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Heteronormative communication with lesbian families in antenatal care, childbirth and postnatal care

Gerd Røndahl, Elisabeth Bruhner & Jenny Lindhe

Abstract

Aim. This paper is a report of a study of lesbian parents' experience of antenatal care, childbirth and postnatal care.

Background. In a strictly heteronormative-based care system, 'parents' naturally implies a man and a woman, and all communication and routines are based on heterosexual couples.

Method. A qualitative interview study was carried out in 2008. Ten mothers, eight of whom were in a relationship with another woman, participated. The participants had experience from several care facilities from three different cities in central Sweden.

Findings. Most participants had positive experiences but also complained that the focus was not always on the pregnancy and that no parenthood education had been offered. Heteronormativity was communicated by midwives and nursing staff throughout the process – from antenatal care to postnatal care, via forms, journals, verbal communication and orientation visits. This was experienced as embarrassing for the participant parents, and they also described encountering what they interpreted as embarrassment on the part of care providers. Participants called for increased knowledge about lesbian parenting, since they believed this would influence and facilitate communication, not least with midwives in antenatal care.

Conclusion. Midwives educated in lesbian issues could ask questions and communicate in a more neutral way at the first meeting, and thereby make prospective parents feel less insecure. Special parenthood education groups for lesbians are recommended so that lesbian couple can meet others with similar experiences and so that the focus will be on prospective parenthood and not on their sexual orientation.

Keywords: antenatal care, childbirth, communication, heteronormativity, lesbian families, midwifery, postnatal care

Introduction

Midwives have produced much research on antenatal care, childbirth and postnatal care, but few studies have drawn attention to the special care needs with respect to lesbian parenthood. In Sweden, midwives and nursing staff in obstetrics encounter more prospective lesbian parents today than previously, and the number is expected to rise further as a result of the new insemination legislation, which came into effect in 2005. This requires service development to ensure that lesbian parents receive high quality care.

Background

The healthcare system has based its care and treatment on an assumption of heterosexuality being the sexual orientation of all patients and significant others (Spidsberg 2007). This may lead to poor communication that affects the quality of care and arouses feelings of insecurity among non-heterosexual patients, who feel they are not being treated respectfully (Röndahl 2005). Lack of knowledge about different lifestyles and how these may affect health can lead healthcare personnel to ask inappropriate questions and make incorrect judgements (Platzer & James 2000, Röndahl 2005). Röndahl et al. (2006) reported that heteronormativity was communicated in waiting areas, on patient forms, and when registering patients for admission to hospital wards. When study participants did not match the heterosexual assumptions of the system, nursing staff could show reactions such as perplexity.

In a strictly heteronormative-based care system, 'parents' naturally implies a man and a woman, and all communications and routines are based on heterosexual couples (Spidsberg 2007). There is therefore a risk that prospective lesbian parents will be met and treated with prejudiced behaviour by midwives and nursing personnel if they 'come out' (McManus et al. 2006, Spidsberg 2007).

As of July 2005, Swedish law (SOFs, 2005:17) allows lesbian couples to undergo artificial insemination within the public healthcare system. Although the number of lesbian mothers has increased in recent years (McManus et al. 2006, Spidsberg 2007), they are still pioneers in the society (Buchholz 2000).

Several studies have shown an over-focus on sexual orientation rather than the pregnancy by midwives at maternity clinics (Platzer & James 2000, Wilton & Kaufmann 2001, Lee 2004, Spidsberg 2007) or, alternatively, an under-focus, where sexuality is not mentioned at all (Spidsberg 2007). Lesbians expecting a child have expressed a need to be responded to in the same manner as any other pregnant woman and her family (Wilton 1999, Platzer & James 2000, Spidsberg 2007). Lesbian couples experience this discrepancy in focus as unprofessional, and as placing them in a vulnerable position (Platzer & James 2000, Wilton & Kaufmann 2001). A lesbian mother has the same needs as a heterosexual woman for midwives' understanding of her social and emotional needs, and this extends to the co-parent (Renaud 2006).

A study by Wilton and Kaufmann (2001) showed that treatment of prospective lesbian parents was something that requires training. The acquisition of basic knowledge in the field should be compulsory and facilitated for all midwives. Attention to the choice of words in meeting with the prospective parents can make all the difference to how the relationship between the midwife and the parents develops. Questions that may be relevant for continuing care were sometimes presented in ways that were seen as a curious invasion of the parents'

privacy. Also, questions that heterosexual parents would never be asked were asked of lesbian couples without reasonable grounds.

In previous studies, lesbian parents have drawn attention to the importance of healthcare professionals being educated about different types of personal relationships (McManus et al. 2006). One option to improve communication and to avoid possible barrier to a good relationship was for them to be better prepared for dealing with health and illness with lesbians' (Buchholz 2000). The use of more gender-neutral forms and terms like 'partner' are two things that are easily achieved (McManus et al. 2006).

Antenatal care, childbirth and postnatal care in Sweden

The Swedish National Board of Health and Welfare is a government agency that falls under the country's Ministry of Health and Social Affairs. Its areas of activity are wideranging, and its many different duties span the fields of social services, health and medical services, environmental health, communicable disease prevention and control, and epidemiology. The policy guidelines for the Board's work, including maternity care, are set out by the government (National Board of Health and Welfare; <http://www.socialstyrelsen.se/en/>).

Maternity care is part of the country's preventive health care and is the responsibility of county councils. Pregnancy tests and all visits are free. When a pregnancy is suspected, the prospective parents contact a maternity care clinic to arrange an appointment with a midwife, who will then follow the pregnant woman through the prenatal care leading up to the birth. The midwife documents names, addresses and social security number, records details of previous diseases, blood type, weight, stomach growth, possible blood work, and other information of importance in a special journal that the expectant mother keeps with her. Any thoughts or problems that the pregnant woman has regarding her pregnancy and childbirth are discussed in the first place with the midwife. Provided there are no complications, there are normally also two doctor visits during pregnancy, the first at about 13–14 weeks and the second at weeks 35–36. All counties have an obligation to provide childbirth and parenthood classes for first-time parents, with instruction in breathing techniques and discussion of options for pain relief during childbirth, and prospective parents are usually offered an orientation visit to the delivery ward they have chosen. In addition to the care provided directly by county councils, there are a number of private clinics that provide care in Sweden. MamaMia is Scandinavia's largest private women's and children's health clinic. Together with a county-owned hospital, the MamaMia clinic has started a project aimed at ensuring that lesbian couples are well-received in maternal health and during childbirth. The hospital's delivery ward has staff trained in lesbian health and other issues (i.e. knowledge and respect towards lesbians and bisexual women). During pregnancy, couples have the opportunity to meet other couples in a lesbian relationship who are expecting children. In addition, they make two visits to the delivery ward with their midwives. At MamaMia, there are also openly lesbian midwives who couples can choose to go to if they want (MamaMia Health Clinic; <http://www.mamamia.se/31/default.asp>).

The study

The aim of the study was to describe lesbian parents' experience of antenatal care, childbirth and postnatal care.

Design

A qualitative descriptive study design was adopted, using semi-structured interviews.

Participants

A volunteer sample was recruited by snowball sampling. Key participants received written and oral information about the study and were also asked to recruit new participants by passing on the information letter. New participants were to contact the second or third author if they wanted to participate. The inclusion criterion was that a participant should be a lesbian woman with experience of antenatal care, childbirth or postnatal care in Sweden. A total of 10 mothers, of whom eight were in a relationship with another woman, participated.

Data collection

To encourage participants to feel relaxed and comfortable with the interview, they were given the opportunity to choose where it would take place. Careful consideration was given to preparing the questions to ensure that they were open-ended, were sensitive in view of the potentially emotive nature of the subject matter, and that they would encourage a narrative flow. An interview guide was designed based on a qualitative interview method (Spradley 1979, Pilhammar Andersson 1996, Trost 2005). The taped interviews took place with each participant in the location of her choice and lasted 30–60 minutes. Demographic data, such as age and information on care experiences, were also collected. The interview started with a question about how open the participant was about her sexual orientation in the context of public health. A second question addressed the experiences of parents and/or coparents in care contexts during the pregnancy. The natural conversational flow was expanded by asking more specific questions and/or for reflections on statements relevant for the study. The interviews were later transcribed verbatim by the second author. The data were collected in 2008.

Ethical considerations

Prior to data collection, we contacted the ethics committee for advice, and were referred to the university department as the decision-making unit as no patient was to be contacted at the hospital or other healthcare settings during the study. Approval was then obtained from the appropriate department heads. All participants received oral and written information before the study started, stating that their participation was optional and that their responses were confidential. Participants were recruited by snowball sampling, informed that only the person who interviewed them knew who they were. They had the opportunity at any time to stop their participation. Assurance was given that data would be kept confidential.

Data analysis

Influenced by the work of Nordgren and Fridlund (2001), Graneheim and Lundman (2004) and the first author's personal experience of qualitative analysis (Röndahl 2005), the analysis was performed in five steps:

- All interviews were repeatedly read until a feeling of what participants had said, a feeling of entirety, was attained.
- The second step was an examination of how participants described their experiences of health care regarding pregnancy and parenthood. During this step, a spectrum of

different perspectives emerged. Similar responses were sorted into positively, negatively and neutrally expressed information.

- The positive, negative and neutral responses were grouped into Antenatal Care, Childbirth and Postnatal Care, and categorized into areas such as Communication and Implications for Antenatal Care, Childbirth and Postnatal Care.
- The different categories were analysed separately and specific concepts identified. These concepts led to subcategories. An example of a category and one of its subcategories are: Communication (category) and Parenthood Education and Forms (subcategory).
- The fifth step constituted an analysis performed to find whether it was possible to raise the level of abstraction to a theme, before a summary of the content was made. All the interview material was then read again and raised to the level of an overall theme of Heteronormativity.

The data were analysed by the authors separately, until agreement was achieved. Revisions of the classifications/ categories/subcategories were made throughout the five steps of the analysis process.

Rigour

The analysts have different educational backgrounds and different sexual orientation, which may be strength for the performed analysis and lead to a higher degree of trustworthiness (Graneheim & Lundman 2004). After the analysis of the data, participants were given the opportunity to read the final results (in Swedish) and to correct possible misunderstandings (participant validation), but no one requested any changes.

Findings

The 10 participants had experience from several care facilities from three different cities in central Sweden. They had a total of nine children and ranged in age from 30 to 46 years. All participants were open about their sexual orientation in public health contexts.

All participants had made a choice about whether they wanted to receive maternity care in their own hometown or at the clinic with special lesbian competence. Several participants had chosen the clinic with special lesbian competence during their first pregnancy and their local maternity care for their second pregnancy. The reason stated for this was that they felt like a beginner and less confident in the first pregnancy, but were stronger and more confident in the second pregnancy. Participants stated that it was important for midwives to focus on their pregnancy and future parenting, and not on their sexual orientation, as some had experienced. Therefore, many wished to be treated just like ‘any pregnant woman’, which was one reason for choosing a clinic with special competence in lesbian issues, as described by this participant:

There’s a focus on what I see as important in the situation, that is to say, the pregnancy...in that situation, I’m just the same as any pregnant woman...because we don’t want to be different.

Communication

Several participants described themselves as insecure or concerned about what the response would be at their first contact with respect to the fact that they were lesbians:

...feeling a little bit hesitant to make contact, and all that with explaining ourselves all the time can be hard, I think...It's so hard if you feel like that on every visit...like it's unpleasant.

However, nearly all also had positive experiences from the first meeting with their midwife in antenatal care. Some midwives reacted with surprise but were still kind and friendly in their response towards the prospective parents. A very important sign of an open-minded midwife was if she included the co-parent from the beginning, so that prospective parents got the feeling of being an established family.

Several participants described how they felt that a negative experience was because of bad 'chemistry' that had nothing to do with their sexual orientation. Interviewees described the importance of including the 'second mother' and other children in a conscious and natural way. By doing this, midwives conveyed an acceptance and tolerance of same-sex parents as family and that sexual orientation was not an issue:

I experienced the antenatal care as a little less professional, if I can put it that way...So I thought it went well in delivery and on the postnatal ward because we felt like they had understood and really treated us like a family, and that we already had a child, a son, at home, so it was all okay. So I guess I think it was more obvious that it was a problem in antenatal care.

Participants described the personnel in postnatal care as being more aware of different family constellations and showed this through their actions:

It was like living at a hotel with every conceivable service, and the staff made a point of treating me like a new parent too. And they put up a little sign, and just wrote 'mother X' and 'mother Y' on it.

I can't imagine it being any different if I'd had my husband with me.

A single parent (without a partner) described the reaction of her first midwife in antenatal care as very embarrassed, and the woman felt that she was looking at her with disbelief and disgust. She experienced the meeting as very unpleasant and offensive in such vulnerable situation and changed to another clinic for her antenatal care.

Parenthood education and forms

None of the participants were offered any childbirth and parenthood education. Some assumed that this was because they were scheduled for caesarean section. However, others assumed that it was because of the fact that the midwife did not know how to handle two mothers instead of a father and a mother, as in traditional parenthood groups.

Some participants described their visits to the delivery ward as performed routinely with no awareness or thought given to different family constellations:

Then she emphasized the whole time that ‘here is where the father can go and get coffee’, and ‘the father can sit there’, even though we were two women couples and two woman-man couples sitting there. So it was very strange since she was looking at us the whole time but saying ‘the mother and father’, ‘the woman and man’ and ‘the man’ and ‘the father’. Yeah, the whole, whole time. There was never any ‘partner’ or ‘supporting mother’ or ‘other mother’ or anything...Even though 50% of the parents there were women couples. So it didn’t feel very good, so we were very upset and got a lot of strange ideas about exactly how aware the staff was. And would we be respected when we got there?

All participants mentioned the conventional information and the questions the midwife had to ask to fill in the forms as a possible source of embarrassment for both the midwife and the prospective parents. Some participants were offended by the standardized forms and saw them as conservative and stereotyped. Some argued that lesbian parents are a minority and therefore always have to assert their existence, but that it is ‘no big deal’:

It always says ‘father’ on all the papers, so we cross it out and write ‘mother’ instead, but we do note it, we do...

Implications for antenatal care, childbirth and postnatal care All participants were asked to comment on the competence and awareness they encountered regarding different family constellations especially in antenatal care. They stated that midwives educated in lesbian issues would probably ask questions and communicate in a more neutral way at the first meeting, and thereby probably make prospective parents less insecure. Some participants argued that personnel did not necessarily need special lesbian competence, but an open mind and sensitivity to prospective parents’ vulnerability:

I don’t think they are familiar with it...then you have to explain and that can be embarrassing and, like, hard to talk about...It’s just that –a little more awareness and a little more education, so we wouldn’t feel like that...

Interviewees also pointed out that it would be easy to change some healthcare routines and forms to be more neutral. This would send a signal of an open-minded approach and make it easier for lesbian patients to come out:

It wouldn’t take that much to make us feel visible – print up a few forms. You don’t want to see ‘father’ on every form. Or something as simple as a bulletin board in the lunchroom, where you write that you want a meal – it should say ‘partner’ there. Little things like that make all the difference.

Some participants said that they had to educate their midwife and other staff about lesbian relationships and parenthood. They had mixed feelings about this: some good, but at the same time also feelings of anger and discomfort:

Part of it is good because she needed to learn, and she seemed open. But then there’s another part that gets mad because I’m not there to be interviewed, I’m not there to...educate their staff, so a part of me is sitting there wishing ‘please stop asking about that’ and find out why I’m having early contractions instead. Because in this situation, all we wanted was help...By all means – acquire the

knowledge, but not through the patients. I can come and talk about it later, but not when I'm there to have a baby. I'll come and talk about it as a lesbian or a parent, but not when I'm a patient...

Participants called for special parenthood education groups for lesbians, citing the importance of groups with like-minded experience, so that the focus would be on prospective parenthood and not on sexual orientation:

Then maybe we'll have something to talk about; otherwise we maybe just sit there and feel like a monkey that everyone is staring at.

Discussion

Study limitations

Information saturation was achieved after seven interviews. Most participants related similar experiences, despite having been recruited from three cities in central Sweden. Platzer and James (1997) state that the weakness of the snowball sampling method is that similar data are received from participants recruited in this way. This method was chosen, however, as it has proved most effective in comparable studies (James & Platzer 1999). The 10 participants may not have been representative of all lesbian prospective parents, but they were able to illustrate lesbians' experiences of midwifery in a heteronormative communication context.

What is already known about this topic

- Earlier researchers have reported an over-focus on sexual orientation rather than the pregnancy by midwives at maternity clinics.
- Questions that heterosexual parents would never be asked are asked of lesbian couples without reasonable grounds.
- Lesbians expecting a child have expressed a need to be responded to in the same manner as any other pregnant woman and her family.

What this paper adds

- Several participants described themselves as insecure or concerned about what the response would be at their first contact with respect to the fact that they were lesbians.
- Several described how they felt that a negative experience was because of bad 'chemistry' that had nothing to do with their sexual orientation.
- None of the participants were offered any childbirth and parenthood education; some assumed that this was because of the fact that the midwife did not know how to handle two mothers instead of a father and a mother, as in traditional parenthood groups.

Implications for practice and/or policy

- Midwives educated in lesbian issues could ask questions and communicate in a more neutral way at the first meeting, and thereby make prospective parents feel less insecure.
- Changing some healthcare routines and forms to be more neutral would send a signal of an open-minded approach and make it easier for lesbian patients to 'come out'.
- Special parenthood education groups for lesbians are recommended so that lesbian couple can meet others with similar experiences and so that the focus will be on prospective parenthood and not on their sexual orientation.

Discussion of findings

Our participants could feel insecure and vulnerable, depending on the reactions they encountered from midwives and nursing personnel in their first pregnancy. Most had positive experiences but also complained that the focus was not always on the pregnancy and that no parenthood education had been offered. Their negative experience of responses from their midwives was explained more as a case of bad personal chemistry than negative attitudes. Heteronormativity was communicated by midwives and nursing staff throughout the process – from antenatal care to postnatal care, via forms, journals, oral communication and

orientation visits. This was experienced as embarrassing for participant parents, and they also described encountering what they interpreted as embarrassment on the part of their care providers. Participants called for increased knowledge for healthcare staff, since they believed that this would influence and facilitate communication, not least with midwives in antenatal care. They also stated the importance of not using prospective parents as an educational resource, and how easy it would be for the healthcare system to update old routines and forms to more neutral ones.

Participants felt vulnerable and defenceless in the face of the responses of midwives and nursing staff, especially during the first pregnancy. Earlier researchers have reported similar findings regarding feelings expressed by homosexual patients and their partners (Platzer & James 2000, Røndahl 2005, McManus et al. 2006, Røndahl et al. 2006, Spidsberg 2007). Even though most participants in the present study had positive experiences from maternity care, they reported an over-focus on their sexual orientation. This confirms similar findings from earlier studies and may also serve as an explanation for the negative feelings participants expressed (Platzer & James 2000, Wilton & Kaufmann 2001, Lee 2004, Spidsberg 2007). They also expressed dissatisfaction with the fact that they had not been offered the parenthood education usually offered to heterosexual expectant families. This may have been because of poor communication and incorrect assessment, with consequences for the quality of care as earlier described by Røndahl (2005) and Platzer and James (2000).

Participants believed that the negative experiences of communication they had had with their midwives were probably related more to the 'chemistry' between prospective parents and midwives than to intolerance toward lesbian families. This finding may also be explained in terms of the heteronormative bias in communications and routines regarding parenthood in the midwifery context, which have been described in earlier studies (McManus et al. 2006, Spidsberg 2007). This heteronormativity was communicated verbally and non-verbally throughout the entire process by midwives and nursing staff. This was experienced as awkward, and expressions of embarrassment were attributed to midwives and other care providers. This has also been described in earlier nursing studies by Røndahl (2005) and Røndahl et al. (2006). A potential solution to these heteronormative issues and to facilitating communication in the midwifery context is education on basic lesbian issues, as earlier researchers have suggested (Buchholz 2000, Wilton & Kaufmann 2001, McManus et al. 2006). Our participants also called for this training, not least for midwives in antenatal care. However, they clearly emphasized the importance of not using lesbian families as the educational source for this, as well as the need to change conservative heteronormative routines and forms. Introducing more neutral wording in forms is an easy way to effect such change (McManus et al. 2006).

Conclusion

The lesbian families in this study had mostly positive experiences during their pregnancy and also afterwards. Their greatest wish was to be treated as any pregnant women and family would be, and when they were it increased the positive experiences. Heteronormative communication – verbally as well as non-verbal – was seen everywhere and influenced the participants' feelings of insecurity, which made most of them choose the clinic with special lesbian competence for their first pregnancy. Of all medical contexts, it is likely that heteronormativity is most prominent in obstetric care environments because of historical heterosexual tradition and care associated with reproduction. This requires all healthcare professionals in midwifery contexts to be aware of different family constellations that may

exist and not to take for granted that all families are heterosexual. Furthermore, special education for lesbian competence would be an excellent addition to maternity service provision to guarantee lesbian parents high quality care.

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Conflict of interest

No conflict of interest has been declared by the authors.

Author contributions

GR, EB and JL were responsible for the study conception and design, and performed the data analysis. EB and JL performed the data collection. GR was responsible for the drafting of the manuscript, made critical revisions to the paper for important intellectual content, obtained funding, provided administrative, technical or material support and supervised the study.

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