had one stillborn baby and another died soon after birth, "It's different to have a child come home and one or two not come home. Because you're happy for your child but you're sad." John reflected on the early stages of his relationship with his partner, "She had had a couple miscarriages; we had chosen not to have kids on a few occasions before we did have a kid."

Some participants ultimately came to terms with miscarriages ($n = 2$), especially when they catalyzed the birth of their subsequent child. Dana had two miscarriages in between her first and second child, and in retrospect feels that if the first pregnancy had been carried to term, her children would have been born too close together.

> The first trimester's when anything and everything can go wrong…So we didn't tell anybody and it was hard to get support when nobody even knew…When I got pregnant the next time, 3 months later, we figured we weren't keeping it a secret. People needed to know. I knew I was pregnant but it was 6–7 weeks along and I miscarried at home. And I did actually miscarry and that's a horrifying experience…They said you need to wait at least 6 months. So I did that. We got pregnant again. I was definitely crazy in the beginning of that pregnancy because I'd been through these miscarriages. Every time there was an ultrasound it was nerve wracking. You don't know until you're there. Miscarriages are really hard to explain (Dana).

Shai had a miscarriage before having her daughter and feels resolved about it. "When I had my daughter, just wow. The only one I want. And I now feel weirdly happy that I had that miscarriage because that means I could have [daughter's name] who—I'm so madly in love with her. So I look back on the miscarriage, I don't feel upset about it at all" (Shai).

Discussion

Although previous parenting research has often collapsed all sexual minority parents (e.g., lesbian, gay, and bisexual) into a monolithic category, the results of our study demonstrate that it is important to examine bisexual individuals separately in terms of their own unique, as well as shared, parenting experiences. Goldberg et al. (2014) pointed out that the majority of LGB families are created through different-sex relationships, as bisexual parents constitute the majority of LGB parents. We saw the same pattern in our participants, with the majority being in different-sex relationships; as such, these individuals will not be captured within literature about "same-sex parents." With the majority of participants raising their children in committed long-term relationships with a partner of a different gender, the influence of the heteronormative model of the family for bisexual individuals may warrant further examination. Furthermore, future research should examine whether bisexual individuals' reproductive goals influence their choice of partner as they near their preferred reproductive age.

Our findings are aligned with a previous study on bisexual parents in Australia in which the majority of participants were parenting children from previous partnerships (Power et al., 2012). However, this simplification alone does not capture the diversity of previous and current partnerships. Participants in our study were co-parenting with previous partners, had various relationship structures, locally and long-distance, and also had part or full custody (some of them for all of their children's lives), and some met their children much later in life (e.g., Timothy, who met his daughter when she was 14 years old).

Several participants experienced fertility difficulties and some adopted or explored adoption. Rates of infertility and infertility treatment for bisexual individuals are unknown, and their experiences have been only superficially included in adoption and infertility literature (e.g., Peel, 2010). However, as eight participants (only one woman) had a child when they were over 36 years of age, this is not unexpected as paternal age is often greater than maternal and more women are giving birth later (Martin et al., 2009). Philippe's experience of planning an adoption while also using fertility treatments is common. Findings from the 2002 Family Growth Survey revealed that 57% of women receiving fertility treatments also considered adoption (Martinez, Chandra, Abma, Jones, & Mosher, 2006). Bisexual individuals' motivations for adoption may be unique from individuals of other sexual identities. Bisexual individuals' perceptions of inclusion in sexual minority communities may also be affected by adoption. For example, bisexual individuals who adopt children may feel more ties with same-sex couples who have adopted because of the prioritization of those with similar parenthood experiences. Among lesbian and bisexual women trying to conceive, the support of others who experienced challenges with conception was more important than support from sexual minority individuals (Yager, Brennan, Steele, Epstein, & Ross, 2010). More research is needed to examine the ways bisexual individuals conceptualize fertility challenges and their unique experiences with adoption.

Participants' reasons for timing of their children resonate with previous research on women including *individual factors* (stable relationship, genetic health factors, declining fertility) and *familial factors* (financial stability, partner readiness) (Benzies et al., 2006); interestingly, however, *societal factors* (social acceptability, divorce rates, policy) were not reported by participants in our study. This may be due in part to a lack of specific interview questions about societal factors influencing timing. Alternatively, bisexual individuals may not feel included in societal-level discussions and this may influence their focusing more on individual and familial levels. In addition, perceptions of male–female bisexual couples as "heterosexual" may preclude them from the rigid social restrictions some adoption agencies place on same-sex couples (Ross & Dobinson, 2013). We did not ask participants about the influence of partner's gender (and implied ability to have a genetic child) on their partner choice. One single participant contradicted this notion by having chosen to utilize ART in an effort to have her children. More representative samples are needed to fully understand the ways bisexual parents become parents. Several participants did have children at an early age; this is consistent with research that shows that teen pregnancy is common among sexual minority adolescents (Tornello et al., 2014).

Our findings do not reflect a simple delineation between unintended and intended pregnancies among bisexual parents. By definition, intendedness of a pregnancy is "only identifiable after the pregnancy has occurred" and as a self-reported measure, is subject to recall bias (Moos et al., 2008, p. S281). Participants in our study described multiple circumstances in which they classified a pregnancy as unintended, yet ultimately felt positively about the experience: unintended pregnancy, miscarriage, and differences in ideal child's gender. Rather than recall bias, these results may indicate reframing on the part of the participants, given changes in circumstances or feelings about the situation. This reframing may be a facet of their resilience (i.e., mobilizing assets and resources to mitigate the risk of external threats (Masten, 1994) as the differences between expected outcomes (having a child) and realities can cause stress. Another resilience strategy may be the language used around choosing to carry a pregnancy to term or not. Participants used euphemisms that emphasized choice in relation to abortion; this may be a strategy to focus on the participant's (or the participant's partners') agency in the situation. Alternately, it may be due to the negative stigma associated with abortion (Cockrill & Nack, 2013; Kumar, Hessini, & Mitchell, 2009). Lynette, V, and Jamie described their pregnancies as unintended and stressful in part due to emotional distress faced at the time; this additional emotional distress could be linked or com-

pounded by the stress of being bisexual (e.g., experiencing biphobia from a relationship partner, unstable housing situations from possible parental rejection). Research is needed to examine how bisexual identity influences responses to potentially traumatic events, such as unintended pregnancy.

As several participants in our study were or had been ambivalent about pregnancy, this echoes research that nearly a quarter of women were "okay either way" in getting pregnant or not (McQuillan, Greil, & Shreffler, 2011). Most participants who identified as men in our study used "we" when discussing ambivalence to highlight that both partners felt the same. Men's potential pregnancy ambivalence may also be explored in future research. Research on unintended pregnancy outcomes classifies births as "mistimed" (not intended at that time) or "unwanted" (not intended at any time) (Shah et al., 2011), and ambiguity may be situated somewhere between these categories. This ambiguity toward pregnancy and parenting may also reflect acute changes in the goals, priorities, and contexts that influence one's desire for children among bisexual parents, as with any other parents. In previous research on younger heterosexual adults, the majority surveyed indicated ambiguous feelings toward having children, specifying that although they did not currently want children, 53% of men and 52% of women would like to be parents now "if things in their life were different" (Kaye, Suellentrop, & Sloup, 2009).

Poor communication and deception around contraception has implications for unintended pregnancy and sexually transmitted infection prevention, as well as relationship quality and mental health. We observed some discrepancies in knowledge about contraception, such as pregnancies while using the lactation amenorrhea method (Van der Wijden, Brown, & Kleijnen, 2003). This may be caused by misinformation or misunderstandings from providers or general knowledge about birth control. Partner communication is linked to consistent and correct use of contraceptives (Campo, Askelson, Spies, & Losch, 2012; Davies et al., 2006), but men are not often included in the process of selecting and using contraceptives beyond condoms (Johnson & Williams, 2005). Reproductive coercion has been narrowly defined as "birth control sabotage and coercion by male partners to become pregnant and to control the outcome of a pregnancy" (Miller et al., 2014, p. 122); it is often discussed in the context of heterosexual intimate partner violence (e.g., Clark, Allen, Goyal, Raker, & Gottlieb, 2014; Miller, Jordan, Levenson, & Silverman, 2010). Participants in our study, male and female, reported incidences of partner's deception around contraception. Broadening the discussion around "reproductive coercion" to also include a lack of honesty or direct communication among male and female partners may inform education and interventions focused on consent, as well as intimate partner violence. As men and women reported their partners' deception of contraception use, it is important to include women in examining deception around contraception. At least one participant thought their partner's contraception deception may have been connected to their bisexuality. This important link was not something we probed and could benefit from further research to discover if this is a theme.

Strengths and Limitations

Telephone interviews enabled a diverse sample across the U.S. and reduced the burden on participants, as many were taking care of young children even during the course of interviews. The anonymity of telephone interviews may have increased participants' comfort, but also may have reduced the rapport between interviewer and participant. Allowing participants to express preferred gender of interviewer and choose their pseudonym for the study was intended to increase participants' comfort in the interview. The participants in this study were diverse in age, number of children, geographical location in the U.S., as well as their experiences with parenting and reproductive technology. This study included only a small number of non-binary gender-identified individuals, in order to understand their unique experiences. Future research would benefit from exploring parenting experiences among transgender, genderqueer, and others who may not identify as male or female, in general, including those who self-identify as bisexual. While some researchers perhaps have not included parents of non-binary identities in the limited number of studies on sexual minority parents, due to the assumption that the number of people who would report these identities is too low, it may also be the case that we simply have not afforded individuals the option to report such identities consistently in research.

This study examines parenting intentions using cross-sectional data collection and does not include lifetime changes in ideal family size. Iacovou and Tavares (2011) argue for dynamism in childbearing intentions over time, due to the delay between formation and realization of intentions. Future research may also examine parenting and reproductive life plans of bisexual individuals longitudinally. Furthermore, some participants' children arrived many years ago and recalling their parenting intentions may have been problematic. Using Dedoose software for the organization and analysis of data, as well as multiple coders and a codebook, increased the validity of our results.

Conclusion

Participants in our study became parents through a variety of pathways that are not fully captured in binary conceptualizations of *unintended* versus *intended*. Their intentions for parenting, and the factors that they consider, may be similar to parents of other sexual identities. Some participants' reframing of miscarriage and unintentional pregnancies as not wholly negative may be a resiliency strategy to mitigate the impact of an adverse experience. Common contraception methods included sterilization or a long-acting reversible contraception method (e.g., an intrauterine device). Partners' deception around contra-

ception was stressful, and more research is needed to document the prevalence of this experience for male and female bisexual parents. The diverse ways bisexual parents conceptualized their reproductive life plans have implications for all parents, regardless of sexual identity. Future research should further examine bisexual parents' experiences in order to better address their specific concerns and needs. A nationally representative study would be particularly helpful to draw further wide-ranging conclusions about bisexual parents' experiences.

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Compliance with Ethical Standards

Conflict of interest All authors declare that they have no conflict of interest.

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Ethical Approval All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Informed Consent Informed consent was obtained from all individual participants included in the study.

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