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To help celebrate Pride Month, we are delighted to share the chapter, "Chestfeeding and Lactation Care for LGBTQI+ Families" (authors: Casey Rosen-Carole and Katherine Blumoff Greenberg) from the recently published 9th edition of Breastfeeding: A Guide for the Medical Profession; Ruth A. Lawrence & Robert M. Lawrence, editors.

Please feel free to share this chapter with colleagues and friends.

Please also note that this is a corrected version of the original chapter. In the originally printed chapter, a subsection was incorrectly labeled "Transwomen (A Female at Birth, Affirmed Male)," when the proper language should be (and now is) "Transwomen: Assigned Male at Birth, Affirmed Female."

The authors recognize that language has been used historically to segregate and harm LGBTQI+ persons; conversely, affirming language reflects an important change in practice to limit harm, increase access and improve care for this population. As leaders in the field of health publishing, the authors affirm their commitment to inclusive and bias-free care for all people. The publisher would like to thank the authors for their time and thoughtful intention and appreciate their partnership in alerting the publisher to make the necessary corrections.

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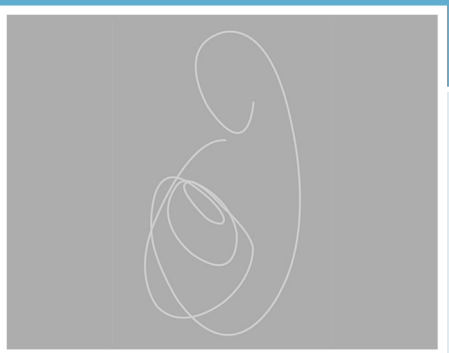

Chestfeeding and Lactation Care for LGBTQ + Families (Lesbian, Gay, Bisexual, Transgender, Queer, Plus)

Casey Rosen-Carole and Katherine Blumoff Greenberg

KEY POINTS

- LGBTQ + families may have unique experiences in providing human milk for their infants.
- LGBTQ + individuals may face particular barriers related to their ability to provide human milk for their infants related to discriminatory policies, restricted donor milk regulations, or anatomic/functional limitations.
- Appropriate care for LGBTQ + families includes the use of both respectful and affirming language and background knowledge of the physiologic impacts of any past or current treatments on milk production.
- As with all families, lactation providers should be careful to provide appropriate information, while not making assumptions or judging parental decisions.

Social science evidence clearly shows that the children of LGBTQ + families thrive on par with children living in different-sex families.[1] Assessments of well-being span cognitive and psychological development, mental health, and adolescent risk-taking behavior, among others.[2] In the United States, where there exist policies related to nondiscrimination, 35% of US LGBTQ + families have children.[3] Internationally, many countries have LGBTQ + -inclusive social norms and policies; however, there are still countries where "homosexual activity" continues to be illegal[4] and many others where same-sex couple adoption is highly restricted. LGBTQ + couples in these countries may have significantly less access to family building opportunities. Box 20.1 lists organizations that provide guidance and information on gender-affirming care.

Family development in LGBTQ + couples may take many forms and can include adoption and assisted reproductive technologies. The infant children of LGBTQ + families may be at risk for health disparities from birth in the form of reduced access to human milk.[5] Children raised in LGBTQ + families thrive on par with children raised in heterosexual, cisgender families.[2,6] However, given the range of anatomy and fertility that may exist within LGBTQ + families, they may be unable to offer a parent's human milk to their children. Because current donor milk policies prioritize medically high-risk infants, babies in LGBTQ + families may also lack access to donor milk (see Chapter 22 for information on expanding donor milk availability). It is therefore critical for providers to both understand how to support and counsel families about their options with respect to lactation and to compassionately approach any constraints they may face.

Providers should not assume that all parents will desire to lactate because they have the anatomy or hormones to do so.

BOX 20.1 Groups and Organizations That Support Gender-Affirming Care

- *Equaldex:* The Collaborative LGBT Rights Knowledge Base. Includes maps and lists of laws applying to LGBT persons around the world. Access at: http://www.equaldex.com.
- *Transcend Legal:* Medical organization statements. List of medical and nursing groups along with their statements of nondiscrimination and the promotion of safe and affirming care for gender nonconforming patients. Access at: https://transcendlegal.org/medical-organization-statements.
- *World Professional Association for Transgender Health:* International, interdisciplinary, professional association devoted to understanding and treatment of gender identity disorders. Access at: http://www.wpath.org.
- *UCSF Transgender Care.* Website for the Transgender Care Clinic at University of California San Francisco. Includes evidence, terminology, environment guidance and clinical guidance for appropriate care. Access at: https://transcare.ucsf.edu/.
- *National LGBT Health Education Center.* A program of the Fenway Institute. Their mission is to advance health equity for LGBTQIA + people, address and eliminate health disparities, and optimize access to cost-effective health care for the LGBTQIA + community. They provide distance learning, videos, and printed educational health materials. Access at: https://www.lgbthealtheducation.org/publication/lgbt-glossary/.

As with any family, human milk feeding may not be a parental goal; in LGBTQ + families, specifically, parents may be taking turns gestating, birthing, and lactating or may have histories of medical treatment that will make lactating, breastfeeding, or chestfeeding uncomfortable or impossible. As with all families, lactation providers should be careful to provide appropriate information while not making assumptions or judging parental decisions.[5,7,8,9]

The Academy of Breastfeeding Medicine (ABM) has a protocol for the care of lactating patients who identify as LGBTQ + , which is available on their website.[10] To best care for patients, it is important to understand some basic terminology used within the LGBTQ + community. Box 20.2 is a list of definitions helpful in this context.

CREATING A RESPECTFUL HEALTH CARE ENVIRONMENT

There are many opportunities for health care systems, hospitals, and clinics to provide affirming care to LGBTQ + individuals. Increasing the amount of LGTBQ + training for health care providers and building inclusive systems and documentation can minimize provider and staff mistakes surrounding an individual's gender or sexual orientation. Examples of inclusive practices include updated intake forms with more options for affirmed gender, affirmed pronouns, and partnership status; single-stall, all-gender restrooms; and gestation and lactation spaces that include all parents, not just those identified as mothers. Coupling training and inclusive practices with displaying signs or statements of inclusivity is a subtle but impactful way to welcome individuals with diverse genders, sexual orientations, and families.[11,12] Patient confidentiality is another cornerstone to LGBTQ + care, because many patients may not be "out" to all of their health care providers,[13] and even a patient's family and friends may not be aware of the patient's gender identity and/or sexual orientation. This information is privileged within provider-patient relationships, and it is critical that providers ask patients about when, how, and why they might disclose their gender and sexuality. Although not a comprehensive list, other considerations include the following:

- An individual's appearance may not match gender identity. Do not assume that a female-appearing individual identifies as female or is interested in breast/chestfeeding.[14]
- Ensure that people are addressed by their affirmed names and pronouns. To know the patient's preference, one needs to ask. For example: "I'd like to address you respectfully, what name and pronouns should I use?"
- Names and pronouns are but one aspect of a parent's experience, and patients may also use different terms for parenting (mom/mama/mum, dad/father, parent, etc.) and lactation (chestfeeding, lactation, breastfeeding, etc.). We recommend ensuring that patients have the opportunity to identify at the beginning of a patient care visit which words they would like to use.
- Calling a patient by a name, pronoun, or parenting term other than the patient's affirmed name/pronoun, is generally referred to as *misgendering* and is hurtful to the patient. If intentional, misgendering damages the patient–provider relationship; if unintentional, it is an opportunity for providers to acknowledge the mistake, correct it, and continue with the visit using affirming language.[15] Acknowledging the mistake and apologizing is key, but prolonged attention on the mistake may take the focus off of providing appropriate and affirming health care.

PHYSIOLOGY OF LACTATION IN SPECIAL CIRCUMSTANCES

Because of the development of mammary tissue and its hormone responsiveness in critical windows, timing of gender-affirming treatments or practices (e.g., chest binding) may or may not affect the ability to lactate. Following are some examples of hormonal treatments, surgeries, and practices and how they may affect lactation. Because of a dearth of clinical studies on LGBTQ + human milk feeding, many of these effects are theoretical.

Transmen (Assigned Female at Birth, Affirmed Male)

Chest Binding

Transmen may have bound their mammary tissue with tight clothes or special binders during or after puberty. Though this is unlikely to affect the hormonal axis, it may lead to compression atrophy of the mammary tissue. Studies on breast augmentation show that over time, compression of the mammary tissue can lead to atrophy.[16] Chest binding may provide more, or less, pressure than implants for augmentation, and the distribution is likely to be different. Nevertheless, if a person binds mammary tissue and then desires to lactate, the tissue may be less able to generate a milk supply.

Masculinizing Chest Surgery (Also Known as "Top" Surgery)

Transmen may have undergone surgery of the mammary tissue. This surgery is different from a mastectomy, in that not all breast tissue is removed. Rather, the goal is to create a male-appearing chest contour. It is therefore possible that lactating mammary tissue remains. Depending on surgical technique, the nipple may or may not be fully removed during the procedure. If a nipple is fully removed, reanastomosis of the ducts may be anecdotally reported but is likely uncommon. Pregnant patients who have had this type of surgery should be counseled on engorgement management and pain relief in the postpartum period. If the nipple and areola remain attached to a pedicle of mammary tissue during surgery, ductal structures may be less damaged, and it may be easier to lactate. Studies on breast reduction have shown that preservation of the subareolar mammary parenchyma results in the highest rates of successful breastfeeding.[20] These approaches

BOX 20.2 Definitions Related to LGBTQ+ Health[10]

Definitions: Several sources have defined terms related to LGBTQ+ health. Here, we reference the University of California San Francisco Transgender Care & Treatment Guidelines[17] and the National LGBT Health Education Center's glossary of terms.[18] However, it is important to note that terminology is fluid and community-specific. In countries speaking languages other than English, these terms may have adaptations or may be irrelevant entirely. Consulting with members of LGBTQ+ advocacy communities in such areas, where possible, may be helpful to ensure that language is respectful and inclusive.

- *LGTBQ+:* A term for people who identify as lesbian (L), gay (G), bisexual (B), transgender (T), queer (Q) or questioning (Q) and people with other diversities in sexual orientation and gender identity (+). There are a variety of these terms internationally with their own acronyms. This term is meant to be inclusive.
  - ***Lesbian*** (adj., noun): A sexual orientation that describes a woman who is emotionally and sexually attracted to other women.
  - ***Gay*** (adj.): A sexual orientation that describes a person who is emotionally and sexually attracted to people of their own gender. It can be used regardless of gender identity, but is more commonly used to describe men.
  - ***Bisexual*** (adj.): A sexual orientation that describes a person who is emotionally and sexually attracted to people of their own gender and people of other genders.
  - ***Transgender*** (adj.): Describes a person whose gender identity and assigned sex at birth do not correspond. Also used as an umbrella term to include gender identities outside of male and female. Sometimes abbreviated as trans.
  - ***Queer*** (adj.): An umbrella term used by some to describe people whose sexual orientation or gender identity are outside of societal norms. Some people view the term queer as more fluid and inclusive than traditional categories for sexual orientation and gender identity. Because of its history as a derogatory term, the term queer is not embraced or used by all members of the LGBT community.
  - ***Questioning*** (adj.): Describes individuals who are unsure about or are exploring their own sexual orientation and/or gender identity.
  - ***"+"/Plus:*** The plus sign represents the ever-growing list of terms people use to describe their sexual orientation or gender identity. There are many different variations of the LGBTQ+ acronym, and the "+" acknowledges that it is not possible to list every term people currently use.
- ***Affirming care:*** Refers to care that supports a patient's gender identity and must include inclusive terminology, practices, insurance coverage, and knowledgeable providers.
- ***Affirmed pronouns and name:*** Pronouns and name that are chosen by the individual and therefore best represent the person's gender identity. People in the LGBTQ+ community may have changed their name and gender, informally or legally, to those that affirm their true gender identity.
- ***Assigned Female at Birth, Assigned Male at Birth:*** These terms refer to gender assignment at birth medically and socially, generally based on genital anatomy. These terms may be abbreviated (AFAB, AMAB) to communicate birth anatomy in medical documentation.
- ***Cisgender:*** Someone whose gender identity aligns with the gender assigned to them at birth. For example, someone who was assigned female at birth who identifies as a woman.
- ***Chestfeeding:*** A term used by many masculine-identified trans people to describe the act of feeding their baby from their chest, regardless of whether they have had chest/top surgery (to alter or remove mammary tissue).[19]
- ***Co-lactation:*** When more than one parent breastfeeds/chestfeeds their child.
- ***Gender-affirming surgery:*** Surgeries specific to transgender people include feminizing and masculinizing procedures that align secondary sexual characteristics with a person's gender identity. These may include facial, voice, genital, and hair removal/addition procedures.
- ***Gender-expansive, genderqueer, nonbinary:*** All different terms for a broad category of gender identities in which the individual identifies outside of a binary concept of gender (binary meaning "male" and "female"). This can mean identifying as both feminine and masculine or as neither.
- ***Gender identity:*** Persons' innate sense of their own gender. It does not necessarily correspond to anatomy, sex assigned at birth, or how someone expresses self. Examples include but are not limited to cis woman, cis man, trans man, trans woman, nonbinary, gender expansive, and gender fluid. Not the same as sexual orientation (see later).
- ***Gender incongruence, formerly "gender dysphoria" or "gender identity disorder":*** Incongruence between an individual's experienced or expressed gender and assigned sex.* Dysphoria refers particularly to suffering as a consequence of this incongruence.
- ***Heteronormative/cisnormative:*** The assumption and/or preference of individuals and institutions that everyone is heterosexual and cisgender. This leads to invisibility and stigmatization of people in the LGBTQ+ community.
- ***Transition:*** The process and time during which persons assume their affirmed gender expression, which may or may not include legal, medical, or surgical components.
- ***Sexual orientation:*** The aspect of someone's identity, which refers to the gender(s) of the people to whom they are attracted. Examples include but are not limited to homosexual, lesbian, gay, heterosexual, bisexual, asexual, and pansexual.

* World Health Organization. *International Classification of Diseases.* 11th ed. Geneva, Switzerland: WHO; 2018.

should be discussed with patients during a lactation consultation, and a clear history obtained because the scars may look identical.

Testosterone Therapy

Hormone therapy may be used to masculinize features for transmen. It may be started as early as the late teenage years and has been shown to interrupt mammary gland development.[21] For some patients using testosterone after completing female puberty, this may result in a smaller chest, though for others the difference in the mammary gland may not be grossly obvious. It is possible that this type of therapy inhibits anatomic lactocyte development. It may also interrupt the hypothalamic-pituitary axis of milk production and let-down because this axis is influenced by gonadal hormones, though this is incompletely understood.[22]

"Chestfeeding"

The term *chestfeeding* originated in the transmale lactating community as a term that encompasses both gender-affirmed language and the embodied experience of feeding an infant from one's own body. Transmen may or may not have dysphoric feelings toward their chests; if they do have chest dysphoria or have experienced trauma, abuse, or overt discrimination related to their chest, the word "breast" may raise negative emotions. Some in the lactation community have pushed back against this term, as possibly marginalizing an experience long thought to be quintessentially female. However, one must consider the difficulties encountered by lactating transmen along with any histories of gender dysphoria. Furthermore, using a patient's own language concerning their body is widely considered the foundation of respectful provider–patient interactions. Therefore one also should not assume that because a person identifies as "trans" that the person would prefer the term "chestfeeding" over "breastfeeding." As discussed earlier, patients should be asked about their preferred terms, and those terms should be used. Finally, any handouts, videos, or applications (apps) used should be reviewed before being suggested, because many contain gendered language along with highly gendered assumptions about lactation, families, and children.

Transwomen (Assigned Male at Birth, Affirmed Female)

Gender-Affirming Mammoplasty

Transwomen may have undergone augmentation mammoplasty. If this is the case, implants are most often subpectoral, and incisions are most often inferior to the breast. This means that the nipple may not be divided from any ductal tissue, as in masculinizing chest surgery. However, the visual appearance may mask low volumes of mammary tissue or provide uncomfortable pressure during engorgement if mammary tissue is present. Patients with breast augmentation should be counseled to express milk or feed an infant more often in the postpartum period (10 to 12 times per day rather than 6 to 8 times per day), to prevent downregulation of milk supply, uncomfortable engorgement, or mastitis.

Feminizing Therapy

Breasts with physiologic mammary tissue may develop over the course of time during treatment with estrogen and progesterone. Androgen-blocking medication, often spironolactone, is typically used for those who have not had orchiectomy as a part of their surgical transition. This mammary tissue has been shown on case report and in anecdotal reports to be capable of making human milk (see later).

Induced Lactation: Case Report

One published report exists of a transwoman who presented with anatomically typical breasts after treatment with estrogen, progesterone, and spironolactone for 6 years.[23] Over the course of 3 months, she induced lactation by a progressive increase in her estrogen and progesterone dosages, then a withdrawal period combined with domperidone (a dopamine-blocking galactogogue) and pumping. She exclusively breastfed for 3 months. Other providers and patients have induced lactation with/as transwomen, but these cases remain anecdotal. See Chapter 19 for more discussion of induced lactation.

TWO OR MORE LACTATING PARENTS AND CO-LACTATION

Although two or more parents who are able to lactate may see the benefit of sharing the work and bonding of infant feeding, because the physiology of lactation requires frequent breast emptying without prolonged pauses (see Chapter 3 on feedback inhibition of lactation), sharing lactation requires planning and careful consideration. In fact, some parents have reported that having two parents maintain lactation while attending to other children, housework, and employment was overwhelming.

For families who desire to co-lactate, a few considerations should be discussed. First, both milk supplies must be maintained. This means all lactating parents must express milk approximately 8 times per day, whether with a child or a breast pump. To avoid dropping prolactin levels, no break longer than 6 hours should be taken between sessions. Generally, at least one parent in these cases is inducing lactation (see Chapter 19). If this is done before birth, a plan for the birth hospitalization should be considered. For some hospitals, prenatal infectious disease laboratory tests will be required of any individual other than the birth parent providing human milk, unless it is pasteurized processed donor milk. A parent inducing lactation may require extra assistance from lactation consultants, including a supplemental nursing system, nipple shield, or flange fit for adequate pumping. If this is the case, choosing a delivery hospital should include these postpartum considerations. Given that the gestational parent is most likely to make colostrum, it is conceivable that some benefit accrues to having this parent provide milk until lactogenesis 2, if desired. In addition, another person breastfeeding in the first 72 hours may risk interrupting the

gestational parent's milk supply by limiting stimulation, emptying, or skin-to-skin contact. However, if the gestational parent can pump, the risk may be mitigated by the extra bonding and stimulation experienced by the other lactating parent.

SURROGACY AND ADOPTION

Same-sex couples may be up to four times as likely to build families through adoption as their opposite-gender peers.[5] In the case of adoption, induced lactation may or may not be possible. If lactation is physiologically possible, patients can be counseled according to their anatomy, hormone status, and time to potential adoption. If it is not possible, parents may still wish to provide their children with human milk. In this case, banked donor milk may be a viable option, though in many countries the cost is prohibitive. If banked milk is not available or is not affordable, some families will turn to informal milk donation. The ABM has a position statement on informal milk donation and summarizes the risks, benefits, and considerations involved. In sum, human milk should not be purchased informally, because this increases the possibility of contamination and/or improper handling. When sharing, an open relationship is ideal, with sharing of medical records and infectious disease/prenatal laboratory test results when possible. Proper handling should be ensured, and pasteurization may be considered. A position statement on informal milk sharing was released by the ABM in 2017 and can be found online.[24]

In the case of surrogacy, and sometimes in adoption, the gestational carrier or birth parent may be willing to provide colostrum or human milk for a time. If there are no contraindications, this milk should be encouraged and can be given by supplemental nursing system at the breast/chest by the surrogate or adoptive parents, if desired. In the case of induced lactation, even when successful, colostrum production has not been seen. Rather, the inducing parent makes mature milk. Therefore colostrum provided in this way is likely an incremental benefit to the newborn. In the case of induced lactation for an adopted infant or an infant born by surrogacy, birth hospitals may require infectious disease/prenatal laboratory test results of any parent providing human milk or breast/chest feeding.

FACTORS COMMON TO ALL OF THESE CASES

LGBTQ + parents who desire to breastfeed, chestfeed, or lactate require routine and robust lactation support, as is the standard of care for any parents. In addition, they should have access to advanced lactation support provided by breastfeeding medicine providers and board-certified lactation consultants. They may desire to use supplemental nursing systems or galactogogues to promote infant time at the breast and milk supply. For further reading, Chapter 19 discusses induced lactation and cross-nursing and Chapter 11 covers galactogogues, as does Appendix I (ABM Protocol #9).

The Reference list is available at www.expertconsult.com**.**