When complications arise during birth: LBTQ people's experiences of care

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A R T I C L E   I N F O

Article history:
Received 26 December 2022
Revised 30 January 2023
Accepted 9 February 2023

A B S T R A C T

Objective: To explore the care experiences of lesbian, bisexual, transgender, and queer (LBTQ) people during births where complications have arisen.

Design: Data were collected through semi-structured interviews with self-identified LBTQ people who had experienced obstetrical and/or neonatal complications.

Setting: Interviews were conducted in Sweden.

Participants: A total of 22 self-identified LBTQ people participated. 12 had experienced birth complications as the birth parent and ten as the non-birth parent.

Findings: Most participants had felt invalidated as an LBTQ family. Separation of the family due to complications elevated the number of hetero/cisnormative assumptions, as new encounters with healthcare professionals increased. Dealing with normative assumptions was particularly difficult in stressful and vulnerable situations. A majority of the birth parents experienced disrespectful treatment from healthcare professionals that violated their bodily integrity. Most participants experienced lack of vital information and emotional support, and expressed that the LBTQ identity made it harder to ask for help.

Conclusions: Disrespectful treatment and deficiencies in care contributed to negative experiences when complications arose during birth. Trusting care relationships are important to protect the birth experience in case of complications. Validation of the LBTQ identity and access to emotional support for both birth and non-birth parents are crucial for preventing negative birth experiences.

Implications for practice: To reduce minority stress and create conditions for a trusting relationship, healthcare professionals should specifically validate the LBTQ identity, strive for continuity of carer and zero separation of the LBTQ family. Healthcare professionals should make extensive efforts to transfer LBTQ related information between wards.

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I n t r o d u c t i o n

The significance of the birth experience

A positive childbirth experience is a worldwide objective for birthing care, and there is comprehensive evidence that a positive birth experience can contribute to increased long-term health and ease the transition to parenthood (Lundgren et al., 2009; WHO, 2018). Care during birth and the relations to healthcare professionals [HCPs] are well known to be significant for birth outcomes and birth experiences, and continuous support during birth reduces the risk of complications as well as a negative birth experience (Bohren et al., 2017; Elmir et al., 2010). A negative or traumatic birth experience can contribute to higher levels of postpartum mental illness in both birth and non-birth parents (Andersen et al., 2012; Goodman, 2004; Söderquist et al., 2006; Zhao and Zhang, 2020). Mental illness and fear of childbirth during pregnancy increase the risk of obstetric and neonatal complications and negative or traumatic birth experiences (Chung et al., 2001; Fekadu Dadi et al., 2020; Yildiz et al., 2017; Ryding et al., 2015; Sydsjö et al., 2014).
LBTQ people's mental and reproductive health

Lesbian, bisexual, transgender and queer (LBTQ) people in general experience increased levels of mental illness (Borgogna et al., 2019; Brännström, 2017; Spittlehouse et al., 2020), which has been explained to be the consequences of exposure to minority stress (Brännström, 2017; Meyer, 2003). Lesbian and bisexual women have an increased prevalence of depression and anxiety during pregnancy, as well as an increased prevalence of postpartum depression (Flanders et al., 2016; Gonzales et al., 2019). Experiences of loneliness and dysphoria during pregnancy have been described among transgender people (Ellis et al., 2015; Greenfield and Darwin, 2021). The prevalence of fear of childbirth is increased among pregnant LBTQ people (Hallström et al., 2022) compared to a general pregnant population (O’Connell et al., 2017). Minority stress has been shown to constitute a central aspect of LBTQ people’s fear of childbirth (Malmquist et al., 2019). American population studies point to increased obstetrical and neonatal complications when sexual minority women give birth, compared to heterosexual women (Everett et al., 2019; Leonard et al., 2022).

The significance of care during complicated births

Experiencing complications at birth predisposes one to a negative or traumatic experience (Ayers et al., 2015; Boorman et al., 2014). Care experiences commonly deteriorate when unexpected obstetrical interventions or patient-provider disagreements arise (Bohren et al., 2015; Vedam et al., 2019). However, it has been shown that birthing people often do not identify the intervention in itself as traumatic, but rather how interventions are performed, making the interactions rather than interventions significant for the traumatic experience (Hollander et al., 2017; van der Pijl et al., 2020). HCPs have the potential to create conditions for a more positive birth experience even in complicated births (Berg and Dahlberg, 1998). A trusting relationship between the midwife and the person giving birth has been modelled as the base for empowering support during birth in different midwifery models of care (Fontein-Kuijpers et al., 2018; Peters et al., 2020).

Negative experiences of birthing care

Subjective negative experiences of care during birth are one of the most significant factors for the development of postpartum PTSD (Patterson et al., 2019; Andersen et al., 2012). Experiencing a lack of information and support during birth increases the risk of trauma in childbirth and non-birth parents (Beck and Casavant, 2019; Etheridge and Slade, 2017). Negative interactions with HCPs, such as disrespectful treatment, threats and violation of integrity, feelings of powerlessness and stigma, and lack of trust and consent, have been shown to increase the risk of a traumatic birth experience (Bohren et al., 2015; Elmir et al., 2010; Heys et al., 2022; Hollander et al., 2017; Reed et al., 2017). Abuse in reproductive healthcare can be defined as a patient’s subjective experience of a voided care, where patients suffer and feel they lose their value as human beings (Brüggemann et al., 2012). Abuse in healthcare is often unintentional, but when it happens, it violates the trust of the HCPs and sometimes of the whole healthcare system (Brüggemann et al., 2012; Schroll et al., 2013). People with a history of abuse are more likely to experience abuse in healthcare (Wijma et al., 2019). It is also common not to tell HCPs about earlier experiences of abuse.

LBTQ people’s experiences of reproductive healthcare

Many expectant LBTQ people fear deficiencies in care, e.g. that non-birth parents will not be treated as equal parents or that transgender people will be misgendered and invisibilized (Greenfield and Darwin, 2021; Malmquist, 2015; Klittmark et al., 2019; Larsson and Dykes, 2009; Malmquist et al., 2019). Earlier studies on LBTQ people’s experiences of encounters with HCPs in reproductive healthcare in Sweden show diverse experiences. Many lesbian and bisexual women report having been met with openness and acceptance, but also point to deficient treatment due to hetero/cisnormative assumptions, invisibilization and exclusion of the non-birth parent (Malmquist et al., 2019; Klittmark et al., 2019; Erlandsson et al., 2010). Studies on pregnant and birthing transgender men and non-binary people point to cisnormativity and a lack of trans-relevant knowledge among HCPs (Falck et al., 2021).

Aim

LBTQ people are at increased risk of obstetric and neonatal complications. Experiencing complications increases the risk of negative or traumatic birth experiences. Hetero/cisnormative structures and attitudes, together with minority stress, might give LBTQ people lower possibilities for experiencing support from HCPs in birthing care. However, no previous study has addressed this matter in the specific context of birth complications.

The present study aimed to explore birth and non-birth LBTQ parents’ experiences of care from HCPs during births where obstetrical or neonatal complications arose, to generate knowledge that can contribute to better care and treatment of LBTQ people in birthing care.

Methods

Design and data collection

In this qualitative interview study, a convenience sample of 22 participants was recruited through advertising between January and March 2022 in different Facebook groups for LBTQ parents in Sweden (n = 9), emailing participants in an antenatal education program for LGBTQ parents provided by the Swedish Federation for Lesbian, Gay, Bisexual, Transgender, Queer and Intersex rights (n = 8), and by snowball recruitment of partners of already interviewed participants (n = 5). The inclusion criteria were self-identified LBTQ birth or non-birth parents who had experienced obstetrical and/or neonatal complications when their child was born. Participants received oral and written information about the study and gave their written informed consent to participate. In total, 28 people showed an interest in participating. All these people met the inclusion criteria. Six people did not answer after receiving the information letter. A total of 22 semi-structured individual interviews were held, lasting between 46 and 120 min. After these interviews, recruitment was terminated, as the interviews contained rich data on each participant’s experiences, and this number of interviews is considered reasonable for a qualitative study (Brown and Clarke, 2006). The interviews were held between February and April 2022, audio recorded and transcribed verbatim with pseudonyms replacing names.

Participants

Among the 22 participants, 12 had experienced birth complications as the birth parent, and ten as the non-birth parent. Most participants described the birth of their first child. All participants were married or cohabiting with their co-parent at the time of their child’s birth. Twenty participants were cisgender women who shared parenting with another cisgender woman, while two participants were nonbinary transgender people who shared parenting with a cisgender person. Most participants identified as les-
bian or bisexual. A vast majority were born in Sweden, university educated, living in major cities, and had become pregnant through assisted reproduction within public healthcare. Socio-demographic details are shown in Table 1. The participants had experienced various obstetrical and/or neonatal complications, see Table 2.

Data analysis

The authors followed Brown and Clarke's six-step process for thematic analysis (Braun and Clarke, 2006) and according to that process (1) transcribed, read and reread the interviews to get to know the data, (2) generated initial codes and marked potential quotes (3) sorted codes into potential themes (4) processed themes and codes (5) defined and named the final themes and (6) finalised and chose quotes that anchored the analysis in the data. As part of the second step, codes from the interviews that did not relate to this study's aim were left out, continuing the process with codes relevant to the study's aim. Steps 4 - 6 were discussed between all authors until the final themes were formed. Trustworthiness was strengthened by researcher triangulation, where the authors represent the fields of midwifery, psychology, and obstetrics. The composition of researchers enabled several analytical perspectives, where each profession brought their pre-understandings of the material.

Results

Deficiencies in care when obstetrical and/or neonatal complications occurred had a significant negative impact on the participants' birth experiences. Most participants described how deficiencies in care contributed to a negative or traumatic experience, while a few participants described how support from HCPs protected the experience from becoming traumatic. Three themes were constructed from the analysis: (1) Invalidated as an LBTQ family, (2) Disrespectful treatment during birth and (3) Lack of information and support. Theme 1, Invalidated as an LBTQ family, de-
scribes how hetero/cisnormative deficiencies in HCPs’ treatment caused invalidations of the LGBTQ families and how the experienced birth complications raised the number of invalidating hetero/cisnormative assumptions at a very stressful and vulnerable time for the participants. Theme 2, Disrespectful treatment during birth, describes that a majority of the birth parents experienced disrespectful treatment from HCPs that violated their bodily and/or personal integrity, which became part of negative birth experiences. Theme 3, Lack of information and support, describes the participants’ experiences of a lack of vital information and emotional support and how the experienced complications elevated these deficiencies.

Invalidated as an LGBTQ family

All participants emphasized that they wanted HCPs to see and validate them as LGBTQ people and part of an LGBTQ family. All participants described negative experiences connected to hetero/cisnormative assumptions related to relationship status, parental labels, family constellations, or preferred pronouns. Most non-birth parents had been assumed to be the friend, sister, or neighbor of the birthing partner, which made them feel invisible as partners. The non-binary participants and one partner of a non-binary person described a lack of knowledge among HCPs on transgender people. Alex described how being called a “superwoman” by a HCP during birth caused feelings of stress and invalidation as a transgender person.

Several non-birth parents reflected on HCPs reserving the label “mother” for the birth parent, using the label “partner” on them (also in relation to the child), which was perceived as an invalidation of them as parents. In contrast, some participants expressed their appreciation of HCPs that included the non-birth parent in the birth process and as a carer of the newborn child. For female same-sex couples, it was important to be recognized as a family of two equal mothers. They appreciated when both were being called “moms” by the HCPs. They felt validated as a family when HCPs encouraged the non-birth mother to provide skin-to-skin contact with the child or asked non-birth mothers about their potential breastfeeding desires, regardless if they considered breastfeeding or not.

The complications experienced at birth increased the number of wards and HCPs caring for the participants. New meetings with HCPs created additional situations with incorrect hetero/cisnormative assumptions. The complications also led to families being separated, which created invisibilization of the LGBTQ family and the need for coming out at the same time as the participants went through frightening emergency situations. Camilla, a birth mother, described how heteronormative assumptions added considerable stress when she woke up in the post-op ward:

The nurses who took care of me there, they assumed that my partner was a man. [...] I’m not usually like that, take offense or think it’s a big deal, well come on, it’s the most common, yeah, but you know, I’m pretty chill about it generally. But then I felt a bit like this, “But come on”, then I was also a bit drugged, and I was lying there saying, “Look, it’s actually a woman””, then I became a bit like this, uh, “Should I have to explain this in this condition”? (Camilla, birth mother).

Camilla needed information and support in her vulnerable position, but instead, she had to put energy into explaining her relationship with another woman.

Some participants felt exotified when their LGBTQ identities received an exaggerated focus. This was perceived as particularly stressful after experiencing complications at birth:

We are two mothers, it’s not that weird, it’s not that exotic anymore. [...] I’m here because I just gave birth to a baby, it was a really difficult birth, it was vacuum extraction, things happened, I’m injured, the baby is small, I probably have a lot of hormones and crap in me, and I don’t feel very well, please meet me in that instead. (Lo, birth mother).

HCPs in the aftercare had put excessive focus on Lo and her partner being a same-sex couple, overlooking their need to be supported in the stressful situation of just having experienced obstetrical complications.

Kitty, a non-birth mother, explained how her care and information needs had been overlooked because of heteronormative assumptions. When her partner was taken to emergency surgery due to a life-threatening complication, Kitty did not receive any information about her partner’s health status, nor any emotional support. She was left for eight hours without knowing if her partner had survived. When she was finally allowed to see her partner, she was told to leave the child with HCPs. However, as she later returned to her child, another HCP assumed that she was the birth mother (obviously fit and walking around) and blamed her for leaving her child with the staff. In contrast, Monika, another non-birth mother, described when her partner was taken away for emergency surgery. In this situation, the physician made a quick validation of her as a partner:

A very nice and significant thing that happened was that he who was to operate on [birth parent], that is, he who was the doctor in charge of the ward, looked at me, and he saw that I became very sad, and kind of broke down there, when [birth parent] was rolled out, and then he took the seconds he could afford, to put a hand on my shoulder and said, “You know what, I know this looks scary, and we’ll do everything we can”, so there, and it was one thing that was very, I carried that with me then, so it felt very important. (Monika, non-birth mother).

A small and gentle gesture made Monika feel seen and validated both as a partner and in her emotional reaction.

Validation as LGBTQ family was often valued more important than other care needs. Linda, a birth mother, experienced a lack of emotional support at the neonatal unit but stated that she was satisfied with the care “anyway” because they had been validated as two mothers to their newborn child.

Disrespectful treatment during birth

A majority of the birth parents in this study experienced disrespectful treatment from HCPs that violated their bodily and/or personal integrity, which became part of their negative or traumatic birth experiences. These participants described negative, punitive and threatening comments and/or actions directed towards them from HCPs and explained how such treatment made them feel bad at birthing, that they did the wrong thing, or were a disappointment to the HCPs. Lo had a midwife shouting at her that she did “97% wrong and 3% right, do more right”, during a birth that ended with vacuum extraction.

Some participants described losing control over their bodies and said that HCPs took over their births without informing or explaining their actions. They felt they had no influence on what was happening to their bodies. They stated that HCPs made them feel selfish when expressing their needs and wishes. They experienced that the HCPs only focused on the baby’s health and overlooked the birth parent’s health, needs and birth experience. Helen had documented her fear of male physicians in her chart and birth letter. Despite this, the midwife who took over at the participant’s birth, started their relationship by saying “if you don’t work better, I will bring a male physician in here to do a vacuum extraction.”
The participant experienced this as a threat. She summarized her birth like this:

I had really hoped to get to feel that my body is my body, but I wasn’t allowed to do that, rather, it really felt like I didn’t get to decide over it. And it kind of connects to past experiences that are not good. […] I’ve had a lot of thoughts about, like this, yeah, it sounds overdramatic, but like “My life is over” […] Just this feeling that I had no value during the birth. (Helen, birth mother).

Helen was not met with respect during her birth-giving, and this led her to associate the birth with previous experiences of abuse, which left her with a feeling of worthlessness.

Participants described actions from HCPs that violated their integrity by not considering their expressed wishes and needs regarding the birth process, which resulted in a loss of control and a sense of powerlessness. Several HCPs failed to obtain informed consent before interventions regarding both birth parents and newborn children. Two participants described painful vaginal examinations done to them without consent or against their expressed will.

Participants also described situations where HCPs failed to consider the participants’ pain or mental states when choosing interventions. Alex experienced frustration and vulnerability when the midwife did not listen to them about insufficient pain relief:

But why is a midwife standing there telling me that I’m supposed to be in this piz, piz, panic unbearable pain when, like everyone I know, uh, who isn’t black or transgender, has like been told that if you have an epidural, you basically shouldn’t feel anything until you get the contractions to push? (Alex, birth parent).

Alex had given birth twice before and had positive experiences of pain relief from the epidural, and attributed the lack of help with the epidural to them being an ethnic minority non-binary person.

Some participants explained that it had been difficult for them to say no to HCPs when being in a vulnerable position. Fredrika, a birth mother, experienced an emergency cesarean, and while still on the operating table, a midwife she had never seen before asked if she could milk her breasts. She said yes to this, but regretted it afterwards. She explained that she had not been in a position to make an informed decision and had felt forced to agree. Therefore, she was very critical of the way she was approached.

The participants with these experiences expressed that their trust in healthcare had been seriously damaged by the mistreatment they experienced.

Lack of information and support

A majority of the participants described a lack of availability from HCPs during their births, which resulted in a lack of vital information and emotional support. This was especially prominent when complications caused a separation of the family.

Several participants expressed that HCPs had no time to be present in the birthing rooms. This contributed to them feeling abandoned, devalued and deprioritized. When complications arose, participants described a chaotic atmosphere where new HCPs entered their rooms without introducing themselves. In some cases, they were screaming at each other without answering questions or giving information about the complications that were arising. Many participants interpreted the lack of information and support to originate from a lack of resources in birthing care, stating that HCPs’ stressful work environment sometimes made them forget or be indifferent to the participants’ needs. Several participants expressed that their birth letters, where they had put information to prevent hetero/cisnormative treatment during birth, were disregarded without explanation or dialogue.

All participants described that access to relevant information as soon as possible was crucial when experiencing complications. Several participants expressed a lack of information during birth, but also afterwards, where HCPs could have made up for the lack of communication earlier. Some birth parents described how HCPs focused solely on their physical health but did not ask questions about their mental health. Other birth parents described a lack of information about their physical health as well. Alma asked for information about her birth injuries:

I had to ask what had happened, and she [the midwife] says to me, this is the same day as it happened, she says, “You can read about it in your chart”, and I just say, “My chart?” I didn’t say anything. I just started crying […] I didn’t know then that they had sutured me, I didn’t know they had put a tamponade in me, which is, well, meter after meter of fabric that you push in to stop the bleeding, I found out about that later, about one day later when they came to pull it out of me, which was an extremely unpleasant feeling, when someone just drags a lot of fabric out of you. (Alma, birth mother).

In this situation, Alma could not get any emotional support in a highly stressful situation. She was left uninformed about her health status, not knowing what interventions had been done to the most intimate parts of her body. In accordance with Alma, many participants lacked emotional support from HCPs. They described that HCPs had a hard time letting them show negative emotions or listening to difficult experiences. They met HCPs, including counselors, in the aftercare that asked only about practical things or did not have time to talk.

Non-birth parents described that their feelings and reactions during birth were given little or no attention from HCPs. Frida, a non-birth parent with previous traumatic birth experiences, needed to leave the birthing room during her partner’s birth because of fearful memories from her previous births. When she sat in the corridor and cried, no HCP stopped to ask how she was feeling. Other non-birth parents stated that feelings of being unimportant were reinforced when they were left alone with the newborn child while the birthing partners’ complications were handled at an operational ward. They did not receive any attention or help from HCPs to handle their reactions. Cornelia overheard the HCPs talking about her partner, who was operated on, without addressing her or giving her support:

I heard them talking about her, and I felt like I was being left there. […] Yeah, it was very hard then, or, like, I thought I would lose, part of me thought I would lose my partner and child, like, it was very tough, and that it went so very fast like, also like this, also to see blood and that I just saw, because it’s quite special, so when they put someone to sleep, it looks a bit like someone disappears. (Cornelia, non-birth mother).

No HCP took the time to support or inform Cornelia in the extremely stressful situation where she thought she might lose her partner and child.

All non-birth parents in this study had a childbearing capacity. A few of them had previous experiences of giving birth themselves, and some had already planned to give birth in the future. Several of them described that HCPs could not give adequate emotional support to them because they lacked awareness of their situation. Many of the non-birth participants experienced witnessing a complicated birth as a trauma, and a majority of them expressed that they did not want to carry a child after this birth experience, or would need professional treatment before being pregnant themselves.
When experiencing stressed HCPs, several participants weighed their care needs against that stress and tried hard to be “good patients”, not calling for attention. Other participants expressed that their LGBTQ identity caused so much inconvenience for the HCPs that they did not feel comfortable asking for more help. When they felt there was a lack of resources, they prioritized to ensure they were respected in their LGBTQ identities, and disregarded to express other care needs toward stressed HCPs. Kim, a non-binary participant, had requested HCPs to use their correct pronoun and felt that this was difficult enough for the HCP, therefore they did not dare to ask for more support. Several participants expressed that their LGBTQ identity decreased their ability to ask for help. Kitty, a non-birth mother, explained that she felt she did not have the same right to ask for help as others. In her experience, society could accept two women having a child together only as long as they would not need any extra help. She did not tell any HCP about her feelings, and it took years before she identified the complicated birth as a trauma and sought treatment. When participants experienced that HCPs were uncomfortable with their LGBTQ identity, they chose not to talk about experienced deficiencies because they did not want to make HCPs more uncomfortable.

In contrast to the dominating picture of lack of support, some participants expressed that feeling supported by the HCPs made a positive difference. One couple had the opportunity of having the same midwife during pregnancy and birth, and the birth mother emphasized how the continuity had helped her feel safe before birth. Another couple, who described the last part of the birth as a terrible and frightening experience with vacuum extraction, had highly appreciated the care at the aftercare ward. They both stated that HCPs’ support protected against the experience becoming traumatic. Non-birth mother Susanne summarized their experiences:

One thing was that they confirmed to [birth mother] that “This was a difficult birth, we understand that you are not feeling well. This is not a normal birth. What you’ve been through is bad, it’s big.” And I think that was really nice for [birth mother] and me to hear. This is not normal, it feels really hard and difficult, because it was really hard and difficult. […] They were so professional, and before we went home, they also had a proper review of the birth process, which also made a huge difference, in getting to go through what happened. It was very good. (Susanne, non-birth mother).

While these positive experiences were rare, many participants expressed that it would have made a difference if HCPs had created conditions for lifting difficult experiences. They expressed that supportive conversations during and directly after the complicated births could have facilitated the experience. Some participants explained that it would have been easier to talk about mental illness with HCPs they already had an established relationship with. However, it was rare to have such relationships.

Discussion

When complications arise during childbirth, both birth and non-birth parents are thrown into a situation of acute crisis and stress, regardless of one’s sexual or gender identity. A majority of the participants in this study gained negative or traumatic birth experiences, and in line with earlier research, mostly made on heterosexual women, HCP’s interactions rather than the interventions themselves were determining for the experience (Hollander et al., 2017; van der Pijl et al., 2020).

Consequences of separation

The complications described in this study often led to the family members being separated, which created many new encounters with HCPs and wards. Even if experiencing complications and separation of family members are connected to more negative birth experiences for families in general (Ayers et al., 2015; Bohren et al., 2015), the separation of family members was particularly stressful for the participants in this study. Separation led to additional stressors for the LGBTQ families, as the number of hetero/cisnormative assumptions and misunderstandings around the family was elevated. Invalidation of the LGBTQ identity or family in these stressful, vulnerable times evoked breaches in trust that caused minority stress and undermined the possibilities of a trusting relationship between HCPs and the participants, also undermining possibilities for good postpartum support. Keeping parents and children together in birthing care is good quality care for all families (van Veenendaal et al., 2022; WHO Immediate KMC Study Group et al., 2021), but striving for zero separation is particularly important for the LGBTQ family, as this lowers the risk of hetero/cisnormative misunderstandings and allows partners to turn to each other for support. If separation is unavoidable, HCPs should make extensive efforts to transfer LGBTQ-related information between wards and HCPs, to avoid hetero/cisnormative assumptions in highly stressful situations.

Need for continuity of carer

Several participants in this study had withheld vital care needs from HCPs and expressed that the LGBTQ identity made it more difficult to ask for help. The tendency to avoid care to protect oneself from discrimination or negative attitudes around the LGBTQ identity is known from earlier research (Baptiste-Roberts et al., 2017). Further, Malmöquist and Zetterqvist Nelson (2014) showed how lesbian parents rhetorically minimized heteronormative obstacles in reproductive healthcare. They formed a ‘just great’ story that had a protecting and normalizing function in a normative society, where the credibility of non-normative parenthood is at stake, making it harder to talk about eventual problems. An active approach where HCPs ask questions on needs, fears and experiences during and after birth is needed to reach a person who is hesitant to address care needs. Continuity of carer before and during birth is extra beneficial for LGBTQ families, as it creates possibilities of building trust for a longer time which may reduce minority stress.

Disrespectful care

A majority of the birth parents in this study experienced disrespectful care when birthing, which violated their trust in healthcare. There is a growing body of research that describes (mostly heterosexual) women’s experiences of disrespectful and/or abusive care during childbirth (e.g. Bohren et al., 2015). WHO calls for greater action on the prevention and elimination of disrespect and abuse during facility-based childbirths (WHO, 2015). LGBTQ people enter birthing care with higher levels of fear of childbirth than heterosexual women (Hallström et al., 2022) and more often have previous exposure to physical and sexual violence, threats of violence, hate crimes and trauma (The Public Health Agency of Sweden, 2022; Kneale and Bécares, 2021). Earlier experiences of abuse are predisposing for experiencing abuse in healthcare (Wijma et al., 2019). In addition, LGBTQ people have lower levels of trust in HCPs, and experiences of minority stress are common (Meyer, 2003; Nadal et al., 2016). The present study emphasizes a need for continued work towards respectful care for all birth and non-birth parents. It is well established that respectful, empowering
and supportive birthing care should not include vaginal examinations without consent or the use of hands-on techniques in breastfeeding support (WHO, 2015; Palmér et al., 2015), as some of the participants had experienced.

Lack of support for non-birth parents

Non-birth parents described that their feelings and reactions during birth were given little or no attention from HCPs and that it was difficult to ask for help with what they had experienced. This is in line with the experiences of non-birth parents that are heterosexual fathers (Etheridge and Slade, 2017). But in couples where both have childbearing capacities, it is common to share pregnancies between partners (Malmquist, 2015). It is crucial to explore non-birth parents’ experiences of witnessing a complicated birth, as non-birth parents of all genders may gain traumatic experiences, but when the non-birth parent has a childbearing capacity, it is important to explore if the experience has affected fears or feelings around being pregnant in the future. The development of fear of childbirth after witnessing a difficult birth could affect future pregnancies (Malmquist and Nieminen, 2021).

The importance of a trusting relationship

Both birth and non-birth parents need access to emotional support during and after complicated births, regardless of sexual or gender identity, but the conditions for emotional support to LBTQ people will be dependent on the HCPs’ LBTQ competence and ability to build a trusting relationship with an LBTQ person.

While the parents in general in this study experienced invalidation in connection to their relationships and parental roles, the non-binary transgender people also experienced invalidation when HCPs systematically misgendered them or lacked knowledge about transgender people in general, creating an additional stressor. These results align with earlier research on transgender pregnancy and birth experiences (Falck et al., 2021; Greenfield and Darwin, 2021). Respecting pronouns, validation of gender identity and validating the person’s vulnerability in reproductive healthcare are factors contributing to safety during birth (Hoffkling et al., 2017). This can be seen as the basis for a trusting relationship between HCPs and transgender people at all times, but will be crucial in stressful situations such as in case of complications.

Conclusion and implications for practice

Disrespectful treatment and deficiencies in care contributed to LBTQ people’s negative experiences when complications arose during birth. Trusting relationships with HCPs are important to protect the birth experience in case of complications. For LBTQ families, validation of the LBTQ identity or family, and access to vital information and emotional support for both birth and non-birth parents are crucial for preventing negative birth experiences.

- If complications arise at birth, HCPs need to specifically validate the LBTQ identity and/or LBTQ family to build trust, reduce minority stress and create conditions for protecting the birth experience during a stressful and vulnerable situation.
- Birthing care should strive for zero separation of the LBTQ family, to avoid hetero/cisnormative assumptions in highly stressful and vulnerable situations.
- If separation is unavoidable in an emergency situation, HCPs should prioritize and make extensive efforts to transfer LBTQ related information between wards and HCPs to not create breaches of trust.
- Continuity of care, e.g. case-load midwifery models, is beneficial for LBTQ families, as it creates possibilities of building trust for a longer time, which may reduce minority stress.

- HCPs need to develop an active approach for emotional support during and after complicated births, asking questions to both birth and non-birth parents on their experiences, as LBTQ people might be hesitant to address care needs.

Limitations and directions for future research

The participants had similar socio-cultural backgrounds. The chosen recruitment methods attracted mostly white middle-class cisgender women in same-sex relations. In future research, it would be valuable to think about how to reach people with other backgrounds and choose other kinds of recruitment methods, as it is important from an intersectional point of view to explore obstetrical and neonatal complications in a broader sample.

A majority of the participants had negative or traumatic birth experiences. Further research is needed on birth trauma, postpartum care and long-term postpartum health effects after birth complications in the LBTQ population.

Declaration of Competing Interests

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Credit authorship contribution statement

Sofia Klittmark: Conceptualization, Data curation, Formal analysis, Methodology, Project administration, Writing – original draft, Writing – review & editing. Anna Malmquist: Conceptualization, Formal analysis, Funding acquisition, Methodology, Project administration, Supervision, Writing – original draft, Writing – review & editing. Gabriella Karlsson: Data curation, Formal analysis, Writing – original draft. Aniara Ulfsdottier: Data curation, Formal analysis, Writing – original draft. Hanna Grundström: Conceptualization, Writing – original draft. Writing – review & editing. Katri Nieminen: Conceptualization, Funding acquisition, Writing – original draft, Writing – review & editing.

Ethical approval

Approved by the Swedish Ethical Review Authority.

Acknowledgements

The authors would like to thank all the participants who generously shared their experiences in this study.

References


Wijma, B., Persson, A., Ockander, M., Brüggemann, J., 2019. Kränkningar i vården är vanligt förekommande - Viktigt med aktivt arbete mot att patienter kränks [Abuse in healthcare - lessons learned during two decades of research]. Lakartidningen 116 FDYC.


