Minority stress adds an additional layer to fear of childbirth in lesbian and bisexual women, and transgender people

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Abstract

Objective: To explore and describe thoughts about and experiences of pregnancy, childbirth and reproductive healthcare in lesbian and bisexual women and transgender people (LBT) with an expressed fear of childbirth (FOC).

Design: Data were collected through semi-structured interviews with self-identified LBTs with an expressed FOC.

Participants: 17 self-identified LBTs participated. 15 had an expressed FOC, and two were non-afraid partners.

Findings: Participants’ fears were similar to those previously described in research on FOC, e.g., fear of pain, injury, blood, death of the child or of the parent. However, minority stress, including fear and experiences of prejudicial treatment, in maternity care and at delivery wards add an additional layer to the fear of childbirth.

Key conclusions: LBTs with FOC are a particularly vulnerable group of patients, whose needs must be addressed in healthcare.

Implication for practice: The findings call attention to the need for LBT-competent treatment prior to, and throughout pregnancy and childbirth. In the most vulnerable patients, caregivers must work extensively to build trust, in order to explore and reduce FOC.

Keywords: Fear of childbirth, lesbian women, bisexual women, transgender people, minority stress

Introduction

Childbirth-related fear complicates a considerable number of pregnancies today (O’Connell et al., 2017; Lucasse et al., 2014; Nieminen et al., 2009). The phenomenon is widely studied among pregnant heterosexual women in mostly western countries (O’Connell et al., 2017). A recent meta-analysis indicates a prevalence of fear of childbirth (FOC) of around 14% among pregnant persons (O’Connell et al., 2017). Mental ill-health correlates strongly with FOC (Räisänen et al., 2013, Rouhe et al., 2011). Pregnant people with mental health problems report FOC to a higher extent than those without mental problems (Andersson et al., 2003; Zar et al., 2002). Studies among male partners to pregnant women in Nordic countries show a comparable prevalence of FOC (10-13.6%) during pregnancy (Eriksson et al., 2006, Bergström et al., 2013).

Persons with severe FOC can be afraid of coping with pain, of being injured themselves or that the offspring is injured or dies (Eriksson et al., 2006; Melender, 2002). They can also fear medical interventions such as instrumental birth and caesarean section (Geissbuehler and Eberhard 2002, Ryding et al., 2007). Ongoing discussions in the media regarding lack of personnel and resources at delivery wards may increase pregnant people’s fears. Pregnant people with FOC often worry that staff at delivery wards will not be present or available when needed (Sjögren, 1997; Melender, 2002). The male partners to heterosexual women express comparative themes of fear, but can also express feelings of helplessness or lack of knowledge (Hanson et al., 2009). Severe FOC interferes negatively with the pregnant person’s and the
partner’s life during pregnancy and birth, and can predispose them to a traumatic experience of birth (Wijma, 2003). Severe FOC can be associated with prolonged labour and an increase in both instrumental and caesarean deliveries (Ryding, 2015; Sydsjö, 2014; Gottvall and Waldenström, 2002). For the society severe FOC generates higher costs compared to low FOC, when the pregnant people follow the ordinary antenatal programme (Nieminen et al., 2016).

The present work focuses on fear of childbirth in lesbian and bisexual women, and transgender people assigned female at birth (LBTs). Childbearing in female same-sex relations has increased over the last decades (Kolk and Andersson, 2018). In Sweden, female same-sex couples gained access to fertility treatment in 2005 (Malmquist, 2015). Several previous studies have focused on lesbian couples’ experiences of Swedish reproductive healthcare (e.g. Appelgren Engström et al, 2018; Larsson and Dykes, 2008; Malmquist, 2016; Malmquist and Zetterqvist Nelson, 2014; Rozental and Malmquist, 2015; Röndahl et al. 2009). Generally, a mix of positive and negative encounters has been presented. While many appreciate their contact with midwives, who are described as caring and knowledgeable, several also describe heteronormativity in their contact with maternity care and delivery wards. Heteronormativity can be expressed in face-to-face encounters in form of prejudicial or normative assumptions or questions, or built into the structure of the organisation, such as when forms are pre-printed with “mother” and “father”. While many lesbian and bisexual women experience positive contact with reproductive healthcare, negative experiences are also common, and recurrently shared within the LGBT communities (Appelgren Engström et al, 2018; Malmquist, 2016). Therefore, it is understandable that many approaches reproductive healthcare with an expectation that they will not be well received (Malmquist, 2016).

No published studies have focused on childbearing in transgender men or non-binary persons in Sweden. Internationally, there are some studies on this area (De Roo et al., 2016; Ellis et al., 2015; Hoffkling et al., 2017; Light et al., 2014; Veale et al., 2016). A British interview study of transgender men with experience of giving birth, described a common feeling of loneliness, especially during pregnancy (Ellis et al., 2015). The men had to negotiate their identity in relation to themselves and others, as pregnancy is highly associated with women and motherhood. Further, an American study show how healthcare staff lack routines and knowledge about transgender men’s pregnancies (Light et al., 2014). In Sweden, forced sterilisation as a requirement for legal gender reassignment was terminated in 2013 (Malmquist and Wurm, 2018). Since then, transgender men can keep their childbearing capacity after legal gender reassignment. However, experiences of treating transgender peoples in reproductive healthcare are still marginal, and healthcare staff show lack of knowledge (Anorga Wirén and Seempasa, 2016).

Studies on health and ill-health in the Swedish population show that most LGBT respondents experience good health and high quality of life (Bränström, 2017; Folkhälsomyndigheten, 2014, 2015). However, compared to cisgender heterosexuals (i.e. heterosexual persons who are not transgender), LGBTs have much higher levels of psychological ill-health, with significantly higher self-reported levels of stress, anxiety and suicidality. Transgender people, bisexual women and young lesbian women show particularly high levels of psychological ill-health. Meyer (2003) has explained that increased ill-health among LGBTs is caused by minority stress, i.e. stress caused minorities through stigmatisation, marginalisation, prejudice and discrimination. In a societal context where pregnancy is closely associated to heterosexual intimacy, women in same-sex relations are often construed as ‘other’ or ‘deviant’ in relation to
family formation (Malmquist, 2015). Likewise, cisnormativity (i.e. normative assumptions that gender identity, gender expression and assigned gender at birth are naturally coherent) intertwine childbearing with femininity and maternity. Thereby, pregnant men and non-binary people are construed as ‘deviant’ in so-called ‘maternity’ care (Malmquist and Wurm, 2018). Experiences of minority stress differ significantly among gender and sexual minority people (Meyer, 2003). Also, strategies for and ability to cope with the stress variate. Some LGBTs have developed a hypervigilance for discriminating and prejudicial treatment.

Aim

Due to hetero- and cisnormativity, it is important to address LBT needs in reproductive healthcare. As previously known, people with a severe FOC are particularly vulnerable during pregnancy, childbirth and postpartum. The present study sets focus on self-identified LBTs with an expressed FOC. The aim of the study is to explore their thoughts about and experiences of pregnancy, childbirth, and reproductive healthcare. There is, to the authors’ knowledge, no previous research published on this topic.

Methods

Design and data collection

This qualitative research study drew upon thematic analysis from a critical realistic epistemology. The analysis drew on 13 semi-structured interviews with 17 self-identified LBTs (nine individual interviews and four couple interviews). Fifteen had an expressed FOC, while two partners in couple interviews did not express FOC.

Data were collected in two different contexts. First, in 2010, [Name1] interviewed female same-sex parenting couples within a research project on lesbian parenthood in Sweden (references removed for peer-review). These interviews explored broadly how lesbian couples had experienced the process of becoming parents. The interview questions did not specifically focus on FOC, but this topic was raised spontaneously by four participants, who explained how their FOC had affected their family formation. The narratives on FOC in these interviews were further analysed them in detail for the present study.

[Name 1] main research areas are lesbian and gay parenthood and minority stress among LGBTs (references removed for peer-review). Malmquist worked with [Name2], who is an expert on FOC (reference removed for peer-review), into a joint research project, with the aim of obtaining more comprehensive data on FOC in LBTs. The project was approved by the regional ethics board at [xxx] University. For this data collection, LBTs with personal experience of FOC were inquired to participate. Eleven additional people were interviewed. One couple was interviewed together, upon their request, while the remaining participants were interviewed individually. [Name3 and Name4] conducted most of the interviews. Participants in all stages of family formation were included, i.e. those who planned on having children in the future, those who were currently expecting children, and those who already had children. This diversity was to capture both expectancies and experiences of childbirth in the narratives. The interview guide included questions on FOC, experience/expectancies of reproductive healthcare, and experiences/expectancies of one’s own and one’s partner’s pregnancies and giving birth. The participants were also inquired to fill out the Wijma Delivery Expectancy/Experience Questionnaire after the interview.
Participants were recruited through an advertisement posted in social media groups for LGBT families. Everyone who responded to the ad obtained an information letter by email and were, if still interested in participation, contacted by telephone or email to schedule an interview. Each participant was informed about the structure of the interview, the purpose of the study and in what form the results would be published. Participants gave their written informed consent to participate. All interviews but one were conducted in the participants’ homes. The last interview was conducted at the participant’s office, after work hours. Locations were decided by the participants.

Transcription and analysis

The interviews lasted between 61 and 180 minutes, and were audio recorded. All interviews were transcribed verbatim, pseudonyms replacing names. A primary data analysis was conducted by [NAME3 and NAME4], and is presented in their joint master’s thesis (reference removed for peer review). They followed a six-step process for thematic analysis, as presented by Braun and Clarke (2006). Detailed coding of the data was undertaken, and codes were sorted into broad themes. To ensure high quality in the analysis, [NAME3 and NAME4] worked in parallel with coding the data. Their different coded were discussed and compared, to ensure equivalent coding. Candidate themes were discussed between all four researchers and the analysis was further developed by [NAME1 and NAME2].

Participants

Most participants identified as lesbian or bisexual women, and a few as transgender men or as non-binary. They were between 25 and 42 years of age at the time of the interview and had between zero and four children. Most participants were in a committed relationship with a same-sex partner. A majority had university level exams, and most were employed at the time of the interview. Nine participants resided in larger cities, and six of them in smaller towns.

Three of the participants were pregnant at the time of the interview. Two of them expected their first child, and one had a child born by the partner. Nine had given birth themselves prior to the interview, and three of them also parented children born by their partner. Three had not given birth themselves, and were not pregnant, but parented children born by the partner. Two had no children but planned for having children in the near future. A few participants also had stepchildren or foster children living in their homes.

As mentioned previously, participants from the second data collection filled out the Wijma Delivery Expectancy/Experience Questionnaire immediately after the interview. Their scores varied from 81 (moderate fear) to 123 (phobic fear), with a mean of 97 (severe fear). The vast majority (80%) scored above cut-off for severe fear.

Results

Five themes were construed as a result of the thematic analysis. To suit the limited scope of a research article, only two of these themes, General fear of childbirth and Minority stress – an added layer of vulnerability, were selected to be in focus for the present article. They were selected because they together provide an informative picture of the group’s vulnerability and needs. The remaining themes (Femininity and normativity, Deciding who gives birth, and Experiencing LBT competent treatment) are planned to be reported in future publications.
**General fear of childbirth**

The participants with an expressed FOC explained how their worries were related to a fear of experiencing pain, injections, loss of control, or being left without adequate care. Thus, the focus of their fears corresponds to common fears identified in previous research (Sjögren 1997; Melender et al., 2002; Rouhe et al., 2009). Most participants expressed a strong fear of giving birth themselves, and some of them were also afraid prior to their partners’ deliveries.

**Common fears.** Most participants described their fear of pain, injuries, blood, injections, labour complications, loss of control, panic and death. Fear of uncontrollable pain was central in most participants’ narratives, like Emelie’s:

"I think I might have a low pain threshold, so it like gets to a point where I, I don’t think I will handle it, I think I’m going to faint, I think I’m going to die of pain, so, I know I am like also [afraid] of how my body would react to so much pain, because there’s a risk I’ll just give up or just, I don’t want to, I don’t want to be part of this. And the times in my life I’ve like experienced pain, so I know that my reaction is very much like, ok now I would rather die." (Emilie, pregnant)

Emelie, pregnant with her first child, attributed her FOC to a low pain threshold. As she expected terrible pain during labour, her conclusion was that she might react with hopelessness. In addition to fear of uncontrollable pain, most participants expressed their fear of serious or permanent injuries. Several expressed a fear of an emergency caesarean, while others described their fight for being granted a planned caesarean. About half of the participants explained how their FOC was related to discomfort with their own body or genitals. They described that they were uncomfortable with vaginal examinations in general and assumed that such examinations could be done without their control or consent during labour. For one participant, the fear was related to genital tissue changes due to testosterone treatment during his gender transition. He was afraid that the changes would lead to an increased risk of injuries during labour.

**Fear of insufficient care.** Several participants attributed part of their worries to a fear of insufficient care. They highlighted a lack of resources, competence and personnel at Swedish delivery wards, and expressed fears that they would not receive enough or adequate help during labour.

"They can have all sorts of assistance and things, but if they don’t have the staff and, if there isn’t enough, well you can like give birth in the corridor. Because there isn’t any space..." (Sarah, had given birth)

Due to her fear of insufficient care and lack of labour rooms, Sarah decided to give birth at another hospital than the one she initially was intended to give birth at. For others, there was only one labour ward optional. Some participants described how the lack of midwives and assistant nurses at delivery wards has been debated frequently in media, leaving them terrified of giving birth with no or very poor assistance. For some participants, their fear for insufficient care was attributed to a general low trust in healthcare staff. This will be further developed in relation to the theme _hetero- and cisnormative treatment_.

**Fear prior to partner’s birth giving.** Besides being afraid of giving birth themselves, several participants described their worries prior to their partners’ birth giving. Thus, for someone with
a severe FOC – with a fear of blood, injuries, or death – it was described as a tremendous challenge to participate during the partner’s birth giving, or to have the partner go through childbirth at all. Jeanette explained how she “always” had been afraid of childbirth, which was the main reason for them to let the non-afraid partner, Ina, carry their child.

Jeanette: And, yeah, I was very nervous before the delivery. [...] How would she do and like, would I have the energy to be there?

Ina: That was when my mum promised to be there too. Support her a bit. Which went really well. You managed it really well, even if you were afraid.

Jeanette: Now it’s over.

(Jeanette and Ina; Ina had given birth)

Jeanette described in the interview her worries concerning both her partner’s wellbeing, and her own ability to handle her fears during the birth. Ina’s mother had been present during the birth, not only to support her daughter in labour, but primarily to support her fearful daughter-in-law. Partners are generally expected to be present during childbirth, and for most participants this was presented as natural or obvious, despite their fears. Only one participant had stated beforehand that she would not be present in the case of an acute caesarean.

Minority stress – an added layer of vulnerability

Beyond the general fears described above, most participants also described fears directly related to their minority identity as lesbian, bisexual or transgender, or their minority relationship as a same-sex couple. From their accounts it is shown how hetero- and cisnormativity, and hatred towards LBTs, add an additional layer to the fear of childbirth.

Hetero- and cisnormative treatment. Most participants described positive encounters with healthcare staff, who they depicted as informed, knowledgeable, caring and professional. However, most participants also reported encounters where they experienced deficient treatment in maternity healthcare, or at delivery or postnatal wards. They described hetero- and cisnormative assumptions, tactless questions, and lack of routines for treating LBTs. Petra, who experienced her birth giving as traumatic, described how a midwife had assumed her and her partner to be sisters.

She really assumed that and I feel instead of assuming a relationship she could have just asked “What is your relationship?”, it’s like, it doesn’t take long. And that was really important because amidst all the traumatic stuff it was just another thing that was like difficult to “Don’t assume that we like are sisters, you idiot.” [...] It’s more humiliating to like happen to say the wrong thing than to ask, actually, yes... (Petra, had given birth and partner had given birth)

In Petra’s already vulnerable situation during a traumatic labour, the midwife’s heteronormative assumption added more stress. Likewise, several participants explained how erroneous or tactless assumptions and questions had made them feel offended, invisibilised and stressed. Some of them pointed out that they often handle hetero- or cisnormative assumptions
in their everyday life, but in the labour situation they were particular vulnerable and already stressed due to FOC. For them, minority stress adds an extra layer to an already stressful situation.

**Hypervigilance.** For some participants, previous experiences of deficient treatment in healthcare had had the effect that a homo- or transphobic treatment was their primary expectation in future contacts. They had developed a hypervigilance for others’ prejudicial assumptions and generally had very little trust in healthcare staff. For these participants, fear of deficient treatment was a central aspect of their FOC. Jonathan explained how his previous experiences affected his ability to trust healthcare staff:

> I have very much experience of healthcare, where, even if, or, if people know I’m trans, they take the opportunity to use the wrong gender pronoun, [...], and refer to me as “she” all of a sudden, even though they know very well that, is the wrong pronoun like, and it’s a very vulnerable situation like, when you’re giving birth, and it feels like, people take the opportunity. And it feels like you can’t do much about it, you can’t like get upset and just “No, then we’re not going to do this!”, because, like, if you’ve got a baby in your tummy it has to come out sooner or later, so you can’t like just get angry and leave, get care somewhere else, probably not. (Jonathan, has no children)

Jonathan described in the interview how he and his partner, also a transgender man, had encountered transphobia in healthcare contexts during their transition processes. Healthcare staff had told them that men should not give birth, and that people who do are not actually trans. Staff from the gender dysphoria team had tried to persuade them to be sterilised. When planning to have children, these experiences made Jonathan afraid of future contact with ‘maternity’ care and delivery wards. As he explained in the quote above, birth giving is unescapable when you are in labour. In his worst-case scenario, he imagined how he would be trapped in an unfriendly, transphobic situation. Likewise, a few other participants explained how previous experiences of trauma or homo- or transphobic hatred built up the fear of giving birth, and potentially risk being exposed to homo- or transphobic treatment in this highly vulnerable situation.

**Internalised homo/transphobia.** Some participants described events where they had not been open with their LBT identity, or events where they had been reluctant to talk about it. This can, at least for some participants, be understood as an internalized homo- or transphobia, where a hetero- or cisnormative ideal has been incorporated in their self-images. One participant, Stina, talked extensively about internalized homophobia as an important aspect of her FOC. She had a severe FOC but was determined to become pregnant despite her fear. For her, a good support from her partner during a future birth was important. However, the partner was uncomfortable with disclosing their intimate relationship. Stina explained:

> The few times we’ve held each other’s hand or like shown like in public that we’re a couple and if someone has said something, then it like affects her experience massively, and she like feels that she has done something wrong and, umm, she doesn’t- she, she doesn’t want to subject herself, or me, to get negative feelings linked to our relationship or to me, and to everything, so that’s why, and it, so, it will be present
ahead of delivery, because she, I think that she thinks that if she acts like she is my partner, holds my hand or kisses me or something, she risks being met by homophobia, which will cause her to get a huge amount of negative emotions and she doesn’t want that, at that time, so she doesn’t do it. (Stina, partner had given birth)

Stina described her partner’s strong feelings of guilt and shame about their same-sex relationship as affecting their relationship at large. While Stina proudly identified as lesbian, her partner was highly uncomfortable with disclosing their relationship. With her FOC, Stina felt particularly vulnerable when imagining a birth situation where her partner would not feel comfortable to show intimacy. A partner who is present and who relates to and supports her as a partner is crucial to her confidence.

Discussion

The present study set out to analyse experiences and expectancies of reproductive healthcare, pregnancy and childbirth among self-identified LBTs with an expressed fear of childbirth. Most participants filled out the Wijma Delivery Expectancy/Experience Questionnaire and scored above cut-off for severe fear of childbirth. Thus, for the participants, the thought of giving birth was connected to a severe fear, causing them ill-health before and during pregnancy, and for some participants, after birth. As presented above, the participants described fear of pain, injuries, blood, injections, labour complications, loss of control, panic and death. Thus, they experienced fears previously well known among patients with an expressed FOC (Sjögren 1997; Melender, 2002; Rouhe et al., 2009).

Treating FOC has been studied in a handful trials in recent years. Different intervention models diminishing FOC have been compared lately (Loughnan et al. 2018; Hosseini et al. 2018; Stoll et al., 2018), revealing a difficulty in finding a consensus on recommendations because of a large variety of methods and limited populations in the trials. There seems to be some evidence for psycho-educative and counselling methods and interventions based on CBT (Nerum et al., 2006; Rouhe et al, 2013; Rouhe et al., 2015; Nieminen et al., 2016; Rondung et al., 2018). The fears expressed by the participants in this study are mostly similar with common fears of primiparous heterosexual women, which could indicate that similar treatment of FOC in LBTs should be helpful. But our results about the added layer of vulnerability among LBTs also highlight the need for specific LBT competence when meeting this group.

Added to the fears directly focusing on childbirth as such, several participants expressed a stress related to lack of resources and staff at Swedish delivery wards, revealing a mistrust of healthcare. The ongoing discussion in the media regarding healthcare resources may have influenced pregnant people’s fears. Previous studies of pregnant people with FOC have shown worries about staff not being present or available when needed (Sjögren,1997; Melender, 2002). This can be an indication of persons with severe FOC being more worry prone than average parturions, a subject studied previously by Zar et al. (2001).

In addition to the fears connected to themselves giving birth, some participants expressed stress related to their partner’s labour. An intense or phobic fear of seeing blood, for example, can also cause anxiety when standing beside one’s partner during labour. For some participants the stress was primarily focused on the partner’s and child’s health, as they expressed their fears that they would be injured or die during birth. This is comparative to male partners to
heterosexual women, where fear of the partner’s or the child’s safety are the most frequent reasons for FOC, apart from fear of feeling helplessness (Hanson et al., 2009). However, the experience of fear prior to the partner’s birth giving might be different in couples where both partners have a childbearing capacity. It is common among female same-sex couples to share the birth giving experience, as they often switch birth parent for a second child (Malmquist, 2016). Thus, the LBT-identified partner may plan on going through pregnancy in the future, which may affect how the partner’s birth giving is experienced. Therefore, it is important that both partners’ expectancies before birth are explored in antenatal care, that both partners’ experiences are attended to during labour, and finally at the postnatal ward.

A central finding of the present work is how minority stress adds an additional layer of anxiety in LBTs with FOC. Most LBTs experience good psychological health and quality of life (Folkhälsomyndigheten, 2014, 2015), and it has been shown that female same-sex couples in general are in good psychological health before and during pregnancy (Borneskog, 2013). However, it is previously well documented that LBTs often experience minority stress in healthcare settings during pregnancy and birth (e.g. Appelgren Engström et al, 2018; Larsson and Dykes, 2008; Malmquist, 2016; Malmquist and Zetterqvist Nelson, 2014; Rozental and Malmquist, 2015; Röndahl et al. 2009; De Roo et al., 2016; Ellis et al, 2015; Hoffkling et al., 2017; Light et al., 2014; Veale et al., 2016). These experiences are important to acknowledge in healthcare routines and educations in general.

Pregnant people and partners with severe FOC are a particularly vulnerable group of patients (Saisto and Halmesmäki, 2009). The present findings show that for LBTs with FOC, minority stress adds additional anxiety to the already high level of stress related to birth giving itself. Experiences of hetero- or cisnormative treatment risk affecting the overall experience of care negatively and seem to increase the participants’ FOC. Quine et al. (1993) have shown that pregnant people who feel supported during pregnancy report less pain during birth and have a better birth experience postpartum. Further, those who feel informed also feel more prepared for the birth, which leads to greater satisfaction. Pregnant people who feel more satisfaction with their birth report less symptoms of stress (Quine et al., 1993). Therefore, it can be expected that positive, well-informed and LBT-competent support during pregnancy allows more attention to be put on reducing FOC and preparing for the birth.

**Limitations and directions for future research**

The present study is a small-scale qualitative interview study. Given the limited number of participants and conduct in one country, the results have limited transferability. Rather, the results can be understood as explorative findings that address issues relevant to acknowledge in clinical work with LBT patients in reproductive healthcare. A larger qualitative study on FOC in LBTs would be needed to thoroughly explore experiences and needs at different stages of family formation. Further, quantitative measures would be relevant to explore the prevalence of severe FOC among LBTs. Such measures may also be useful to explore differences in prevalence between lesbians, bisexuals and transgender people, and between pregnant LBTs and their partners. Further, a quantitative study would be useful to explore potential statistical relations between FOC and experiences of minority stress.

**Conclusion**
It is important to acknowledge that some participants have not “just” experienced indelicate questions or hetero- or cisnormative assumptions. Rather, they described previous experiences of healthcare where they were exposed to transphobic or homophobic hatred or contempt, to a degree that they had little trust in healthcare staff in general, and a hypervigilance for deficient treatment. In addition to their general FOC, these experiences can make pregnancy and childbirth an enormous challenge. Therefore these people need particularly sensitive and professional care. It has been previously shown that mental health problems, especially anxiety disorders and depression, are vulnerability factors for severe FOC (Lucasse et al., 2014). Also, people with previous experience of sexual or physical abuse are more prone to develop severe FOC (Lucasse et al., 2010). Midwives dealing with vulnerable persons need to be competent when addressing the pregnant person’s FOC (Striebich, et al., 2018). Based on the present findings, added to this knowledge is the importance of carefully addressing previous negative experiences of healthcare, and experiences of homophobic or transphobic hatred, as this may affect the ability to trust the caregiver. In the case of the most vulnerable patients, it is likely that the caregiver must work extensively to build trust, in order to explore and reduce FOC.

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