Queer challenges in maternity care

A qualitative study about lesbian couples' experiences

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For Magnus and Sigurd

Scientific environment

This thesis has been carried out within the institutional framework of the PhD programme at the Faculty of Medicine and Dentistry, University of Bergen, Department of Global Public Health and Primary Care. While conducting the thesis I have shared my working hours between my PhD project and my position as assistant professor, teaching midwifery students at Oslo and Akershus College of Applied Sciences and at Buskerud and Vestfold University College.

Professor Kirsti Malterud and professor Venke Sørlie were my supervisors.

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Preface

Looking back, it is difficult to understand that I more or less stumbled across the research area in which I have been totally absorbed for the last years. Going back to 2005, I was struggling to find a topic for my master's thesis. At the same time I followed my daughter and her wife closely during their pregnancy, and we often ended up reflecting upon their experiences with doctors and midwives and their concerns about labour. One day when I was more frustrated than usual, my daughter-in-law burst out: "By all means, - you have the topic for your thesis right in front of you! Why don't you write about lesbian couples and their maternity care experiences?" And there I was.

I felt inspired when I had finished my master's thesis, but in order to continue my work I needed funding. Given my age and topic of interest, it took a couple of years to find an organization that was willing to believe in my project and my ability to carry it through. I was lucky. In 2010 Norwegian Women's Public Health Association decided to fund my project, and in March 2011 I was finally able to start.

Writing up my thesis and looking back at the process, I realize that I have learned a lot. First and foremost I have learned about lesbian life and motherhood from listening to women's experiences. I have made acquaintances and friends in contexts that otherwise would have been unfamiliar to me. I have been fortunate to share my work at several national and international conferences, and more than once I have been contacted by conference participants encouraging me to "keep up the good work". I stumbled into unknown territory, but I was met with open arms. For that I am deeply grateful.

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List of publications

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Abstract

The number of lesbian women opting for motherhood is increasing, implying that healthcare providers are likely to encounter lesbian couples in all maternity care contexts. Although an increasing proportion of the Norwegian population is comfortable with same-sex marriage, a certain scepticism remains regarding lesbian motherhood and altered family structures. As motherhood is still strongly associated with heterosexuality, these encounters may be challenging.

In my thesis I aim to develop knowledge about lesbian women's maternity care experiences as a foundation for adequate maternity care for lesbian couples. For this purpose, three sub-studies were accomplished.

In sub-study I, we explored midwives' experiences from encounters with lesbian women and their partners. Interview data from eleven midwives were analyzed by a phenomenological-hermeneutical method. According to the midwives, lesbian couples were open about their sexual orientation and relationship to maternity care staff. Midwives felt that lesbian couples would have a specific bodily and emotional understanding and believed this closeness helped the co-mother to understand what her partner went through in labour and birth. The midwives also described a lack of knowledge related to co-mother's role. They mentioned negative routines regarding language and documentation forms, but tried to reassure that lesbian couples felt comfortable in the encounter. The midwives also experienced that feelings of uncertainty sometimes dominated their professional conduct.

In the second sub-study we systematized research knowledge about lesbian women's experiences with healthcare providers in the birthing context. Thirteen qualitative studies including 240 lesbian women were identified by a systematic review. Noblit and Hare's meta-ethnography was used for analysis. The women described issues related to covert or overt homophobia where bad or strange staff behaviour occurred in a subtle manner, creating feelings of discomfort or uneasiness that was difficult to interpret. Confidence was created when staff presented knowledge and support, and although they expressed a desire to be treated as "any other woman" in labour, they

welcomed encounters with staff showing a little explicit acknowledgement of their particular family situation.

In the third sub-study, we explored co-mothers experiences with healthcare providers in the maternity care services. Qualitative interviews from a convenience sample of eleven co-mothers were analysed with systematic text condensation. Analysis showed that ordinary tokens of recognition and well-chosen words could create feelings of being included, while lesbian self-confidence played a major role in awkward encounters. Being neither father nor biological mother could bring forward identity challenges for co-mothers. Being a woman was helpful to understand and find their role in the maternity care context, but they had to find other ways of mothering than if they had given birth themselves. Co-mothers addressed themselves with different terms and perceived some concepts as unnatural or excluding. Parental identity was defined by their relation to baby, and the term "co-mother" was perceived as a bureaucratic concept.

My thesis indicates the close relationship between disclosure, visibility and recognition for lesbian couples encountering maternity care, demonstrating in concrete detail the links between being seen and feeling recognized. The presence of lesbian couples may challenge conventional heteronormative ideas of motherhood and family practices within and without the maternity ward. Challenges related to naming and identity demonstrates heteronormative assumptions and a subsequent need to adapt and adjust language and terms for all parts involved. Because they are women, co-mothers are provided with a first-hand understanding of pregnancy and labour. At the same time, their presence adds a "queer touch" to the maternity care context by challenging traditional notions of femininity and masculinity. Finally, my analysis reveals how encounters with maternity care staffs are moral encounters where staff's attitudes related to sexual orientation may influence responsible conduct. Awareness of the connections between moral perception and moral performance may enhance professional conduct in the specific context of intimate citizenship for lesbian couples in maternity care.

Sammendrag

Selv om en økende del av befolkningen i Norge er positivt innstilt til at lesbiske og homofile par kan inngå ekteskap er man mer forbeholden når det gjelder muligheten for lesbiske kvinner til å få barn og stifte familie. Likevel ser vi at stadig flere lesbiske kvinner velger å få barn, og dette innebærer at helsepersonell må regne med å møte lesbiske par i alle områder av fødselsomsorgen. I og med at moderskapet fortsatt er sterkt knyttet til heteroseksualitet, kan disse møtene bli utfordrende.

Målsettingen for denne avhandlingen er å utvikle kunnskap om lesbiske kvinners erfaringer med fødselsomsorgen som kan bidra til utvikling av god behandling og omsorg. For å fremskaffe kunnskap utførte vi tre delstudier.

Delstudie I var en empirisk studie av jordmødres erfaringer fra møter med lesbiske kvinner og deres partnere. Vi intervjuet elleve jordmødre og analyserte data ved hjelp av fenomenologisk-hermeneutisk metode. Ifølge jordmødrene var lesbiske par vanligvis åpne om seksuell orientering og parforhold i møter med helsepersonell. De beskrev at lesbiske par hadde en kroppslig og følelsesmessig felles forståelse som gjorde det enklere for medmor å forstå partnerens opplevelse av svangerskap og fødsel. Samtidig sa jordmødrene at de hadde lite kunnskap om medmødres rolle. De følte det var viktig å unngå rutiner og uegnet språk, og opplevde at dokumentasjon var en utfordring. Det var viktig for dem å forsikre lesbiske par om at de var komfortable med deres seksuelle orientering, men de opplevde samtidig usikkerhet knyttet til egen praksis.

I den andre delstudien utførte vi en syntese av 13 primærstudier som omhandlet lesbiske kvinners erfaring med helsepersonell på fødeavdelingen. Systematiske søk fremskaffet et datamateriale som omfattet 240 kvinner. Noblit og Hares metaetnografiske metode ble benyttet til å analysere data. I studiene beskrev kvinnene temaer relatert til skjult eller åpen homofobi hvor helsepersonell viste merkelig eller negativ atferd på en subtil måte. Dette førte til ubehag eller uro fordi situasjonene var vanskelige å forstå. Når helsepersonell hadde kunnskap om deres situasjon og viste ved sin atferd at de støttet kvinnene oppstod møter preget av tillit. Selv om kvinnene

sa de ønsket å bli behandlet som alle andre, så var det tydelig at de satt pris på å møte helsepersonell som viste at de forstod og anerkjente deres spesielle familiesituasjon.

I den tredje delstudien undersøkte vi medmødres erfaringer med helsepersonell i fødselsomsorgen. Vi intervjuet elleve medmødre og analyserte data ved hjelp av systematisk tekst kondensering. Analysen viste at i møter med helsepersonell var valg av ord og holdning avgjørende for å føle seg inkludert og anerkjent, mens lesbisk selvtillit spilte en avgjørende rolle i møter preget av usikkerhet eller ambivalens. Det faktum at medmor var verken biologisk mor eller far til barnet kunne av og til være utfordrende for hennes identitet. Å være kvinne var nyttig for å forstå og finne en god rolle i møte med fødselsomsorgen, men medmødre fortalte at de måtte finne sin egen måte å være mor på siden de ikke selv hadde født barnet. Det var relasjonen til barnet som definerte deres identitet som forelder, ikke biologiske bånd. Ordet medmor ble betraktet som et byråkratisk begrep, og i dagliglivet benyttet kvinnene en rekke andre ord som var mer personlige og tilpasset deres familiesituasjon.

Avhandlingen viser at for lesbiske par et det en nær forbindelse mellom det å tilkjennegi sin seksuelle orientering og opplevelsen av å bli sett og anerkjent av helsepersonell i fødselsomsorgen. Konvensjonelle heteronormative forestillinger om moderskap og familie utfordres av lesbiske pars tilstedeværelse, i fødselsomsorgen så vel som i andre sammenhenger. Utfordringer knyttet til bruk av navn og opplevelse av identitet bekrefter heteronormative antakelser og tydeliggjør behovet for tilpassing og justering av begreper og språk. Det at man selv er kvinne bidrar til at medmødre får en spesiell forståelse av svangerskap og fødsel, men samtidig utfordrer deres tilstedeværelse den tradisjonelle oppfatningen av maskulinitet og femininitet i fødselsomsorgen ved at de tilfører en aldri så liten skeiv vri. Avhandlingen peker på den moralske dimensjonen i møtene ved å vise at helsepersonells holdninger til seksuell orientering påvirker deres yrkesutøvelse. Ved å bli bevisst sammenhengen mellom moralsk persepsjon og moralsk handling kan helsepersonell i fødselsomsorgen bli bedre i stand til å ivareta omsorgen for lesbiske par.

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1. Aim and research questions

The overall aim of the thesis is to develop knowledge about lesbian women's maternity care experiences as a foundation for adequate maternity care for lesbian couples.

For this purpose, I have explored:

- midwives' experiences from encounters with lesbian women and their partners
- lesbian women's experiences with healthcare providers in the birthing context
- co-mothers' experiences with healthcare providers in the maternity care services

2. Background

Preconceptions and professional experience

My professional and personal experiences, hypotheses, theoretical perspectives and understanding of the midwifery discipline have motivated and influenced my thesis (1).

In this thesis, I define *lesbian women* as women who identify themselves as lesbians and direct their sexual desire toward other women. My clinical experience with lesbian couples was scarce when I started working on my master's degree in nursing science in 2004. The lesbian women I had met in maternity care had been very discrete about their situation. I had limited experience and no knowledge about lesbian couples, except from recent personal experiences in my close family.

Two years later, I had conducted a qualitative study about lesbian couples' maternity care experiences. I had then become aware of some of the challenges these couples faced when they opted for motherhood and family life. I was familiar with concepts like *homophobia*, defined by Wilton (2) as irrational hatred, intolerance and fear of lesbian, gay and bisexual (LGB) people and *heteronormativity*, defined by Anderssen and Hellesund (3) as "those cultural and social institutions, norms, and practices (including language) that imply and reflect that society and people are organized around certain given differences between men and women and their mutual sexual attraction". While working on my master's thesis, I experienced that, in general, lesbian couples seemed to be open about their sexual orientation to doctors and midwives. Nevertheless, they described that sexual orientation sometimes ended up being "the elephant in the room", demonstrating that not all maternity care staff were comfortable in the encounters. Thus, when I started working on my thesis, I expected that the interviews would bring forth stories about experiences related to disclosure and caring or lack of caring. I also expected that the gender-neutral marriage law would be brought up in the interviews as it had recently been introduced (2009). I

wondered whether, and in which way, legal changes had influenced the women's maternity care experiences.

Authoritative knowledge is defined by Jordan as the knowledge which counts to a profession (4). When I worked as a practicing midwife, I performed my work conscientiously, but I hardly ever reflected upon authoritative midwifery knowledge. In hindsight I see clearly that my actions were influenced by knowledge recognized by the maternity unit where I was employed. Davis-Floyd (5) describes three paradigms that influence maternity care: the technocratic, the humanistic and the holistic, arguing that, if combined, they would create a great obstetrical system. Blåka argues that modern midwifery is practiced within two different belief systems, the biomedical and the phenomenological (6, 7). Although the authors use different concepts, the discourses they describe have similar features. One describes birth as a medical event, the other frames birth within a humanistic or life-world perspective. The description of these perspectives later helped me understand the professional continuum I experienced from teaching active birth and attending homebirths to becoming STAN supervisor in a technological birthing unit. STAN is a method used for monitoring heart rate and risk of hypoxia in the fetus by performing an ST analysis of the fetal ECG waveform (8, 9). Gradually, I became familiar with technological births as well as natural and alternative birth contexts but I never doubted my own understanding of pregnancy and birth as a normal process. My aim as a midwife was always to enhance normal birth.

Knowledge about women's maternity care experiences is essential to enhance normal birth and provide optimal care. Below, I present research about issues that have been considered important by birthing women.

Maternity care experiences in general

In this thesis, I define *maternity care* as the period from start of pregnancy up to six weeks after the baby's birth. Studies about women's maternity care experiences have been conducted worldwide, mostly without focusing the specific situation for lesbian

couples. These studies all point towards the importance of the woman-midwife relationship. In an Icelandic study (10) mothers described that they felt vulnerable, insecure and dependent, furthermore they longed for a sense of control of self and circumstances. The need to be in control could be threatened by pain, medication used for pain relief, and an uncaring birth attendant. The authors argued that the presence of a midwife perceived as uncaring might result in a loss of sense of control, and thereby a birth experience influenced by feelings of helplessness. On the other hand, a midwife who collaborates with the woman, providing encouragement and support, is likely to result in a best possible labour experience.

Lundgren and Berg (11) identified overlapping pairs of concepts of women's and midwives' experiences. The need for the woman to be in control was present, but also the need to surrender to herself, her body and the process of labour. Trust was an essential element, which implied trusting oneself as well as healthcare providers. The findings also demonstrated that if a midwife was unable to mediate security, the women felt less able to manage the process of labour. Furthermore, the women expressed a need to be seen as unique, and they wished to be supported and guided on their own terms. A sense of empowerment was also included in the women's need to participate in what happened during birth. Feelings of abandonment or loneliness could be experienced when the women sensed their midwife to be physically or mentally absent.

Hunter and co-workers (12) describe how women's experiences, healthcare providers' experiences, quality of maternity care and clinical safety are interwoven elements influencing birth outcome, with relationships as the invisible warp threads that holds this tapestry together. Thus, procedures and policies have limited value if the relationship fails. The quality of the relationship is linked to the quality of communication, and effective communication is linked to safe practice, the authors say. They point towards a deficit in communication skills and emotion management skills in maternity care, and argue the need to enhance these skills.

A recent systematic review of studies about continuous support for women during childbirth demonstrated that women who were given midwife-led care or one-to-one support were more likely to give birth spontaneously, without the use of vacuum, forceps and cesarean section (13). Continuous support was also associated with shorter duration of labour, reduction in intrapartum analgesia and reduced risk of dissatisfaction with childbirth experience. Furthermore, the study demonstrated that the consequences of continuous support could be respectively enhanced or reduced by the birthing context (the situation describing the birth of a child in a hospital setting) and the relationship between healthcare provider and the woman (13).

Dahlberg and Aune (14) demonstrated that it is important for women as well as their partners to establish a positive relationship with the midwife during pregnancy and childbirth. Furthermore, predictability during pregnancy and childbirth is important. The quality of the relationship depends on interpersonal competence, and for some midwives, the ability to provide emotional support may be challenging. Hunter argues that the professional "with woman" rhetoric has made it almost impossible to talk about negative experiences of the midwife-woman relationship or to criticize a client, at least publicly (15). The possibility for midwives to offer continuous support and work in accordance with basic principles of midwifery can also be challenged by medically oriented labour wards and different professional ideologies, resulting in moral dilemmas (16).

Where does this leave birthing women and lesbian women in particular? Women want to be cared for by a healthcare provider they can trust. This professional should be supportively present, provide individualized care and communicate with and empower them. Hunter describes how emotionally challenging situations sometimes arise "when the boundaries of expected relationships between midwife and woman is disrupted in some way" (15, p315). I suggest the possibility that the presence of lesbian couples might act as a challenging factor in maternity care. To explore this issue further in my thesis, I will introduce some specific issues arising when lesbian couples opt for motherhood.

Lesbian motherhood in the context of heteronormativity

According to Hellesund (17), *the modern lesbian woman* in Norway was conceptually born in the 1920ies and 1930ies, when society took a turn towards sexual liberation and the spinster lost her place in the culture. At that time, neither psychology nor psychoanalysis accepted homosexuality (the tendency to direct sexual desire toward another of the same sex). On the one hand, sexual liberation led to an increased awareness about female sexuality, on the other hand, female sexuality was understood within an exclusively heterosexual context. For some women who loved women, the changing discourses became positive, providing the possibility to establish an identity and to live a modern lesbian life. For others, they were negative, since love relations between women were framed in a sexual context (17). Thus, relationships of love between women which were previously natural were now given another value, signifying deviance and "otherness".

Although the issue of *lesbian motherhood* is hardly mentioned in research about lesbian women before the 1980ies, there is no reason to doubt that lesbian women have opted for motherhood earlier (18). However, some authors described the lesbian mother as an oxymoron, since motherhood was compulsory linked to *heterosexuality* (the tendency to direct sexual desire towards the opposite sex) (18). Beresford argued that lesbian motherhood is rendered invisible due to society's inability to find terms that can be used to deal with the situation. One of her main concerns is that of legal definitions and the fact that lesbian mothers must conform to norms used in a heterosexual society to become visible. She says that they even challenge the common sense of what is "normal" or natural" (19). The empirical findings used to discuss lesbian maternity care experiences in this thesis (article III) are drawn from interviews with lesbian co-mothers. These were all married or co-habited with the biological mothers when their babies were born. In the meta-ethnography (article II) I the samples included in the primary studies included lesbian couples as well as some single lesbian women. The midwives (article I) described their experiences of caring for lesbian couples. Thus, my thesis is concerned with lesbian couples, although single lesbian women opt for motherhood as well.

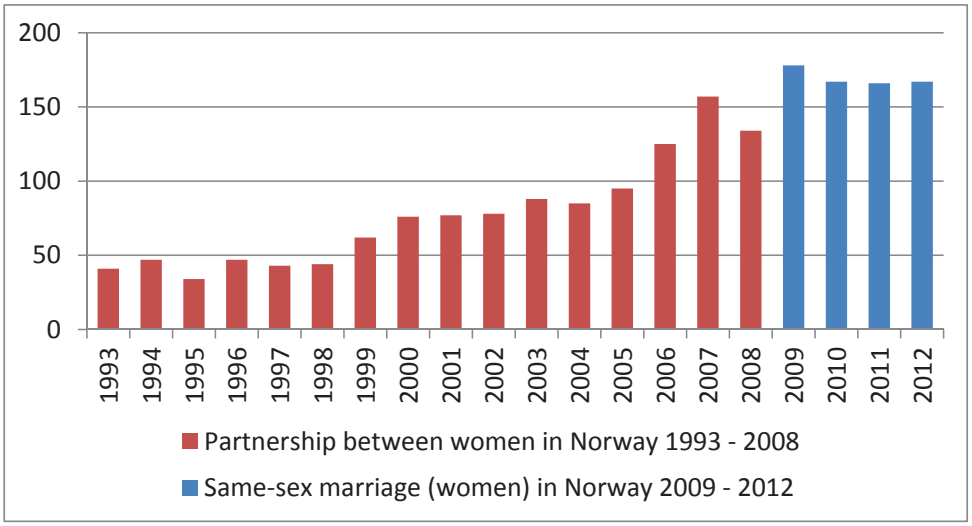
In order to understand the societal conditions for lesbian maternity, I will pay some attention to some notions of the concept heteronormativity. According to Röndahl, (20), *heteronormativity* denotes the powerful heterosexual structure and normative principle which permeates our culture as taken-for-granted. Therefore, homosexual individuals are likely to be treated as heterosexuals and assumed to be heterosexuals until they upset this assumption. In the maternity care context, a lesbian woman can choose to hide her sexual orientation and pass for a heterosexual woman until she does or says something that changes the heteronormative assumption.

Heterosexuality is implemented as a normal, natural and privileged institution in our culture (21). Perlesz and co-workers (22) explain how homosexuality and homosexual relationships have become excluded, stigmatized, marginalized and minoritized. The authors identify three processes of normative change that have influenced a historical shift in the landscape of same-sex sexuality in Europe, which are also valid for Norway: 1) Same-sex practice has become formally legitimized, 2) the lesbian, gay, bisexual and transperson (LGBT) populations have been offered protection, and 3) intimate relationships have become recognized in society. In Norway, § 213 of the 1902 Penal Code criminalizing sexual actions among men was not removed until 1972, and homosexuality was repealed as a disease diagnosis by The Norwegian Society for Psychiatrists in 1977. This shift is described by Roseneil et al as a turn from heteronormativity towards homotolerance (21).

The possibility for gay and lesbian citizens to become legally registered partners was introduced in Norway in 1993, followed by the approval of gender-neutral marriage legislations in 2009. The numbers of lesbian women who became legal partners (23) or were married (24) in Norway in the period from 1993 - 2012 are presented in figure 1. The Norwegian gender-neutral marriage law removed references to sexual orientation, and also equalized parental rights and adoption rights for same-sex couples that married (25). Furthermore, lesbian women were given legal access to assisted fertilization and co-mothers were given equal parental rights as heterosexual parents (21).

Figure 1

Legalized partnerships 1993 – 2008 and same-sex marriage 2009 - 2012 between Norwegian women (total numbers)



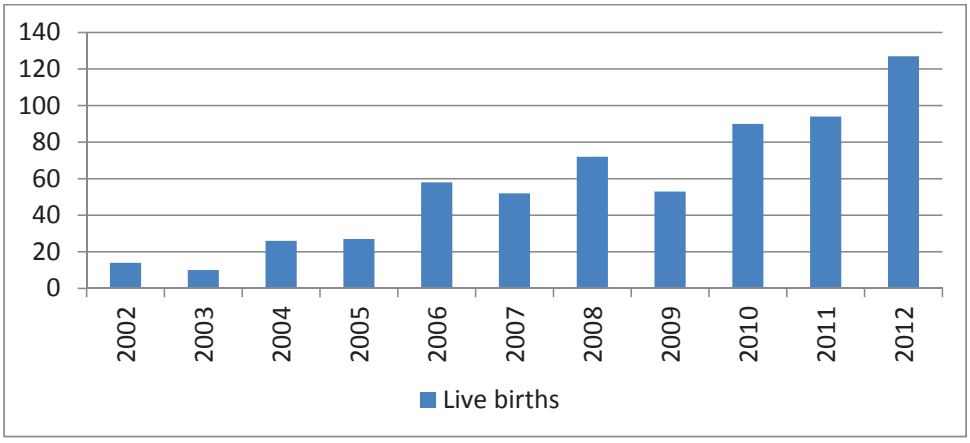
Although Norway is gradually becoming a more homotolerant society, *homonegative* attitudes and behavior still occur (26), challenging human rights and healthcare outcomes. Several studies argue that healthcare practitioners still presume heterosexuality and neglect the fact that their patients are a sexually diverse group (27-29). In Norway, midwives and other maternity care staff working in large hospitals will encounter lesbian couples on a regular basis. Although lesbian couples have equal rights as heterosexual couples regarding marriage and parenting, prejudice and homonegative attitude may still occur in healthcare encounters. I will continue this review of lesbian motherhood with a brief presentation of the lesbian family before exploring lesbian women's maternity care experiences.

Lesbian families

According to Statistics Norway (30) 58995 children (live births) were born in Norway in 2013. The numbers of live births by lesbian women are presented in figure 2 below, and a further increase is expected in the future (31). The number of live births by lesbian women is not regularly published at Statistic Norway's website. According to advisor at Statistics Norway, Tove Irene Slaastad (personal email, 16 October 2013), the numbers of children born by lesbian women in Norway are uncertain, since systematic information about co-mother and information regarding same-sex parents are left out from national statistics concerning live births.

Figure 2

Live births by lesbian women (married and legally registered partners)



Assisted fertilization can take place within public health services in Norway or health services abroad approved by Norwegian authorities. It may also take place in clinics abroad unapproved by Norwegian health authorities, or through private arrangements. Until 2009, lesbian women travelled from Norway to Copenhagen to become inseminated at the Stork Klinik, a private clinic for assisted fertilization, certified by

the Danish Medical Agency. In September 2009, the clinic had offered altogether 2 125 inseminations on Norwegian lesbian women (32). A number of other Danish clinics as well as clinics in other European countries and in the US have also been used for insemination by Norwegian lesbians. Furthermore, lesbian women arrange private insemination without the interference of health care. Some prefer to use a known donor, while others prefer an anonymous donor. Some clinics offer the possibility to use a "dedicated" donor (a donor that the woman knows personally) or a donor with an "extended profile" (a donor who has given extended information and must be regarded as more or less known).

Lesbian families may challenge the general understanding of motherhood and family life being an image of the "proper" family (33). But what counts actually as a proper family? According to Plummer, the lesbian family consists of two mothers and one or more children, representing what he describes as "families of choice" (34). Others use the term "planned families" (35, 36) or refer to families as the group of people we define as family (37). In this thesis, I shall refer to same-sex female couples encountering maternity care as lesbian couples or lesbian families.

The American population is moving toward a more encompassing definition of family that includes same-sex households (38, p216). Similar attitudes were reflected in a recent study about the Norwegian population's attitude towards LGBT people as well, where 68 % of the male population and 83 % of the female population said that same-sex couples should be allowed to marry (26). This study also demonstrated that 44% of the male population and 62% of the female population in Norway support equal rights for lesbian couples regarding assisted reproduction. There is an increase in positive attitudes towards homosexual men and lesbian woman. When it comes to parenthood or family creation, the Norwegian population demonstrates a more reluctant attitude. This probably reflects a powerful link between family institutions and basic understandings of family, indicating that cultural understandings of family change more slowly than family forms (39).

In this thesis, I refer to the non-biological mother as *co-mother.* Others have used the terms "social mother" (36), "nonbirth mother" (40), "nonbiological mother" (41), and "mather" (42). Due to changes in the marriage law, the term co-mother (Norwegian: "medmor") was introduced in the legal vocabulary. For co-mother to become a legal parent from birth certain conditions must be met regarding relationship status and choice of donor. Assisted fertilization must take place within a clinic approved by Norwegian public health services or at an abroad clinic offering the use of semen from a known donor. If the couple decides to use an unknown donor, co-mother must go through with a step-child adoption procedure in order to become the child's legal parent. Co-mothers' legal situation in Norway has been thoroughly clarified compared to many other countries and this is likely to influence their experiences with the maternity care services.

Lesbian women's maternity care experiences

Studies demonstrate how healthcare outcomes for lesbian women and their partners may be affected by healthcare providers' attitudes and actions in general healthcare (27, 43-48).

In my master's thesis I observed that lesbian couples were concerned about disclosure of their sexual orientation (49). They described how they would usually reveal their sexual orientation to midwives and other maternity care staff, while they chose not to disclose in situations where they felt uncertain about their medical rights. Similar findings are described elsewhere (50, 51). The participants also described situations where they felt exposed, describing themselves as a "theme", a "mute theme" or a "non-theme", depending upon the outcome of the situations. Sometimes their sexual orientation became the topic of antenatal care, on other occasions it was overlooked (49). This simultaneous over- and under-emphasis on sexual orientation has been described in several other studies as well (52-55).

In the maternity care context, research also demonstrates that healthcare outcomes for lesbian women and their infants may be affected by attitudes and actions of

healthcare providers (56). In several studies, lesbian women's interpersonal experiences with staff are described as positive. In this context, positive experiences included situations where midwives made the couple feel welcome and accepted their sexual orientation (51). Positive encounters also included situations where staff provided inclusive, supportive and individual care (50) or when the couples felt that staff engaged with them emotionally, such as involving co-mother in cutting the umbilical cord or caring for the baby after birth (57, 58). The lesbian couples also welcomed staff's awareness of different family constellations and their willingness to include co-mother as parent (52, 59). Continuity of carer was important for some couples, as it enabled them to establish a trusting relationship with their healthcare providers (55). However, several studies described situations where the couples felt they had to educate staff, demonstrating the need for knowledge improvement (52, 55, 58, 60).

A number of studies about lesbian women and maternity care services have demonstrated experiences of deficient care (61, 62), uncertainty and ambivalence (59) or outright homophobia (50, 55, 60, 63). My previous study reflected similar findings (49). One woman experienced being examined vaginally by a rough midwife while she was in labour and had to cope with painful contractions, another experienced that her doctor withdrew his support when he understood that she was a lesbian woman trying to conceive. First he tried to frighten her from becoming pregnant, and when that did not work, he forgot to mail her the test results. When she contacted his office, she was told that the results were inaccessible and the doctor was on holiday.

Some healthcare providers demonstrate negligence or exhibit behavior that may be interpreted as embarrassment, uneasiness or discomfort by the couples, such as the nurses' "busyness", their studiedly "neutral" attitude or lack of cooperation (52, 55, 58, 59). In such situations, the lesbian women ask whether this uneasiness or negative behaviour is a result of their sexual orientation or the healthcare provider's personality (50, 57, 59, 60, 64).

Studies indicate that co-mothers' prefer to be included as parent rather than co-parent while receiving information concerning the baby and being allowed to care for partner during birth (59, 65). Legal concerns are demonstrated (58, 62, 64). Still, knowledge about to what degree the stigma factor in marginalized groups will interact with factors that are important for parenthood and family formation is lacking (66).

Theoretical perspectives

In this thesis, I have explored experiences from encounters between lesbian couples and maternity care staff in the context of a heteronormative culture. Below, I present three selected theoretical perspectives that have supported my interpretations of interpersonal and contextual phenomena, Honneth's theory of recognition (67), Plummer's theory of intimate citizenship (34) and Vetlesen's theory of preconditions on moral performance (68).

Critical theory (CT) was initially developed by "The Frankfurt School" by philosophers and researchers in social sciences connected to the Institute of Social Research in Frankfurt am Main. CT seeks to study and understand, as well as to critique and change society. Influenced by Marxism, these theories are concerned with matters of power and justice, race and gender (69). CT questions social structures that are taken-for-granted, and challenges societal discourses regarded as natural and neutral.

Axel Honneth, present director of the Institute of Social Research, turned to Hegel's early perspectives on intersubjectivity and integrated them in his normative theory about recognition. Honneth's theory of recognition argues that personal autonomy and self-realisation must be achieved intersubjectively by the individual being recognized by significant others. In his major work, "The Struggle for recognition", Honneth returns to Hegel's early ideas, outlining three types of relation to self that are essential for identity formation: self-confidence, self-respect and self-esteem (67).

In the first level of recognition, love is the basic mode, and *self-confidence* (Selbstvertrauen) is established in primary caring relationships and with close persons. By gradually achieving a basic level of trust, the individuals become able to express their needs and desires without fearing the risk of being abandoned (67). Murphy describes this elementary form of self-relation as "the bedrock" of Honneth's theory, as, according to Honneth, this level is vital to human existence, while the second and third forms are "products of historically changing relations" (70, p7). The second level is legal recognition. When a person's capacity for autonomous moral and legal actions is recognized and s/he is able to exercise these actions, development of *self-respect* (Selbstachtung) occurs (67). Hence, the connection between self-respect and rights are important as they give human beings an opportunity to exercise one's capacities. The third level of recognition is related to *self-esteem* (Selbstschätzung) (67). Self-esteem implies a sense of qualities and qualifications that constitute the person as a unique individual, and for the contributions she or he is able to pay to society due to these particular qualities. The characteristics that distinguish a person from others must be regarded as valuable by society. For lesbian couples, this implies that society acknowledges co-mothers' parental role as well as their family constellation.

The levels presented above are processes dependent upon cultural and historical changes. Honneth describes various forms of disrespect related to the three modes of recognition, such as violation of physical integrity, denial of rights and denigration of ways of life (67).Thompson (71, p162) summarizes the forms of disrespect as follows: "If I am maltreated, I will feel humiliated, and my self-confidence will be damaged. If I am excluded from citizenship, and denied the rights to which I am entitled, then my self-respect will suffer. If the way of life with which I associate myself is denigrated, then my self-esteem is at risk". Lesbian couples run the risk of being disrespected on all levels in the encounters with maternity care.

In everyday language, "queer" means unusual or odd, something diverging from what is usual. *Queer theory* (QT) was developed by feminists such as Teresa de Lauretis and Eve K. Sedgwick in the late 1980ies, but is also influenced by the ideas of Michel

Foucault, according to Halperin (72,73). He defines the term as follows: “As the very word implies, “queer” does not name some natural kind or refer to some determinate object; it acquires its meaning from its oppositional relation to the norm. Queer is by definition whatever is at odds with the normal, the legitimate, the dominant. There is nothing in particular to which it necessarily refers” (73, p63).

British sociologist Ken Plummer positions himself within QT as well as within critical humanism (74). Plummer introduced the concept *intimate citizenship* for areas of life considered personal, but are “in effect connected to, structured by, or regulated through the public sphere” (34, p70). *Citizenship* refers to an individual’s belonging to and participation in a group or community, with certain rights and obligations. The concept *intimate* is used to describe the inmost relationships people have with self and others, such as relationships with friends, family, children and lovers, but also the experiences we have with self, including our feelings, bodies, emotions and identities. According to Plummer, people *do intimacies* when they get close to these emotions, still always within the frames of a structured and regulated public sphere.

Plummer proposes a model related to particular challenges of citizenship in a postmodern culture. His model recognizes a plurality of groups living within a global world where the understanding of citizenship is challenged and changing. Identities of citizenship are often considered solid or essential. Plummer argues, various movements, such as the women’s movement or the lesbian and gay movement have raised potentially new identities who expect to be recognized, and to have the right to claim values and obligations. Changing intimacies brings along questions related to moral conflicts and rights such as the changes taking place in the reproduction technologies that enables lesbian couples the possibility to have children. They raise questions about the right to have children (or not) and the right to give birth (or not), thus challenging the normative idea of motherhood and family (34, p39).

The citizenship concept signifies that a person belongs to and participates in a group or a community, with members of the group defining themselves as “us” compared to those who stand outside the group. However, some groups refuse to be categorized.

They refuse to be part of what is regarded as "normal" or "natural", instead they rework or push established boundaries, problematizing the citizen concept and the subsequent categories. Lesbian couples can deliberately or unintendedly constitute a group that pushes established boundaries for citizenship and thereby *do* intimacies in new ways.

In *moral philosophy*, the relation between reason and emotion is frequently discussed. While reason is often presented as the universal and objective foundation of morality, emotions are granted secondary importance. Thus, reason is perceived to be" the power that guides moral conduct and enables respect for the dignity of others" (68, p1). The distinction between reason and emotion are reflected in the distinction between respect for and concern for others and should be called into question, according to Norwegian philosopher Vetlesen (68). He argues that respect and concern should include, rather than preclude each other as they have equal significance, and the moral domain includes respect as well as concern. Although Vetlesen acknowledges the moral importance of respect, in his theory of the preconditions of moral performance, his interest is turned towards concern. For lesbian couples, it is important to be respected by staff, but in order to receive culturally sensitive care, the ability to perceive and be addressed by the women's weal and woe is equally important.

Vetlesen (68) proposes that emotions play an important role by providing access to the moral domain, and in this regard, the faculty of empathy is indispensable. In his study of preconditions for *moral performance*, he asks which "essential cognitive and emotional resources in the subject are required for the subject to recognize the other as a moral addressee" (68, p4). He argues that moral performance is made up of perception, judgement and action, and that *moral perception* takes place prior *to moral judgement* and moral performance (68). To "see" a circumstance and to see oneself as addressed by it, and thus to be susceptible to the way a situation affects the weal and woe of others, is to identify a situation as carrying *moral significance.* Lesbian couples run the risk of being marginalized due to heteronormative structures affecting staffs ability to perceive their weal and woe. Vetlesen (68, p162) argues that

moral perception is grounded in a sensuous-cognitive-emotional openness to the world that provides human beings with a direction or capacity to "tune in" to specific attributes in a given situation (68, p162). Consequently, if the ability to perceive a situation as morally relevant fails, moral performance will fail as well. By being "touched" or "moved", the subject's perception of the moral obligation in the situation is affected. Hence, the emotional engagement of the midwives encountering the lesbian couples at the maternity ward is a precondition for the moral perception needed for moral performance. A professional distance, on the other hand, may jeopardize the ability of the professionals to notice how their behaviours affect the weal and woe of the lesbian couples. In my master's thesis, lesbian couples described being a "mute theme" to maternity care staff, demonstrating that when staff avoided using words like lesbian or donor child in order to avoid marginalizing the couples, the encounters turned out awkward. While emotions may direct people's attention, they do not thereby dictate the course of action. The "gut" feeling is modified, elaborated, questioned and deepened by the use of cognitive powers in a back-and-forth movement between perception, judgment and action (68). Vetlesen's theory on moral perception, addressing perception, judgement and action – is therefore helpful to understand professional challenges inherent in the encounters between lesbian couples and maternity care staff.

3. Design, material and method

In this chapter, I present the scientific approach that underpins the studies and account for research design and ethical issues. I present the three sub-studies included in my thesis separately, regarding recruitment and data collection processes as well as procedures for data analysis.

Table 1

Overview of sub-studies (Articles I, II, III)

	Title	Aim	Data collection	Data analysis
I	"An expression of love – midwives' experiences in the encounter with lesbian women and their partners."	To describe midwives' lived experiences of caring for lesbian women and partners	Individual interviews (N = 11)	Phenomenological hermeneutical method
II	"Lesbian women's experiences with healthcare providers in the birthing context: A meta-ethnography."	To explore research knowledge about lesbian women's experiences with healthcare providers in the birthing context	Qualitative primary studies (N = 13)	Meta-ethnography
III	"Neither father nor biological mother – A qualitative study about lesbian co-mothers' maternity care experiences."	To explore lesbian co-mothers' maternity care experiences and their implications for the caring encounter	Individual interview (N = 11)	Systematic text condensation

Scientific approach

Creswell discusses four philosophical key premises that are folded into interpretive frameworks used by qualitative researchers (75, p23). *Ontology* concerns what constitutes reality and issues related to the nature of reality. *Epistemology* concerns the nature of knowledge developed from a certain ontological position. *Axiology* concerns the researcher's values and positions, and how these perspectives have an impact on the study. Finally, *methodology* concerns the choice of procedures suited

for exploring an ontological domain according to epistemological and axiological positions (75).

My thesis is situated within the *interpretivist* research tradition. Interpretivism is sometimes referred to as constructivism (76), an interpretivist/constructivist paradigm (77), or it is used as an umbrella term to group together social constructionism, phenomenology and hermeneutics (78). Within this tradition, the ontological nature of "reality" is viewed as socially constructed. Research aims to develop knowledge by understanding human phenomena, thus the focus of interest is with the specific and unique, such as human experience, subjectivity and individual interpretation. The subsequent epistemological position is that knowledge is relative, bound to context, time and culture, and focus on human meaning (79).

Studies located within the interpretivist tradition focus on meaning, employ multiple qualitative research methods and are inspired by different philosophical perspectives and theoretical frameworks. A broad range of methodological classifications have been proposed, with partly overlapping conceptualizations derived from different traditions of research, philosophy, or methodology (75).

The ontological domain of encounters between lesbian couples and maternity care staff are interpersonal relationships, socially constructed and taking place between people from marginalized and non-marginalized groups. These encounters are likely to be affected by staff's knowledge and their professional and personal values as well as the lesbian women's previous life- and healthcare experiences. Thus, an interpretive approach with qualitative research methods fitted well with the research questions. These interpersonal relationships do not take place in a vacuum but are formed by social and cultural contexts. Within the axiology of this study, they are situated within a medical system in a heteronormative society. My interpretations are supported by three specific theoretical frameworks which I briefly have presented in the previous paragraph (34, 67, 68). In different ways, these perspectives elucidate the interpersonal and societal perspectives of the encounters within the study context.

My choice of these specific theories is connected to the aims of the study and my own positioning within the field.

In the sub-studies, knowledge was developed inductively, as the empirical data were drawn from two sources, individual interviews and results presented by other authors in previously published primary studies. Still, my studies are not utterly data-driven; since my preconceptions, theoretical perspectives and values have influenced the process of data development and analysis. The overall aim of the thesis is to develop knowledge and insight about lesbian women's maternity care experiences as a foundation for adequate maternity care for lesbian couples. Hence, knowledge development has a practical side as well as a theoretical side.

My understanding of phenomenology and hermeneutics has developed and changed while I worked my way through the empirical studies. When I conducted study III, I wanted to explore human experience without having to devote my study to an orthodox phenomenological tradition, and I wanted to use the term "interpretation" without defining myself as a hermeneutist. Thorne (80) contrasts the practical side of qualitative research in nursing with methods derived from social sciences, arguing that these methods have limited value in applied health research as their main issue has a general character, whereas health research aims to solve everyday problems of practical importance to the applied disciplines. Consequently, Thorne (80) suggests that nursing research should consider interpretive description a viable alternative, rather than watering down or modifying phenomenology or grounded theory. Patton (81, p136) argues that it is unnecessary to "swear vows of allegiance to any single epistemological perspective to use qualitative methods", meaning that methods can be separated from the epistemology out of which they have emerged. Nevertheless, interpretive studies conducted within healthcare settings are still informed by philosophical underpinnings, as studies may have "hues, tones, and textures" from phenomenology, grounded theory, ethnographic and narrative studies (82, p337). In health research, qualitative analysis may be conducted as a pragmatic form of interpretation, supported by relevant theoretical perspectives to generate "credible and defensible new knowledge in a form that will be meaningful to the applied

practice context" (80, p51). In my thesis, this understanding is reflected in the methodological approach as a result of a growing interest in the increasing use of pragmatism as a means to develop knowledge in nursing (83).

Ethical permissions and issues

The interview studies I and III were assessed by the Regional Committee for Medical Research Ethics (REC) and considered to be outside the remit of the Act on Medical and Health Research (S-09221d, 2009/3746; 2012/591 A). They could therefore be implemented without approval from the REC. Further, approval to conduct the studies was granted by the Norwegian Social Science Data Service (21412; 30612). Although the studies could be implemented without ethical approval, we were concerned about ethical challenges and decisions that had to be taken throughout the research process (84). The participants received written and oral information before the interview started and they were told that information given in the interviews would be anonymized and treated confidentially throughout the process.

Study I

This is a qualitative interview study with midwives about their experiences in the encounter with lesbian women and their partners (85). Data were analysed using a phenomenological-hermeneutical method (PHM) inspired by Ricoeur (86).

Recruitment, participants and data collection

I recruited a convenience sample (81) of midwives who met the following inclusion criteria: being professional and working with lesbian women and their partners in delivery rooms, maternity units or health centres. Permission to access two major hospitals was applied for and granted. Information about the study was distributed by head midwives in the maternity wards at both hospitals to avoid direct contact with the participants. In one major hospital, this was a time consuming process, and only four midwives responded to the invitation to volunteer as study participants. An

advertisement about the study in a midwifery journal resulted in one additional participant. The last six participants were recruited by snowballing (81) with midwives passing flyers or information by word of mouth to colleagues they believed would fit the inclusion criteria. The final sample for this study consisted of 11 registered midwives, aged 30-59 years, from four Norwegian counties. The range of their professional experience was 4-32 years.

I conducted individual interviews with the included midwives between June and December 2009. Ten interviews were conducted at the participants' work site, one in a private setting. Field notes were taken to comment on situational aspects, languages and interaction. I encouraged the participants to share experiences from their encounters with lesbian women and their partners, invited with the initial open-ended question:

> *"What have your experiences in the encounter with lesbian women and their partners in pregnancy, labour and the postnatal period been like?"*

Participants were given the opportunity to talk freely, and I interrupted only when there was a need for elaboration or clarification. The interviews lasted 40-80 minutes, and they were audiotaped and transcribed verbatim by me.

Analysis

For analysis we used Lindseth and Norberg's phenomenological hermeneutical method for researching lived experience (86). The method is inspired by the French philosopher Ricoeur's theory of interpretation (87). The method, which includes a structural thematic analysis, aims to "elucidate essential meaning as it is lived in human experience" (86, p146). It was originally used to interpret morals and ethical thinking in interviews with doctors and nurses. The authors state that for research purposes, lived experience must be fixated in texts and interpreted. They argue that it is not the text that is the matter of investigation, but the ethics expressed in the texts.

In this study, individual interviews were transcribed verbatim and looked upon as a text. The following three steps guided the analysis (86). The first step is a *naïve reading.* This is an open-minded, superficial reading aimed at gaining an overall impression of the text, in this case supposed to provide access to the lived experience of the midwives encountering lesbian women in the maternity care services. According to the authors, we must allow the text to speak to us and to become touched by it to grasp the meaning of the text. During this step, we switch from a natural to a phenomenological attitude, putting within brackets "our judgments about the factual, about what is the case, in order to become open to our own experience and to the understandable meaning implicit in this experience" (86, p149). Below I give an example of my summary of a naïve reading of an interview text (translated from Norwegian to English):

> *Encounters were influenced by uncertainty regarding the couple's needs and co-mother's needs in particular, but also about decisions regarding use of language and about the fear of saying or doing something that might upset or offend the couples. This changed when the midwife became more experienced and no longer felt the need to tiptoe around the couples. She had noticed that humour worked well in the encounter with lesbian couples. The responsibility to contribute to a trusting relationship belonged first and foremost to the midwife, but also to the couples. Sensitivity was important in the encounters with lesbian couples; however, there was a fine line between being sensitive and being prejudicial if too much focus was placed on sexual orientation rather than maternity care matters.*

According to Lindseth and Norberg (86), the naive reading is then validated by the next step which is a *structural analysis*. This implies a decontextualization of the meaning units from the text as a whole. In this step, we divided the interview transcripts into meaning units, consisting of parts of sentences, whole sentences or paragraphs. These were read and reflected upon, and in turn condensed to themes and sub-themes. In table 2, I present an example of a meaning unit related to the

naïve reading and demonstrate how the unit was condensed and divided into sub-themes and themes.

Table 2

Structural analysis – from condensation to sub-themes and themes

Meaning unit	Condensation	Sub-theme	Theme
I need to be aware that I don't put on my midwifery autopilot and all of a sudden… you're so used to relate to mum and dad that you need to overrun the autopilot to avoid saying dad, or to forget that you should relate to the actual situation.	Being aware of the actual situation to avoid using the autopilot	Overrunning the autopilot	Creating a confidence
When you strike that note and find a way to dare… I use a lot of humour in general during labour. When you dare to meet on common ground, a barrier is broken.	Using humour as a way to dare meet the couple	Striking the note	

The third and final step is called *critical comprehension* (86). The themes and sub-themes were summarized. Again, we read the text as a whole, taking into account the researcher's preconception, the naïve reading and structural analysis, but also previous research and relevant theory while writing up the text. An example of the text developed from the structural analysis is given below:

> *Striking the note implies an expectation that the other accepts and receives the note (Anderssen 1998), thus the note cannot be neutral. The midwives felt they were challenged to strike a note in the encounter, creating a confidence. This implied to find a way to be open and at the same time respect the couples' need for privacy. Speaking freely implies being open. However, openness can only be looked upon as a genuine openness if it is united with the zone of untouchability, respecting the other's autonomy (Anderssen 1998, Martinsen 2003a).*

Study II

Study II is a meta-analysis based on articles from primary studies identified by a systematic literature search for qualitative papers about lesbian women's experiences with healthcare providers in the birthing context. A meta-ethnographic approach as described by Noblit and Hare (88) was used to synthesize the findings.

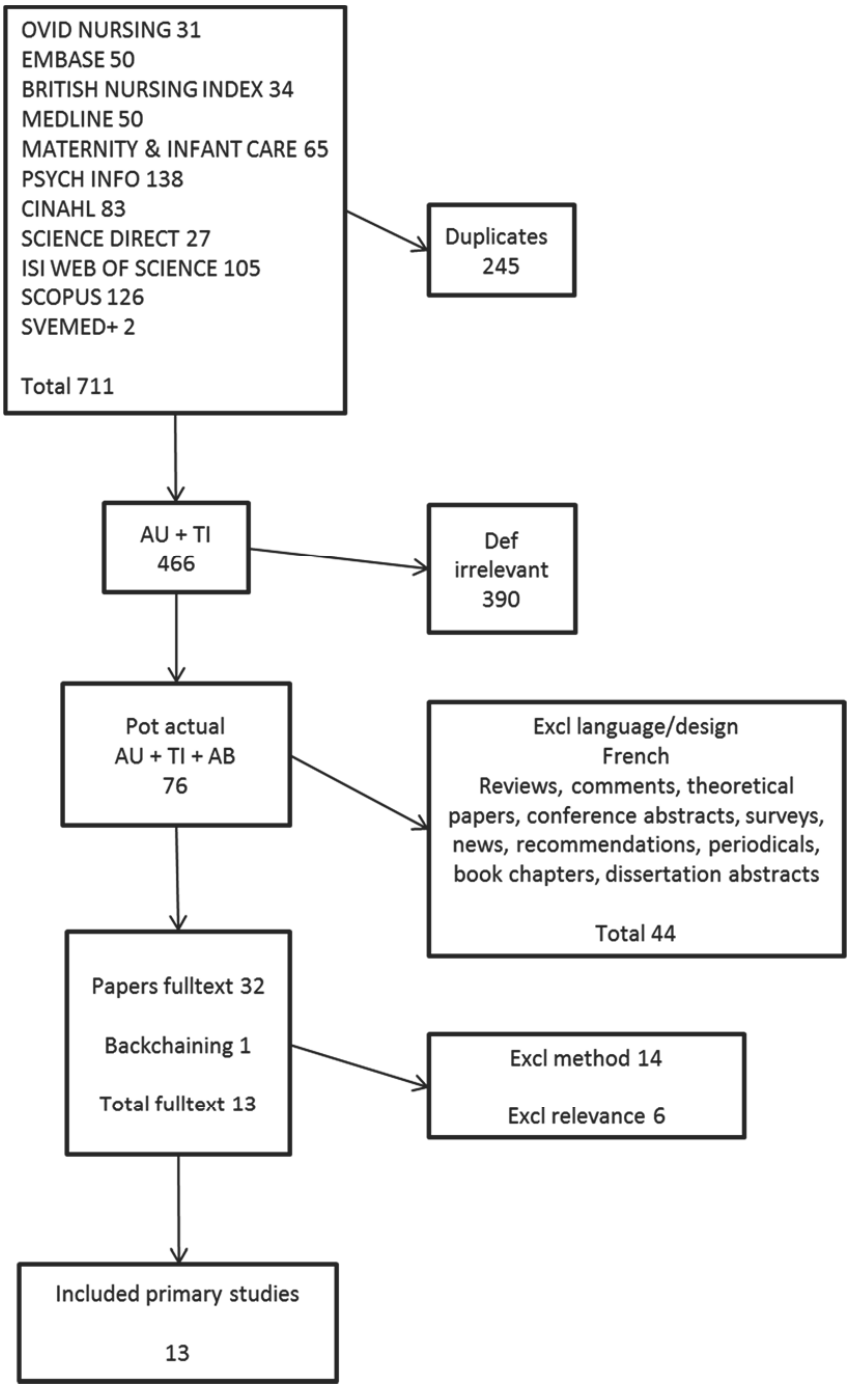
Identification and selection of primary studies

This meta-ethnography is based on findings from 13 articles about lesbian women's experiences with healthcare providers in the birthing context. We included empirical qualitative articles in English or Scandinavian languages that presented relevant findings and sufficient level of research quality.

The systematic literature search was performed between January and May 2011in the following databases: Ovid Nursing, EMBASE, British Nursing Index, MEDLINE, Maternity & Infant Care, Psych INFO, CINAHL, Science Direct, ISI Web of Science, SCOPUS and SveMed+. Relevant Medical Subject Headings (MeSH headings) and text words were entered individually and in combination, spelled in full and in short forms using an asterisk, including: lesbian, female homosexual, comother/ co-mother, maternal health services, prenatal care, postnatal care, perinatal care, childbirth and delivery. We did not use search filters to limit study categories or publication year as we looked into a limited material and were afraid to overlook relevant studies. This search provided 711 hits. An overview of search strategy and stepwise outcomes is presented in figure 3.

After identification and dismissal of duplicates and irrelevant publications, we were left with 76 articles. These were screened for language and design, resulting in the exclusion of an additional 44 articles. The remaining 32 fulltext papers were screened, resulting in another 14 articles being excluded due to design and six due to relevance. Backchaining was performed of the included papers and identified one additional relevant article. The eligible articles were assessed for quality independently by two authors, guided by a checklist for qualitative studies (89).

Figure 3 - Search strategy and outcome



The 13 articles which we finally included for further analysis were undertaken in Sweden, Canada, Norway, UK and America 1984-2011. These studies included a total of 240 female participants, with samples varying from 6 to 70 women and are presented in table 3 below.

Table 3 - Characteristic of primary studies

Author (Year of publication) Country	Sample size	Sample selection method	Data collection method
Buchholz (2000) USA	5 couples	Convenience	Open-ended, in-depth interviews
Dibley (2009) UK	4 couples 2 single women	Snowball	Unstructured interviews
Erlandsson et al. (2010) Sweden	6 co-mothers	Purposive	Open interviews
Goldberg et al. (2011) Canada	5 nurses 3 birthmothers 4 co-mothers	Purposive	Phenomenological interviews
Larsson and Dykes (2007) Sweden	7 couples 4 single women	Snowball	Interviews (personal/telephone)
Lee et al. (2011) UK	8 women	Snowball	Unstructured interviews
Olesker and Walsh (1984) USA	9 women	Snowball	Interviews using open-ended questionnaire
Renaud (2007) USA	70 women	Purposive/snow-ball	In-depth interviews (21) Focus groups (3 couples) Observations (43)
Ross et al. (2006) Canada	23 women	Purposive	Focus group interviews
Röndahl et al. (2009) Sweden	10 women	Snowball	Open-ended interviews
Stewart (1999) UK	7 women	Snowball	Semi-structured in-depth interviews
Spidsberg (2007) Norway	6 couples	Snowball	Joint interviews
Wilton and Kaufmann (2001) UK	50 women	Convenience/ snowball	Self-completion questionnaire

Analysis

Empirical data for analysis consisted of results from the articles reporting the primary studies chosen for inclusion. Noblit and Hare's method for meta-ethnography was used to analyse the data (88). The method consists of seven steps. In *step 1-getting started*, we identified our research topic (lesbian women's maternity care experiences) and defined the aim of the study (to explore and synthesize qualitative research knowledge about lesbian women's experiences with healthcare providers in the birthing context). In *step 2-deciding what is relevant to the initial interest*, we decided on criteria for inclusion respectively exclusion, we performed a systematic literature search as presented above, and decided on eligible studies chosen for inclusion. In *step 3-reading the studies*, we read the result sections of the included articles closely, paying attention to the details in the text and marked what we found to be the interpretive metaphors, such as content issues, themes, concepts and phrases. Together, we identified an index article among the primary studies, which was characterized by rich data and acceptable methodological quality (55), and used this as a starting point for our analysis. In the next step, *step 4 - determining how the studies are related*, the interpretive metaphors were identified and processed into a grid listing studies horizontally and interpretive metaphors vertically (illustrated in table 4), all the time maintaining the concepts and terminology used by the primary authors. At this stage of the analysis, we got a first impression that the findings across the studies were mostly comparable. *Step 5- translating the studies into one another*, was a creative and time consuming step of analysis, where the grid enabled us to keep an overview in the process. We compared related metaphors or content issues from the studies. Some results were removed as they turned out to represent nurses' voices. One row was dissolved as the findings easily could be integrated elsewhere, resulting in four rather than five main categories. Furthermore, issues from the same row were synthesized into a common concept by reciprocal translation in *step 6-synthesizing translations*. The outcome of this analysis is described as a *second order analysis* by Noblit and Hare (88). It was negotiated by all authors in our study and is presented in table 5. Finally, in *step 7-expressing the synthesis*, we developed a text where we described the content in the different categories and used quotations from the primary

studies to exemplify the text. Throughout the text, we referenced the articles reporting the primary studies to describe how and where they underpinned the text.

Table 4 - Grid used for second-order analysis

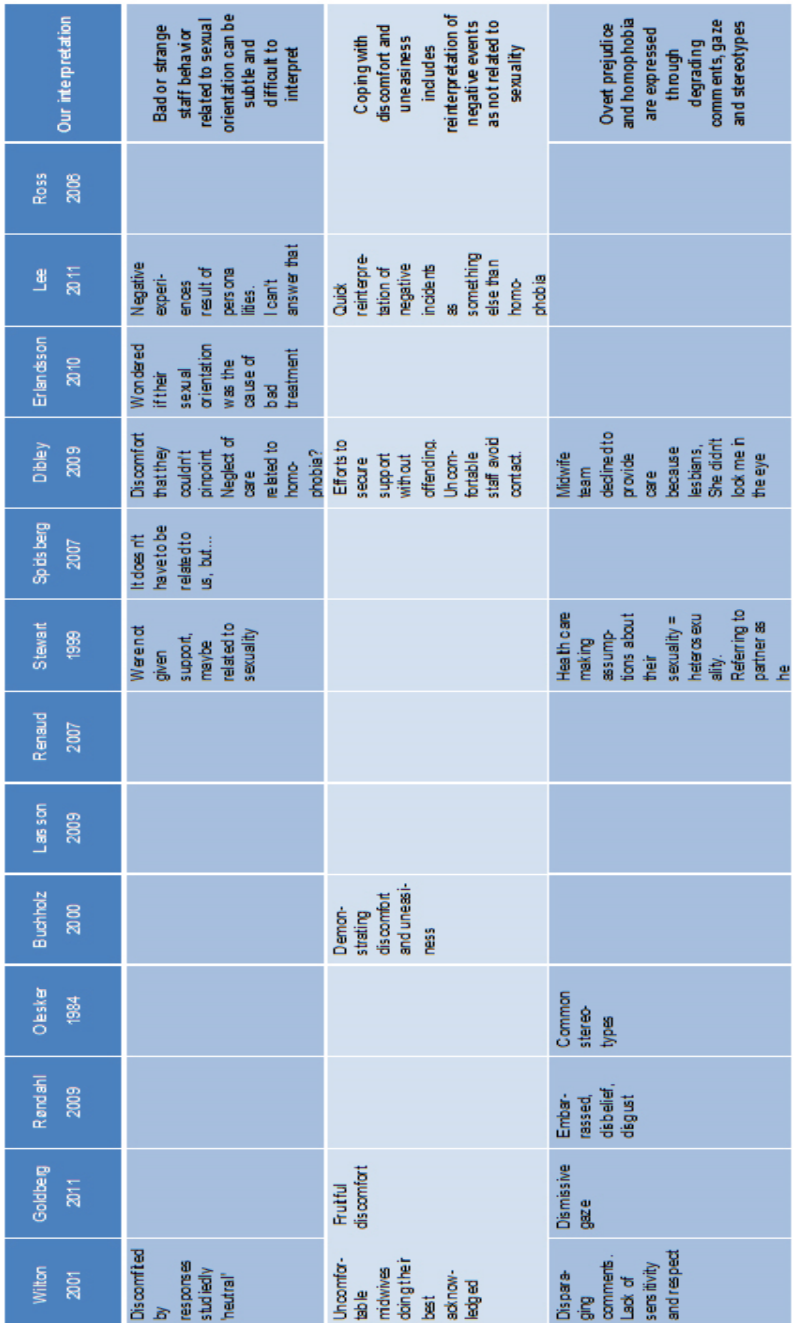


Table 5 - Second-order analysis

Result of synthesis (our interpretation)	Theme
• Bad or strange staff behavior related to sexual orientation can be subtle and difficult to interpret • Coping with discomfort and uneasiness includes reinterpretation of negative events as not related to sexuality • Overt prejudice and homophobia are expressed through degrading comments, gaze and stereotypes	Encountering and managing overt and covert prejudice
• Staff need to know more about lesbian life, yet curiosity should be disciplined at the ward • Staff can mediate positive attitudes and create confidence by small gestures of support	Confidence can be created when professionals present knowledge and support
• Invisible lesbian orientation until proven otherwise by the women themselves • Coming out as lesbians may be very risky • The right choices may be required for lesbian couples to establish a necessary level of control	Disclosure of sexual orientation – important, but risky unless you are in charge of context
• Making co-mother visible is necessary to acknowledge the lesbian couple as legitimate parents • Being accepted as individuals and as a couple is necessary to be treated as a family for same-sex couples • Instead of taking lesbian sexuality as normal and natural, awareness can be exaggerated as well as underestimated	Accepting the lesbian family by recognizing both mothers

Study III

This was a qualitative interview study with lesbian co-mothers exploring their experiences with healthcare providers in maternity care. We conducted a thematic cross-case analysis with systematic text condensation (STC) (90).

Recruitment, participants and data collection

I started recruitment by contacting Hanne Børke-Fykse, who was senior health advisor of Pink Expertise Health, a national collaboration between the Norwegian

Directorate for Health and the National Association for lesbians, gays, bisexuals and transgender people (LLH). Pink Expertise Health offers education that provides healthcare professionals with the skills needed to encounter the LGBT population in the healthcare context with cultural sensitivity.

Information about the study was published on the organisation's website along with an invitation to participate. Furthermore, Børke-Fykse contacted two key-persons in the parent group "Homofile med barn" (English: Queer Parents), and requested their assistance. They distributed an email to the group members in August 2012, and information about the study was forwarded to a Facebook site for queer parents by one of the members. Within a few days I had a number of emails from lesbian co-mothers who were interested in participating or requested information about the study. I established a convenience sample (81) consisting of 11 co-mothers aged 30-52 years living in different parts of Norway. They met the inclusion criteria of being a self-defined lesbian living in a relationship with another woman who is pregnant after insemination by donor. The participants were all married or lived as cohabitants with the biological mother when their babies were born. Six participants had themselves given birth before their partners' babies were born, and three of them already co-mothered two children. Most participants were employed, working full-time, though one was unemployed and one lived on disability benefits. I conducted eleven individual semi-structured qualitative interviews (84) in August and September 2012.Three interviews took place in the participants' homes, four in the first author's work site, two in the participants' work site and two in public places chosen by the participants. All participants had received written information about the study in advance and three of them wanted me to repeat the information before we started. All gave their written consent, and they were informed about their possibility to withdraw from the study. They were encouraged to narrate freely, and I interrupted if elaboration or clarification was necessary. The interviews lasted 38-78 minutes, were audiotaped and transcribed verbatim by me, and started with the question:

> *"What have your experiences with healthcare providers in the maternity care services been like?"*

Analysis

We wanted to explore experiences presented by study participants as crucial. Rather than searching for a possible underlying meaning of what the participants said, we acknowledged their reported experiences as a source of valid knowledge. Data analysis followed STC (1, 90). STC implies analytic reduction, with specified shifts between decontextualization and recontextualization of the data material. Miller and Crabtree introduced three strategies for analysis (91). Within an *immersion/crystallization style*, the researcher organizes the findings intuitively by reading the text thoroughly and then crystallizing significant parts of the text. In *editing analysis style*, the researcher identifies units in text suited for developing databased categories. These are in turn used to reorganize the text, and theories are iteratively used to elaborate and discuss the findings. Finally, within *template analysis style*, the researcher uses a theoretical framework to categorize data. In study III, I used theoretical perspectives in editing analysis style rather than as a template framework, in order to "add important surplus value to descriptive, empirical findings" (90, p802).

The analysis followed four steps and was performed by both authors in collaboration. In the first step: *from raw data to themes*, we established an overview by reading the total data material to get a general impression of the whole (90). At this stage, we tried to bracket our preconceptions and encounter the data material with an open mind. We ended this step by identifying and agreeing upon the following preliminary themes in the data material:

> *Identity, historical perspective, the impact of protective legislation, various ways of being included, differences related to being experienced or first time parent, lack of good concepts to describe the couples' particular situation.*

In the second step: *from themes to codes,* we started the coding process by identifying and organizing elements in the data material that represented various aspects of co-mothers' maternity care experiences (90). The transcript was read line-by-line to identify meaning units, which are parts of the text that contains information that is

relevant to answer or elucidate the research question. The meaning units were sorted out, classified and labelled, and related meaning units were connected in code groups. All the time, we adjusted code groups derived from the preliminary themes identified in the first step of the analysis. In this iterative process, we aimed for a flexible approach where we allowed the codes to become cultivated and refined, while looking for commonalities and differences within and across the coding groups. We agreed upon three code groups:

- *Challenges related to identity*
- *Use of terms and concepts*
- *Being included and acknowledged*

Various technical alternatives can be used to organize meaning units in code groups. In this study, we used the "cut-and-paste" function on the computer. Meaning units were copied, cut and pasted into a new document. Then the meaning units were sorted out and connected in code groups that represented related information.

In table 6 (next page) I present an example of meaning units that were coded under the code group *Being included and acknowledged:*

Table 6

Step 2 - From themes to codes

Meaning units	Code group
"When they are open and include me and see us as a family, kind of…communicate with both of us…smile and nod to us. It's…to be treated as who you are, as a partner to the person giving birth."	Being included and acknowledged
"My lesbian identity has major influence because it is much more difficult to communicate with a person who responds with one single word. And who is afraid to communicate because one might approach something that it is uncomfortable or difficult to talk about."	

In the third step*: from code to meaning*, we summarized and condensed the content of each code group (90). Empirical data were reduced into code groups across the individual study participants. We continued the analysis, paying attention to one code group at the time and sorted the meaning units in each group into a couple of subgroups. The study's research question and our theoretical perspectives guided the analytical process and our decision of which subgroups to prioritize. We turned to one subgroup at the time, and reduced the meaning units into a condensate (an artificial quotation), reviewing and abstracting the data. By using the first-person perspective when writing the condensates, we were reminded to work systematically through the text, starting with a particularly rich meaning unit and adding text from the remaining meaning units around this unit. During this process, we identified quotations to illustrate the subgroups, and we discussed and adjusted the names and boundaries of the code groups. Below, I present part of a condensate as an example from the subgroup *Ways of being included*:

> *The encounter with the ultrasound midwife was positive. She acted natural, and communicated with both of us. I remember she sat on a stool and explained what happened. She looked at me, looked at both of us. I like being seen without being examined critically. She shook hands with both of us, and I*

> *noticed that it was all right. No feelings of uncertainty, just natural. I was given a lot of information and support during labour and birth. I felt safe. Afterwards we received a lot of information together, as a couple. The fact that staff used the word <u>you</u> (plural) affected the encounters and made me feel good. There <u>you</u> come again. They signalize that they see both of us. Eye-contact is important too, particularly when it is combined with a smile.*

In step 4: *from condensation to description and concepts*, we reconceptualised the data (90). We synthesized the contents of the condensates within each code group and developed descriptions and concepts that contributed to elucidate the research question. In third person format we developed an analytical text including the contents from all code groups and quotations carefully chosen to illustrate the findings. The analytical text was refined and condensed, and was presented in the submitted paper as follows:

> *"According to co-mothers, most encounters with healthcare providers were positive and uncomplicated and staff seemed to be aware of the lesbian relationship. The importance of being met with a handshake when they arrived in hospital was underlined, being perceived as staff recognizing their family situation. Eye contact was another token of recognition, particularly when it was combined with a friendly and welcoming smile, as it made them feel visible without over focusing their particular situation. Furthermore, staff's choice of words was important. The use of notions such as "you" (plural) or "both of you" created the feeling of an inclusive atmosphere. A few doctors and midwives seemed troubled to find the right words, but this was unproblematic as long as their overall attitude was perceived as inclusive.* "

We paid much attention to elaborate the category headings, as they communicated a concentration of the results, and thus should be clearly anchored in the data material and the analytic text. Finally, findings were compared to previous research, elaborated and interpreted, supported by Honneth's theory of recognition (67) and Plummer's theory of intimate citizenship (34) (see chapter 2).

4. Main findings

Paper I

Spidsberg BD, Sorlie V.

An expression of love - midwives' experiences in the encounter with lesbian women and their partners

J Adv Nurs. 2012;68(4):796-805.

The aim was to describe midwives' lived experiences of caring for lesbian women and their partners. Eleven midwives, aged 30-59 years, were included. A phenomenological-hermeneutical method was used to analyze the data from individual interviews. Three themes were developed from the empirical data. In the first, "being open", midwives described that, in general, lesbian couples were open about their sexual orientation and relationship. Yet, there were a few situations when they chose to be anonymous as lesbians, and this was respected. Some midwives regarded it as their responsibility to open up the encounter, others awaited the couple's initiative. "Being different" was the second main theme. Midwives understood the lesbian relationship as a love relation as well as a close female friendship. They recognized the friendship as practical and strengthening, and described how the women would speak the same language and have a genuine bodily and emotional understanding. This closeness and understanding helped co-mother understand what her partner went through. A lack of knowledge related to co-mother's role was also described. The last theme was about "creating confidence". Midwives said they needed to avoid routines regarding language and documentation forms and to reassure lesbian couples that they felt comfortable in the encounter. They were concerned about behaving properly, but they experienced that feelings of uncertainty sometimes dominated their professional conduct, and that lesbian couples occasionally needed more time than heterosexual couples to establish a trusting relationship.

Paper II

Dahl B, Fylkesnes AM, Sorlie V, Malterud K.

Lesbian women's experiences with healthcare providers in the birthing context: a meta-ethnography

Midwifery. 2013; 29(6): 674-81.

In this meta-analysis we aimed to identify and synthesize qualitative research knowledge about lesbian women's experiences with healthcare providers in the birthing context. Thirteen primary studies, including 240 lesbian women as participants, were included. Noblit and Hare's method for meta-ethnography was used to analyse data, and four themes were developed. In the first theme, the women described issues related to "encountering and managing covert or overt prejudice". Bad or strange staff behaviour occurred in a subtle manner and created feelings of discomfort or uneasiness that was difficult to interpret. It could be staff's "neutral" responses or their task oriented behaviour. In the second theme, "confidence can be created when professionals present knowledge and support", small gestures of support were described to make a huge difference. Participants were reassured by staff taking interest without being intrusive, and eye contact with staff resulted in feelings of empowerment. In the third theme, "disclosure of sexual orientation-important, but risky unless you are in charge of context", the women described being offended by forms used in maternity care, manifesting their invisibility. However, invisibility could also occur when staff overlooked sexual orientation. Thus, they described a need to be in control or they made deliberate choices before disclosing. Finally, "accepting the lesbian family by recognizing both mothers" implied that staff recognized both mothers and looked upon lesbian sexuality as normal and natural. Making co-mother visible was described as vital to recognize her as legitimate parent. Although the women expressed a desire to be treated as "any other woman" in labour, they welcomed encounters with staff showing a little explicit acknowledgement of their particular family situation.

Paper III

Dahl B, Malterud K.

Neither father nor biological mother. A qualitative study about lesbian co-mothers' maternity care experiences

Submitted

The aim was to explore lesbian co-mothers' maternity care experiences and their implications for the caring encounter. Individual interviews were conducted with participants from a convenience sample including eleven co-mothers, aged 30-52 years. Data analysis was accomplished by both authors in collaboration, following systematic text condensation, a strategy for thematic cross-case analysis. Three themes were developed. The first, "small things make a big difference for co-mothers to feel recognized" showed how in interpersonal encounters with staff, choice of words and attitudes were important for co-mothers to feel recognized. In positive encounters, ordinary tokens of recognition and well-chosen words could create feelings of being included, while lesbian self-confidence played a major role in awkward situations where elements of uncertainty was included. Secondly, "being neither father nor biological mother sometimes result in identity challenges" demonstrated that co-mothers considered being a woman helpful to understand what their partners went through and made it easy for some to find their role in the maternity care setting. Still, they had to find other ways of mothering than if they had given birth themselves. Finally, in the category "co-mothers address themselves with different terms and may perceive some concepts as unnatural or excluding" the concept "co-mother" was perceived as a cold, bureaucratic concept, constructed for documentation. In daily life, the women adopted other names that were more personal and fitted their family situation, and they stated that parental identity was defined by their relation to baby rather than by biological bonds. Formal documentation often had to be corrected, and for some this underlined the fact that their family was different from other families.

5. Discussion

In this chapter I present a discussion of methodological strengths and limitations and ethical considerations, followed by a discussion of the main findings.

Strengths and limitations

Below, I discuss methodological issues regarding reflexivity, internal validity and external validity according to Malterud's metacriteria for assessing qualitative studies (89).

Reflexivity

As a researcher, the question is not whether I have influenced my work, but in which ways my personal and professional background, my motives for doing the study, my knowledge and presuppositions and my choice of theoretical perspectives have had an impact upon the entire research process (1, 89). Below, I shall account for factors that have been influential to my approach and discuss some of the consequences. More specifically, I will focus issues such as insider versus outsider perspectives, my personal experiences, and my professional position. I shall return to the discussion of the impact of my theoretical frameworks later in this chapter.

I am not a lesbian, thus I have an outsider perspective on lesbian life, health and family matters. When I started interviewing lesbian couples for my master's thesis in 2005, I had very little knowledge about lesbian health and motherhood apart from family experiences. When I recruited co-mothers for study III in 2012, I had achieved rather extensive knowledge about lesbian couples' experiences with the maternity care services, including a good overview of the research field. I had become a member of the Pink Expertise board, and I was acquainted with people within the Norwegian LGBT organization, thus I knew whom and where to ask for assistance regarding the recruitment process. An insider status reduces problems regarding access, sampling, gatekeepers, stigma issues and cultural sensitivity, and there is also

a possibility that my outsider perspective may have reduced the risk of going native (92).

At the same time, my preconceptions have changed during the process. When I conducted my first study, I felt like an anthropologist encountering unknown territory. I was nervous and anxious to misunderstand the information the couples shared with me. I was happy when lesbian women said they recognized the findings in my study. When I conducted study III, this tension was gone. Thus, it became even more important for me once again to reflect upon my preconceptions before conducting the study and focus on listening to the women.

When I started reading studies about lesbian health and social inequalities, and later, when I became involved with maternity care for lesbian couples, I reflected quite a lot upon my own position in the essentialism/constructivism discussion of homosexuality (72). E*ssentialism* implies the understanding that homosexuality is an essence or a part of a person's nature or personality, - often meaning that one is born a homosexual. *Social constructionism* argues that cultural and social processes define what is seen as "sexual" and "sexual orientation", meaning that there are different ways of doing homosexuality as well as heterosexuality (93-95). Svare (93) takes a position of mild essentialism, in the sense that the traditional categories and understanding of sexual orientation are definitely at use, while at the same time acknowledging that culture plays an important role in shaping a person's experiences, feelings, life-style and actions. My own position regarding these issues is best described as being underway. I am neither an essentialist in the pure sense of the word, nor do I have a purely social constructivist understanding of what it is to be lesbian. My position today can also be characterized as a *pragmatic culturally oriented approach* (26).

Bjørkman refers a common assumption that female researchers undertaking research on lesbians are lesbian themselves (96). I have attended conferences where midwives and nurses have approached me after I have given my presentation, and from the way they addressed me, it was obvious that they believed I was lesbian. However, I never

stated my sexual orientation explicitly to the participants in my studies, and I do not know whether this strategy influenced their willingness to participate, or the answers they gave in the interviews. My own prejudices were ambiguous: on one hand I suspected to meet subversive attitudes among midwives towards lesbian women, on the other hand I expected myself and my colleagues to treat all groups of women appropriately. The fact that I was a midwife probably influenced midwives' willingness to participate, as some commented on the need for knowledge about lesbian couples' situation, particularly that of co-mothers'. It is also possible that my professional experience influenced co-mothers' willingness to participate in the study. The women were eager to share their personal experiences, and some stated that they thought it was important to contribute to my research as midwives lack knowledge about their situation.

When conducting study I about midwives' experiences with lesbian women and their partners, I identified myself with an insider perspective. Being an experienced professional midwife certainly influenced the interview situation. My professional experience sometimes provided helpful in order to understand the midwives, as I was able to recognize situations about workload limiting the caring situation or gossip about patients taking place behind their backs. On the other hand, I may have taken aspects of their stories for granted, or I may have believed that I understood what they spoke about and thus avoided further probing.

My professional perspectives and experiences are reflected all through this thesis, thus my most important glasses certainly have a midwifery lens. When I listened to lesbian women's stories about their maternity care experiences while interviewing for my master's degree in 2005, I was struck by the ambiguity in their stories. In short, the women seemed genuinely satisfied with their maternity care encounters, in spite of the considerable difficulties they encountered. Still, studies show that factors directly related to relationships, such as the quality of the relationship between the woman and her caregiver and the quality of support she receives from caregivers, determine labour outcome and experiences (13). Gradually, I became increasingly aware of the associations between the prevailing cultural context of heteronormativity

and the subtle nuances of the interaction at the maternity ward. I am convinced that for marginalized groups, such as lesbian couples, positive birth outcome and experience cannot always be expected to be a straightforward process.

Internal validity

Internal validity depends on the degree to which the study has investigated what it meant to investigate, and whether the chosen methods have been appropriate (89). According to Mays and Pope (97) it is essential that the process of data collection and analysis is described with transparency, in order to offer intersubjectivity. I start with a discussion of validity aspects regarding use of individual interviews and systematic literature search, followed by a discussion of methods used for interpretation of data in the studies.

In study I and III, I used *individual interviews* as a source for empirical data. The qualitative interview is an interpersonal situation comparable to a conversation about a theme of common interest to the interviewee and the interviewer, though different to an everyday talk by means of their structure and aim to generate knowledge (84). I aimed for rich descriptions, and encouraged the participants to narrate as freely as possible, avoiding set questions. In both studies the interviews started with an initial question, and I interfered only when there was a need for elaboration or clarification. Some participants felt comfortable narrating freely, while others said they had expected that I presented a set of questions to be answered.

In an interview situation, it is not uncommon that pauses occur and that participants need to think and reflect before they answer a question or elaborate a statement, as exemplified by an interview where the midwife answered my question with only one sentence. I could feel the tense situation, and started a normal conversation instead. From the email she had sent me where she asked to be included in the study, I knew that she was an experienced midwife. Talking freely about her experiences with lesbian couples, on the other hand, was impossible. However, after a few minutes, she

seemed less tense and was able to share a number of interesting experiences with me, thus I decided to conduct the interview as an informal conversation.

Meaning making is a collaborative enterprise by the persons involved (98), and the quality of the information that is obtained in an interview depends to a large extent upon the researcher (81). In Norway, the LGBT populations are legally protected against discrimination, and healthcare professionals are expected to conduct their work in accordance with ethical guidelines (99). This has probably reduced the risk of overt homonegative behavior, such as inappropriate language.

Negative attitudes may still be reflected in staff's behavior and body language, and some argue that they are able to provide neutral care in spite of personal negative attitudes towards homosexuality (100). Lee and co-workers (57, p8) ask if "protective legislation and equality driven policies simply suppress homophobia rather than deal with it at an attitudinal level". This may be one possible explanation of why midwives who were opposed to lesbian mothers were unwilling to talk to me. In hindsight, I wonder if the interviews somehow challenged the participating midwives on an attitudinal level, as they all seemed eager to identify themselves as "gay-friendly and tolerant. Having conducted a focus-group study instead of individual interviews (101), I assume that the normative pressure that may occur in a focus-group would have made it difficult for the midwives to disclose potentially homonegative attitudes. An alternative approach could have been observational studies of the midwife-woman interaction combined with data on midwives' experiences gathered in a natural setting. Still, interpreting data collected in observational studies is challenging, and gaining access to the clinical field would probably be difficult. Gaining access to explicit homonegative data is problematic, thus I consider this a study limitation.

When conducting the interviews, it took some time before I was able to hear that the midwives often used indefinite and generalizing pronouns in the interviews, talking about what "one" ought to do rather than what they did in the actual situations. These kinds of statements appeared to be too general to provide content validity of

individual experiences, and most of them were therefore omitted from the analyses. An alternative to deleting such statements could have been to conduct a discourse analysis (102), focusing on use of language.

In study II we conducted a meta-ethnography (88). The sample consisted *of results from articles reporting qualitative primary studies* judged as relevant to the research question (103). We conducted a broad literature search, avoiding the use of search filters, thus we were left with an abundant amount of "noise" that had to be sorted out manually. We performed a thorough search strategy in collaboration with an experienced librarian, but we are aware that our keywords may not have been comprehensive, inclusion criteria may have resulted in loss of valuable information, and papers may have been published after our search was finished. Still, we do not believe that any search strategy guarantee coverage of all relevant primary studies.

We identified a sample of articles holding sufficient quality to be included in the synthesis, and the analysis demonstrated that our sample provided empirical power to illuminate our research question broadly. Sample size is frequently discussed in literature about meta-ethnography (104). Due to the amount of information included in the studies, 10-12 studies are often recommended (105). Conducting a meta-ethnography including a too limited or an excessive number of studies would have risked the possibility for ending up with insufficient or abundant amount of data, both jeopardizing the possibility to answer the research question. We concluded that our sample was appropriate since our analysis demonstrated findings exceeding the results from the individual studies (106).

Another methodological aspect is whether studies using different qualitative methods should be included for synthesis (103, 107). According to Noblit and Hare (88, p14), meta-ethnography is intended to enable "a form of synthesis of ethnographic or other interpretive studies". We decided to include studies using different qualitative methods, such as phenomenological and thematic content analyses. According to Zimmer (103) a combination of studies using closely related methodologies will provide a more coherent interpretation than if the findings come from studies using

various methodologies. She argues that is possible, but challenging, to synthesize studies with same or closely related methodologies. However, some methodologies are more compatible than others due to their epistemological stance, but still it is possible to synthesize across methodologies if one takes into consideration the differences in methodological assumptions underpinning the studies (103). In this study, we synthesized across heterogeneous methodologies (108), and we found that this strategy positively increased the variation of our findings.

Before including the studies in our meta-analysis, we performed a critical assessment guided by a checklist. The use of checklists for assessing quality is debated (109), and several lists have been presented. Some are comprehensive, others less detailed, and often they overlap (89, 110, 111). In our study, we performed assessment according to Malterud's checklist (89). This checklist contains a number of questions to be considered with regards to study aim, reflexivity, method and design, data collection and sampling, theoretical framework, analysis, findings, discussion, presentation and references. We found this checklist suitable for our purpose, allowing a thorough overall assessment without scoring the single studies (89).

Analysis and synthesis of the empirical findings from the articles from the primary studies generated descriptions of a wide range of experiences and repetition of themes in all studies. Some of the findings confirmed previous studies, such as strategies regarding disclosure and the need to recognize co-mother as legitimate parent. The meta-ethnography directed us towards the importance of subtle details taking place in the encounter, such as healthcare providers' inability to have eye contact, their dismissive gaze or particular way of blinking. This issue was confirmed by co-mothers in study III.

A discussion of internal validity also includes reflections upon different choices regarding methods used for qualitative analysis. We used phenomenological-hermeneutical method (PHM) (86) in study I, Noblit and Hare's meta-ethnographic method (88) in study II, and systematic text condensation (STC) (90) in study III. The

transcripts were read by my coauthors and findings were discussed, resulting in a thorough process.

In hindsight I believe that study I might have benefited from another method for analysis. My understanding of phenomenology and hermeneutics has changed since I started working on my thesis, and so has my understanding of a good methodological approach underpinned by one or both philosophical traditions. PHM is inspired by Ricoeur's interpretation theory (87) and it is not the only methodological approach claiming to be influenced by Ricoeur (112-116). In PHM according to Lindseth and Norberg, I miss the critical aspect in Ricoeur's hermeneutics regarding conflicts of interpretation and his focus on the importance of metaphors. Thus, I would rather have chosen an approach that included these aspects if I were to conduct a phenomenological-hermeneutical study inspired by Ricoeur today.

The use of various approaches to phenomenology and hermeneutics in qualitative studies has been criticized for method slurring (117) and for not paying sufficient attention to central concepts within philosophical traditions, resulting in misunderstanding and misinterpretation of the philosophical traditions and their usability in qualitative studies (118, 119). When conducting study III, I decided to use STC (90). STC is a pragmatic approach which includes a detailed, stepwise description of the analysing process, thus enabling an iterative process when working with the data, allowing various theoretical perspectives to support analysis.

In study II, we used Noblit and Hare's meta-ethnographic method (88). The method was described in 1988 and is frequently used in healthcare studies (106). The individual steps are not described in great detail, and the process of synthesising translations seems to be understood and conducted differently by different authors (120). This makes it difficult to grasp how the authors managed the data or conducted the analysis in detail. According to Noblit and Hare (88, p28), synthesis "refers to making a whole into something more than the parts alone imply". Furthermore, the authors argue that, if the number of studies included is large and the resultant translations are numerous, it may be possible to conduct a second level of synthesis,

"analysing types of competing interpretations and translating them into each other" (88, p28). In study II, synthesis was conducted in an editing analysis style (91). By using a grid which was saved in different versions of revisions, we were able to maintain overview of the data material and to keep track of our decision trail. As a starting point for our synthesis, we chose an index paper characterized by rich data, while others have chosen the oldest study as an index paper (111). Campbell and co-workers demonstrated how meta-ethnography can incorporate and reflect change over time. They included studies undertaken over a 20-year period, but found no changes in patients' experiences of diabetes or diabetes care during that time span. Our studies were conducted between 1984 and 2011, and our studies demonstrated opposite findings, documenting important changes in lesbian women's maternity care experiences.

Meta-synthesis is supposed to provide a new, integrated and more complete interpretation of findings, offering an in-depth understanding that transcends the sum of individual studies (106). Means to validate findings include returning the synthesis to the original researchers asking them if the integrity of their work is intact (121). Others suggest the use of letting other researchers check each step of the process independently (122). We validated the study by a joint working with the data at every step of the process, including rereading the articles from the primary studies.

External validity

According to Malterud (123, p485), "In qualitative inquiry, the aim with respect to external validity is to ascertain whether or not the study hypothesis or results can be applied in other settings". Other qualitative researchers ask whether the findings can be generalized beyond the setting where they were generated (97). Below, I shall account for my three different samples as well as demographics and study setting and discuss strengths and limitations regarding transferability.

The sampling strategy which is usually recommended for qualitative research is a purposeful, information-rich sample with a capacity to provide knowledge that can

answer the research question (81). Patton argues that there are no rules for sample size, instead "purposeful samples should be judged according to the purpose and rationale of the study" (81, p245). In studies I and III, a purposive sample would have been ideal, allowing a consideration of variables that might have influenced the findings while elucidating the research question. In order to recruit a sufficient number of participants for the studies, we had to use various starting points for sampling, including snowballing. Hence, the samples included in studies I and III are best described as *convenience* samples (80), that is samples including participants who were close at hand and willing to participate in the studies. Convenience sampling may limit credibility due to challenges related to justifying interpretation of the study findings, according to Thorne (80). Since a convenience sample may vary significantly from other samples, the researcher must pay particular attention to the interpretation of finding, the author says.

In study I, eleven midwives represented caring experiences ranging from one to several lesbian couples. Furthermore, they worked in maternity units and health centers in four Norwegian counties, rural as well as urban, their age varied from 30-59 years and their professional experience ranged from 4-32 years. Half the sample was included by snowballing, the remaining half through formal invitation. Snowballing is often used to locate hard-to-reach populations, such as lesbian women (92), thus running the risk of not generating a sufficiently diverse sample, as the first participants will influence further recruitment. In study I, snowballing came up after an informal conversation after one interview when the participant suggested she should contact a colleague with recent experience of caring for lesbian couples. From that point on it was impossible to know who passed on information to whom, and if there existed one or more chain of referrals.

Altogether, it is difficult to know to what extent the participants represented the target population per se (124). However, the sample provided a large amount of in-depth information about midwives' caring experiences and aspects of the findings were repeated to some extent in later studies, thus supporting external validity. Transferability in qualitative studies is also demonstrated by the study's ability to

communicate an augmented understanding of the phenomenon in settings outside the study setting. For this to take place, the reader must understand the study findings and find them reasonable (125). Hence, the transferability of my findings may later be approved by being recognizable for the LGBT population in general, as well as other marginalized groups.

The sample in study III included co-mothers from urban and rural areas, with comparable age and had similar bias regarding residence, education and ethnicity as the midwife participants in study I. Two participants were experienced co-mothers, adding a historical perspective to co-mothers' situation in Norway. Still, our design and sample did not allow for analytic comparisons according to demographic differences. This sample of co-mothers also demonstrated sufficient empirical power to illuminate the study's aim. A broad range of experiences were described and repetition of themes occurred with considerable variation. Few negative experiences were reported. This may be indicative for the everyday situation for co-mothers in Norway, while similar findings are also reported in other European studies (59, 64). There is a risk that co-mothers with negative experiences would have been reluctant to participate in the study. Furthermore, some of the participants belonged to a network for lesbian parents, which may have influenced positively their willingness to participate in the study. Nevertheless, this study would have profited from participants from non-Western cultures in order to add variety to the data (126).

Study II, the meta-ethnography, is to our knowledge the first to synthesize lesbian women's experiences in the maternity care setting. A decade ago such a study would have been unfeasible due to lack of relevant studies. Our sample included one article published in 1984, one in 1999 and one in 2000, while the remaining articles were published between 2006 and 2011, indicating an increasing interest in the research area. The eldest of these studies provided interesting historical context. According to Bondas and Hall (107), it is a prevailing tendency to disregard previous research that can be regarded as an inheritance from the quantitative meta-analysis. They argue that fruitful studies sometimes include research that is more than 10 years old. The sample in our meta-ethnography comprised altogether 240 women, representing

women of different status and age with a bias towards Caucasian, well-educated women, living in big cities. Our sample would have profited from an inclusion of primary studies exploring the situations of women living in rural and non-Western cultures (126). Meta-synthesis allows for an understanding of the social and historical context, where the engagement with the texts may result in knowledge grounded in experiences and contexts of the participants included in the primary studies (81). Our sample provided sufficient empirical data to illuminate the research question broadly. The categories generated from the findings were supported by studies from Scandinavian and European countries indicating that our findings can be generated to contexts beyond the study environment.

Ethical issues

When undertaking a study, the aim should not be scientific value alone; the project should also aim to improve the situation for the group of people included in the research (127). In my thesis, I wanted to develop knowledge and insight about lesbian couple's maternity care experiences. A critical perspective (69) was useful when I aimed to develop knowledge about lesbian couples' caring needs which might form a basis for appropriate culturally sensitive maternity care for this group of women.

Confidentiality is particularly important when undertaking small-scale studies with risk of identification. Although we recruited co-mothers living in different parts of Norway, recruitment was obtained through a parent group network and a Facebook site, implying a small risk of information being shared. The same applies for midwives' situation. Snowballing is an efficient method for sampling, but includes a risk of identification. In both studies, we had to consider carefully which quotations to include, reducing the possibility of identification, and how to give a sample presentation without going into too much detail.

In the interviews I strived to gain the interviewees *trust* in order for them to narrate as freely as possible. When interviewing midwives, my insider status required that I paid attention to my role as researcher in order to avoid becoming too close. I was familiar

with the situations they described, thus it was easy to fall into the conversation as a colleague rather than a researcher (1). Before starting the interview, I therefore informed the participants about the interview situation and tried to clarify my role. As healthcare providers, the participants were not protected by the Helsinki declaration (128), which renders them somehow vulnerable. One of the hospitals where I recruited for the study had actually established routines to protect employees who became involved in research projects as participants, and my research protocol and the information flyer were reviewed by the hospital. I was requested to add a sentence in the information flyer stating that participants could contact me after the interview to require that sensitive information was omitted, but none did.

Some midwives and co-mothers expressed that it was difficult to narrate freely. I therefore adopted different strategies in the interviews in order to establish trust and open up the dialogue such as spending some time on small talk before I started the interview if the participants seemed nervous or uncomfortable. Yet, the interview situation resembles an informal conversation, and it is easy for the participants to reveal sensitive personal knowledge that they may regret later. In both studies the participants shared knowledge that might be characterized as intimate, and some co-mothers told me very personal stories about health, family and adoption processes. Although providing important contextual comprehension, these stories were omitted from the analysis, due to lack of relevance as well as confidentiality challenges. Still, I became aware of how the women became vulnerable to my capacity for handling sensitive issues, affecting my preconception, and thus indirectly influencing my interpretation of the data.

Study II, the meta-ethnography, consisted of 13 articles from qualitative empirical studies. Three articles did not describe accomplishment of formal procedures for research ethics (55, 60, 129), one article stated that it could be implemented without approval (59) and the remaining studies had undergone some form of ethical assessment (49-52, 57, 58, 62, 63, 130). Whether or not one should include articles from studies that do not clearly state ethical approval may be discussed. Assessment tools sometimes ask if the included studies describe ethical approval (109). In our

meta-ethnography we chose to include articles from studies that did not include ethical assessment as long as they provided sufficient methodological quality and rich findings. As a result, we carefully considered the quotations we decided to include.

Discussion of findings

Below, I shall highlight the main findings of my thesis across the sub-studies, looking at the following three points from the perspectives of lesbian couples and midwives:

My thesis adds to existing knowledge first by demonstrating the close relationship between disclosure, visibility and recognition for lesbian couples encountering maternity care and describing in concrete detail the links between being seen and feeling recognized. Secondly, the presence of lesbian couples may challenge conventional heteronormative ideas of motherhood and family practices within and outside the maternity ward. Challenges related to naming and identity demonstrates heteronormative assumptions and a need to adapt and adjust language for all parts involved. Because they are women, co-mothers are provided with a first-hand understanding of pregnancy and labour. Their presence also seems to add a "queer touch" to the maternity care context, challenging traditional notions of femininity and masculinity. Finally, the analysis reveals how encounters with maternity care staffs are moral encounters where staff's attitudes related to sexual orientation may influence responsible conduct, demonstrating the connections between moral perception and moral performance in the specific context of intimate citizenship that lesbian couples instigate by arrival at maternity care.

Enhancing visibility and recognition for lesbian couples in maternity care

I am not the first to demonstrate that visibility - to be seen - is a major concern for lesbian couples in the maternity care context (49, 50, 55, 57, 131) or in the health care system in general (28, 44). Yet, my thesis adds to existing knowledge by providing access to a more thorough understanding of the implications of disclosure of sexual

orientation, more specifically by demonstrating the close relationship between disclosure, visibility and recognition.

Disclosure is the "social practice of sharing the details, the "truths" about one's life" (132, p639). It is an ever-ongoing process associated with unpredictability (133) in which the lesbian woman reveal to others something that she has acknowledged to herself (47). Disclosure involves a shift from being invisible to becoming potentially luminescent (54). It is usually associated with growth and improved life-quality (134), positive experiences of identity and sexuality (135) but also with vulnerability (28).

Disclosure of sexual orientation is to *make oneself visible*. Our studies demonstrate in different ways how lesbian couples generally disclose to maternity care staff in order for both women to be included in the birthing process and to be recognized as a family (articles I-III). Similar findings have been described elsewhere (49, 51, 55, 131). Disclosure is associated with visibility management as a coping strategy (136, 137), implying that lesbian women may choose not to disclose when they anticipate poor treatment (49, 55, 133). Our studies also indicate disclosure as a precondition to lesbian motherhood, as previously proposed in an Israeli study (138). The authors describe how lesbian mothers experienced that their "mainstream identity" as mother would override their "marginal" identity as lesbian, implying that it might be easier to come out as a lesbian mother than coming out as a lesbian.

Several studies describe positive aspects of lesbian couples' interpersonal maternity care experiences (50, 64). Our studies add to this base of knowledge by demonstrating in concrete detail the links between being seen and feeling recognized. The participants describe the importance of staff using words that include both mothers, in eye contact, and by meeting the couple with a handshake and a friendly smile (articles II and III). In situations where staffs demonstrate that they are aware of and acknowledge the couple's sexual orientation and family situation, the women feel visible, included and empowered, they feel lucky (article II).

A satisfactory interpersonal relationship between the professional and the woman in labour is essential for a good outcome (10, 12, 14). Midwives say they never doubt the couples' ability to care for their children (article I), still they find it more challenging to establish a trusting relationship with the lesbian couples compared to heterosexual couples. They believe this is a result of previous healthcare experiences. Consequently, they say that they try to pay special attention to language and attitude in order to make the lesbian couples feel included and to avoid situations where they need to explain themselves. Occasionally, they let co-mothers stay after visiting hours or express their sympathy with the couple that documentation forms used in maternity care is inappropriate for lesbian couples. Such details of performance are examples of clinical practice which may enhance the lesbian women's feelings of being visible.

Laboring women in general feel vulnerable and dependent of staff, yet they long for a sense of control (10). Labour pain, insufficient pain management or uncaring birth attendants may jeopardize the feeling of being in charge. While any laboring woman may experience pain and lack of care, lesbian women run the risk of marginalization and invisibility by maternity care staff because of their sexual orientation (51, 130). Labour is a complicated process, where predictability, trust, control and support are essential elements in order to have a positive birth experience. The fact that positive interpersonal maternity care experiences among lesbian women are described is therefore reassuring (50, 59). Still, all our studies present examples of uncaring and ambivalent encounters, often attributable to sexual orientation. Co-mothers describe that staff turn their backs to them and exclude them from conversations (article III), apply careless use of language (articles I-III) or comment the couples' situation behind their backs (article I). Similar findings have been demonstrated elsewhere (57, 60). Yet, overtly homonegative attitudes seem to be scarce. Situations demonstrating covert or ambiguously homonegative attitudes, on the other hand, are frequently described (49, 57, 60, 130). Such awkward situations leave the couples with feelings of uncertainty and the responsibility to interpret and make sense of this uncertainty.

Honneth's theories about recognition, briefly presented in chapter 2, provide a lens for discussing the impact of visibility in this context. He suggests that identity-

formation is dependent upon intersubjective recognition, furthermore that "to recognize others is to perceive an evaluative quality in them that motivates us intrinsically to behave no longer egocentrically, but rather in accordance with the intentions, desires and needs of others" (139, p85). Hence, moral injuries are enacted by refusal of recognition (140). Visibility, according to Honneth, is indicated by expressive acts, such as smiling or shaking hands. These acts have a performative character, confirming social visibility for the person experiencing these bodily expressions. Such positive expressions are meta-acts, implying the probability of proper treatment here and now as well as in the future. Furthermore, the qualities of expressive acts are nuanced, meaning that experiences of being met with respect will result in different caring expectations than being met with "open arms" by staff (141).

In studies II and III, lesbian couples describe how they feel visible and included when staff demonstrate positive expressive acts, anticipating being recognized and cared for, with the "tone" in the expressive act indicating the degree of caring they may expect. On the other hand, co-mothers in study III feel invisible and unimportant when staffs turn their backs on them, excluding them from communication. In such situations, they become invisible after having initially been seen and then, in turn, being overlooked, or being seen through. Thus, invisibility is linked to humiliation and lack of value. Rosenberg (142) describe similar views, arguing that in situations where staff does not mention words like lesbian or donor child as a means of expressing tolerance, this may be looked upon as a discriminating act or a way to maintain heteronormativity.

Since the Norwegian gender-neutral marriage law was introduced in 2009, it has taken very long to adapt documentation forms used in maternity care to include lesbian couples, particularly co-mothers. Participants in all studies comment the use of documentation forms in maternity care. For some co-mothers, being invisible in this context is uncomplicated, for others it adds to the ambiguous feeling of being different. To develop self-respect is to achieve a sense of oneself as a person or a morally sensible agent (67). Thus, legal recognition is disrespected when personal autonomy is restricted due to denial of legal rights or social ostracism. Co-mothers

feel that they are set aside when they have to make space for themselves in documentation forms although they are in fact the baby's legal parent.

Still, to be legally recognized does not equal being socially approved (21). For lesbian couples, whose ways of life is sometimes denigrated, lack of recognition poses a specific threat to self-esteem. In the maternity care context, the couples want to be treated like everybody else, as ordinary families (articles I-III). At the same time the say it feels nice when staff demonstrate specific knowledge about their situation. The lesbian women are aware of power relations, thus it is likely that in encounters where they fear or anticipate being marginalized and experience the opposite, they feel lucky. I find co-mothers' parental situation particularly challenging. Co-mothers represent a new population group in maternity care, and study III demonstrates that co-mothers struggle to find their personal parental role while pushing the cultural standards on gender. In this process visibility is especially important and also having one's ideas of parenting and doing family socially approved.

The challenge for maternity care staff encountering lesbian couples is to be aware of the specific pitfalls of potential moral injury and personal harm related to recognition and visibility. Responsibilities regarding *responsible conduc*t ascribe health personnel a legal obligation to act in accordance with professional standards regarding ethical conduct (143, 144). The International Confederation of Midwives (ICM) (99) also provides a set of guidelines regarding moral professional conduct and offers a philosophy and model of midwifery care stressing the perspective of empowerment and partnership in the midwife-woman relationship. The National Guideline for Antenatal Care (145) emphasizes that midwives must be open to various family settings and consider use of language and communication. Furthermore, midwives should be familiar with sociocultural issues and methods for sensitive approach with various groups of pregnant women, providing appropriate care for all women. Knowledge about caring needs within specific groups is essential to provide tailored or culturally sensitive care. Wilton (2, 146) called for attention towards the knowledge gap about lesbian mothering in midwifery literature in the 1990ies, but it has received limited attention. More than two decades later, lesbian mothering is still

barely mentioned in midwifery literature and the term culturally sensitive care seems to apply exclusively for women from foreign cultures.

Queering maternity care by challenging heteronormative assumptions

Our studies (especially article III) reveal how the presence of lesbian couples may disrupt conventional ideas of motherhood and family practices, thus bestowing maternity care with a "queer touch". These circumstances are often related to co-mothers' situation. Below, I shall explore the role of language and identity in the maternity care context (40, 147, 148), revealing what my thesis adds to previous research.

The issue of *naming* has been discussed from different perspectives in all our studies. The lesbian couples tell about how they sometimes spend considerable time during pregnancy deciding which terms to use in order to describe their parental identity. Often the discussions are related to the use of the terms mother (Norwegian: "mor") or mama (Norwegian: "mamma"). Most co-mothers in study III want to be called mama, sometimes in a combination with their first name. Other couples call themselves mother and mama. Some co-mothers use their first name, stating that they are parents, not mothers, or they create personal names like memo or baba. In the private context, the participants never use the term "co-mother". Similar phenomena have been described elsewhere (40, 149). Midwives are also concerned with the disorderly situation of naming (study I). They sometimes ask the couples what they prefer to be called, or they simply refer to both women as mother. While midwives regard the term co-mother as a useful tool to describe non-biological mothers' family situation (study I), co-mothers experience this term as a cold, bureaucratic concept characterizing them as «mother's assistant" (study III). Similar findings have demonstrated by Gabb (148).

Challenges related to naming are demonstrated in the use of documentation forms as well (articles I-III).These forms can be regarded as stereotypical, demonstrating heteronormative assumptions such as the heterosexual gender binary, equating

women with mothers and men with fathers (150). When the questions do not fit, staff may become confused and avoid asking adequate questions (study II). Co-mothers seem to lack a language that can identify, address and understand them (40, 149). Consequently, to claim an *identity* without a name is difficult. For staff, it is possible that some confusion related to naming is concerned with lack of terms and concepts in the encounter with lesbian couples. However, the risk of limited language may just as well add to the creation of "other" as a category, sustaining heterosexuality as the dominant norm, marginalizing relational structures that fall outside this norm (151).

Creative professionality was described by the participants to adjust and adapt *language* and documentation forms to fit the couples' situation. According to midwives (article I), it is vital to encounter lesbian couples with respect and meet their individual needs. The midwives believe that personal attitudes are more important than finding proper gender-neutral words. Studies have demonstrated the booking visit to be challenging for lesbian women (28, 52). In our studies (articles I-III), we found issues of uncertainty related to language to be most challenging at birth preparation courses. Similar findings are demonstrated in a study by Brennan and Sell (40). In all contexts where midwives encounter a mixture of heterosexual and lesbian couples, they have to find terms to replace "father" in order to avoid excluding co-mothers. At the same time, they are concerned that the use of gender-neutral words may result in fathers feeling excluded (study I). Partner or spouse is sometimes used, but one midwife said she ended up by simply using the term sweetheart (Norwegian: "kjæreste") as it had a positive tone and included both co-mothers and fathers.

According to Gabb (148), lesbian families raise children beyond gender. Nordqvist and Smart (33) ask what constitutes a proper family, and argue that lesbian families must reshape parenthood, changing the familiar twosome model into models containing different combinations of adults. My findings emphasize and expand the impact and ambiguity of the "family" concept. Some of the co-mothers claimed that the nuclear family is outdated, demonstrating the need *for new terms*, for example "house family", to describe their family situation (article III). However, study III also demonstrates that it is important for some couples that their family is acknowledged

as an “ordinary family”. This reflects a need to develop new categories that can replace traditional ways of defining family. One way to describe the variety of family practices is to change the family concept from being a noun to being a verb, from *being* a family to *doing* family (37). According to Powell, Bolzendahl (38, p34), definitions of family have impact on a private level, affecting “who is and who is not a family in day-to-day interactions”. This is reflected in study III as well.

Confusion among professionals related to parenting is also described. Sometimes staffs have not captured who is who in the encounter (article III). Other situations may arise in encounters with unfamiliar staff where only one of the mothers is present. In these situations, some co-mothers feel that they go behind their partner’s back when they are understood to be the baby’s biological mother. They find it difficult to understand why they feel uncomfortable, after all, they are the baby’s legal parent. However, the feeling of being taken for somebody else creates unresolved situations that need clarification and raises the question of “proper” parenthood. Co-mothers also described being treated as “one of the boys” by fathers (article III). Often, this results in ambiguous feelings for the women. Some experiences can be shared, given their status as parents, but co-mothers say they know nothing about being a man. On the contrary, they feel that being a woman provide them with first hand understanding of pregnancy and labour. Co-mothers look upon this as a bonus, enabling them to participate in the birthing process, breastfeeding their babies and facilitating the attachment process. They feel privileged compared to fathers. Below, I will use Plummer’s theory of *intimate citizenship* (34), briefly presented in chapter 2, to elaborate and understand why this kind of trouble takes place.

Plummer (34, p50) uses the concepts “citizenship” and “identity” when he refers to the idea that life is lived within certain boundaries and is guided by some sense of continuities, connections, and sameness. Both concepts serve as group markers, legal as well as social and cultural. Furthermore, he argues that groups of new citizens, such as lesbian families, forge a new language of intimacies and provide their members with new personal identities. According to Plummer (34, p71), the term

"*intimate citizenship"* denotes a plurality of multiple public voices and positions. "Intimate" refers to close relationships with others, as well as personal feelings, bodies, emotions and identities. Furthermore, Plummer emphasizes that the capacity for dialogue is central in all contemporary ideas of citizenship.

The general population in Norway still expresses reluctant attitudes towards lesbian women's reproductive rights (26). According to Plummer (34, p39), conflicts related to the normative nature of motherhood, to parenting and parenting roles "go to the heart of what it means to be a human being". Beresford (19) argue that lesbian mothers are faced with challenges related to the general understanding of natural motherhood as privileged. Lesbian mothers represent non-conformity to this understanding, they "disrupt the taken-for-grantedness of heteronormativity" (130, p178). To disrupt the order of a space, the authors argue, is to "make it uncomfortable by making the people within it uncomfortable in their habits of embodiment and expectation" (130, p180). Study III demonstrates how lesbian motherhood poses a challenge to the common sense of what is normal or natural , when midwives make "humorous" comments behind the couples' back's about who is the man and the woman in the relationship, or when the couples' presence make staff uncertain about what to say or how to react.

Co-mothers (article III) symbolize new citizens in the making, as described by Plummer (34). They may be referred to as a group, but within the group they exhibit a broad variety of ways of doing parenting. Some couples represent conventional attitudes and practices, others struggle to find new ways. Consequently, while all lesbian couples challenge maternity care, given its heteronormative structure, co-mothers seem to add a particular "queer touch" to maternity care. They struggle to carve out a new identity and forge a new language. Plummer refers to Beck's characterization of categories that have outlived their usefulness as "zombie" categories (74). In this context, I find that the traditional category of parenting to be a zombie category, as it is used due to lack of better alternatives.

Plummer (34) regards identity as sameness (idem), referring to the facts that a person has in common with other human beings. It can also be understood as selfhood (ipse), referring to the facts that separates a person from others, to what constitutes him or her as an individual. By contrasting these paradoxes, it is possible to understand identity as a phenomenon that at the same time unifies and separates human beings (152). In order to come into existence, terms and concepts therefore become essential. To name a person is to make that person real and to acknowledge his or her existence (153). Thus, it is essential for co-mothers to find terms that describe their situation as they fit neither the conventional mother, nor the conventional father category, threatening to leave them in an identity limbo (42). Language must also be able to accommodate the ambiguities of the new citizenship practices.

According to Goldberg et al (130, p183), birthing spaces become queered when "dominant understandings of sameness and difference in practices of treatment are questioned". Maternity care staff can sign up with the queering of maternity care by addressing the "tiny sexual difference", being careful not to leave the couples with a burden of explanation (article I). Furthermore, use of terms and concepts to include co-mothers may counterbalance the traditional ideas of what constitutes a family, demonstrating an understanding that families and parenthood may take different forms. This includes avoiding names that position co-mothers as inferior, positioning them as *non- birth* mothers, *second* mothers or *other* mothers. Being defined by what one is *not,* will loosen the link to motherhood, and enhance feelings of being second best or second class citizens (42). In this thesis I have presented several examples where maternity care staffs have been neither willing nor able to dialogue with lesbian couples, demonstrating that interpersonal encounters between lesbian couples and maternity care may be challenging encounters.

Moral perception and intimate citizenship in maternity care

In line with previous research (50, 55, 57-59, 130, 154), our studies have revealed how encounters with maternity care staff and lesbian couples are *moral encounters* where staff's attitudes related to sexual orientation may influence responsible conduct (articles I-III). Our studies (particularly study I) add to existing knowledge by demonstrating the connections between moral perception and moral performance in the specific context of intimate citizenship that lesbian couples instigate by arrival at maternity care.

According to the midwives (article I), a proper midwife should prevent lesbian couples to feel stigmatized in the encounters. The midwives in study I argue that it is important to signal that they regard the couple's sexual orientation as normal and natural, while at the same time avoid over-focusing the issue. Such attitudes would indicate acknowledgement of the intimate citizenship for this group of women (34). Midwives in study I have no time to sit down and reflect upon morals, attitudes or ethical values during their working days, they say. However, after having encountered lesbian couples, they often reflect upon use of language and attitude, asking themselves if they have used the right words and if the couples felt their weal and woe addressed properly. Similar attitudes are demonstrated elsewhere (130), when the nurses described how concerns about language and attitude were in the back of their heads all the time when they encountered lesbian couples. In the above examples, staff seem to acknowledge difference, thus caring is intended to be tailored towards individual needs.

Midwifery quality is associated with communication skills and a caring approach (12, 14), and the attributes of a good midwife are particularly important for groups with special needs, such as immigrants, single mothers and lesbian women (60). To our knowledge, article I and the study conducted by Goldberg and co-workers (130) which included five nurses are the only studies published providing first-hand information about maternity care staffs experiences of caring for lesbian women, demonstrating their intentions as well as the challenges they experience. We found

that it is vital for lesbian couples that midwives regard their sexual orientation as normal and natural (articles II and III). Other researchers have shown how lesbian couples fear or anticipate marginalization related to sexual orientation in the encounter with maternity care staff (136). Thus, it is possible that lesbian couples will profit from continuity of care to avoid anticipating marginalization in the maternity care context. In this regard, relationship quality is important, as a midwife perceived to be uncaring is likely to increase the couple's anticipation of being marginalized.

Acknowledgement of intimate citizenship for lesbian couples implies the need for clinical routines reflecting the heteronormativity inherent in maternity care to be abolished (article I). The midwives describe a number of situations, such as birth preparation courses and postnatal information where they need to avoid using "the autopilot" to include the lesbian couples. They recognize their responsibility to open up the conversations if they take a difficult turn, but often they find this challenging. Hence, they may hand the responsibility over to the lesbian couple, arguing that both parts are responsible for creating good encounters. When midwives become more experienced, feelings of uncertainty or inadequacy are replaced by self-confidence, making it easier to recognize and attend to the couple's individual needs. In study III, co-mothers describe how their lesbian self-confidence (96) sometimes turns out to be a vital asset in awkward situations. Goldberg et al (130) claim that staffs must be willing to resist old terminology and create alliances although situations may prove difficult, in order to make the maternity care context accessible for lesbian parents. This implies a willingness to "playfully and courageously challenge gendered norms of childbirth and parenting even when doing so generates discomfort" (130, p188). In other words, staff must be willing to accept the role of the discomforted to create space for the intimate citizenship of the couples and avoid leaving them with a burden of discomfort.

The midwives in study I perceived the lesbian relationship to consist of two dimensions; lover and close friends. They looked upon the friendship dimension as practical and strengthening, and described how a female couple would speak the same language and have a better understanding of hormonal and emotional variations

than a heterosexual couple has. However, they said they were unable to understand the part of the relationship that involves the love relation, being only external observers to this part of the couples' lives. They believed co-mothers to have a different understanding of the changes that take place in a woman's body throughout pregnancy and labour than fathers do. This bodily understanding probably makes co-mother more vulnerable than a father. They are concerned about co-mothers emotional situation and describe a lack of knowledge related to co-mothers situation. The bodily understanding presented by midwives may reflect a gynocentric attitude, in the sense of taking a feminine point of view or emphasizing feminine interests (155). It is also possible that their understanding of co-mothers' situation reflect traditional values of femininity deeply embedded in maternity care. Midwifery, or the midwife-woman relationship, which is highly valued in midwifery articles (156-159) has been criticized for excluding fathers from the birthing space (160). Co-mothers, on the other hand, seem to be more included in labour and birth because they are women. Yet, their presence also disturbs the heteronormative order of things. Below, I will elaborate the challenges described above and discuss their impact on clinical performance using Vetlesen's theory about moral perception, presented in short in chapter 2.

Vetlesen argues that dependence, vulnerability, mortality, the fragility of relations and existential loneliness are unalterable fundamental conditions of life (161). Caring for the other is to demonstrate *moral responsibility* as a response to human dependency. However, in order to demonstrate moral responsibility in a caring encounter, the moral challenges inherent in the encounters must be perceived, such as issues related to sexual orientation when lesbian couples enter the maternity care services. Our studies demonstrate that maternity care staffs professional performance may be confronted when they care for lesbian women. Some midwives (article I) seem to be aware of the moral implications in the encounters, with an intention to behave professionally appropriate. Others say that use of terms and concepts is an issue in the back of their heads whenever they meet with lesbian couples (130). They seem to perceive moral responsibility by being aware that routines representing

heteronormative maternity care structures may pose a threat to culturally sensitive care (article I). Relationships between midwives and the women they care for involve mutual emotional engagement (15, 162). In our studies, several interpersonal experiences were described by the lesbian couples as positive, implying that they received good care. Still, sometimes the situations turned awkward (articles II-III), with staff taking a detached attitude or providing task-oriented care (163, 164). Similar issues have been described in other healthcare contexts, demonstrating professionals' attitudes towards homosexual patients as a continuum varying from positive to negative attitudes (165, 166).

According to Vetlesen (68), emotions provide access to the moral domain by allowing a person to get an intuitive grasp of the situation, to perceive what is at stake. He says that fundamental conditions of life apply to all human beings (161). It is a fact *that* humans live their lives, given their conditions. *How* humans live and relate to the conditions vary from one person to another. Hence, it is impossible to live the fundamental conditions in a neutral way. Previous studies have demonstrated staffs taking a neutral attitude, along with staffs wish to refrain from nursing for homosexual patients if possible (165). By taking a neutral attitude, staffs argue that personal attitudes do not influence the nursing relationship (167).

Vetlesen argues that a detached attitude leads to constrained perception and empathy. Indifference, he says, is a prime threat to morality, more destructive than hatred or resentment as "the intrinsic logic of indifference sets no limits to its spread" (68, p10). Within the task-oriented professional care, neglecting sexual orientation as a means to avoid discriminating lesbian couples may represent deficits in moral perceptive practice where the needs of the lesbian couples are marginalized. According to Goldberg (168, p81), "as a nurse, it is easy to work with those women who are mirror images of ourselves, who embody those virtues that we hold dear, and reflect that which we love, but the real challenge is to work with women who are not like ourselves". The author argues that these dissimilar women challenge our principles and values, they make us question our being. Thus, feelings of uncertainty

and ambivalence may provide initial discomfort in maternity care staff, but they may also provoke moral reflection where staff is challenged to turn to their blind spots.

My thesis has highlighted the impact of encounters between maternity care staff and lesbian couples as moral encounters, challenging heteronormative family practices and ideas of motherhood and creating vulnerable situations where individual, legal and social recognition is at stake. In these vulnerable situations, caring slowly and cautiously seems to take a queer turn where maternity care staffs are able to perceive lesbian couples' caring needs and willing to change previous professional conduct in order to include lesbian families in maternity care.

6. Conclusions

There is a close relationship between being visible and feeling recognized for lesbian couples encountering maternity care. As a result, encounters between lesbian couples and maternity care staff are vulnerable encounters where the couples risk being humiliated, excluded from citizenship and denigrated their way of life.

The presence of lesbian couples seems to challenge conventional ideas of motherhood and family practices. Simultaneously, the fact that they are both women provides a first-hand understanding of pregnancy and labour and makes it easier to find a comfortable space in maternity care than fathers do.

Encounters with maternity care staff are moral encounters, demonstrating the connection between moral perception and moral performance. In these encounters, feelings of uncertainty and ambivalence may provoke moral reflection, challenging staff to turn to their blind spots.

The findings indicate potential strategies by which staff may support and enhance a process of queering maternity care:

Include sexuality and sexual orientation as an issue deserving reflection in all maternity care areas, particularly in midwifery education. Knowledge about the issue of disclosure should be included in order to increase staffs understanding of the link between visibility and recognition.

Pay particular attention to use of verbal and non-verbal language and ask direct questions in order to help lesbian couples feel acknowledged and recognized as parents. Staff should focus on everyday signs of recognition to counterbalance ambiguous situations and feelings of being invisible or overlooked, and pay particular attention to language used in communication with co-mothers.

Recognize both mothers as carriers of moral rights by showing emotional support, cognitive respect and social esteem. This requires an understanding that there exists a broad variety of ways of doing parenting and family.

7. Future research

My analysis reveals that lesbian couples are satisfied with many aspects of the maternity care services provided in Norway. I have also revealed important challenges related to encounters between lesbian women and healthcare providers in maternity care that deserve further exploration. The findings from my thesis indicate a need for future research in the following areas:

- Feelings of uncertainty and ambivalence may influence midwives' attitudes and actions when they take care of lesbian couples. I would like to know more about how this kind of challenging emotions in midwifery due to disclosure of sexual orientation may be turned into professional assets.

- Heteronormativity in maternity care, leading to feelings of stigmatisation and exclusion, may jeopardize positive labour outcome for lesbian couples. I would like to know whether lesbian women run a comparable risk to heterosexual women regarding labour outcome.

- I would like to know more about co-mothers' role and needs during pregnancy, labour and the post-natal period in order to provide tailored care. I would especially like to know more about how midwives can facilitate the attachment process between co-mothers and their babies.

- Finally, it would have been interesting to know more about the interaction between lesbian women and midwives in the birthing context and how behaviour is reciprocally defined, for example by means of observational research with video recording.

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