Journey to motherhood: Experiences of lesbian de novo families in Australia

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List of abbreviations

IUI: intra-uterine insemination
IVF: in-vitro fertilisation
VI: vaginal insemination
SI: self-insemination
ART: assisted reproductive technology
Abstract

Lesbian mothering is becoming more visible in societies around the world, however to date, little research has explored the experiences of coupled, lesbian women creating de novo families in Australia. The aim of this qualitative study, underpinned by feminist philosophy, was to explore the experiences of lesbian mothers in Australia. To achieve this aim, in-depth, semi-structured, story sharing interviews, journaling and a demographic data collection sheet were used to collect data from the fifteen couples participating in the study. The data were analysed and three main themes were identified: becoming mothers, constructing motherhood and legitimising our families.

De novo refers to a family constellation where two lesbian women who are partnered, plan, conceive, birth and are raising their children in the context of their same-sex relationship. While the literature demonstrates growing acceptance of lesbian mothering, they remain marginalised and subsequently vulnerable. The findings of this study identified that participants deliberately and consciously approached decisions associated with creating their families, they laboured to legitimise the position of the non-birth mother in their families and that, despite growing acceptance, continue to experience homophobia when interfacing with healthcare providers and services.

Complex decisions about which woman in the couple would conceive, their preferred method of conception and the known or unknown status of the sperm donor were encountered with determined commitment by the participants. They
spent many hours, days, months and sometimes years, researching their options about how to create a family. The factors that often determined which woman would try to conceive were age, health and personal preference. Choosing a known or unknown sperm donor was sometimes dependent on the method of conception used to achieve a pregnancy. For example, some couples preferred to use alternate insemination at home and this limited them to a known sperm donor. Aside from the preferred method of conception, the known or unknown status of the sperm donor was considered carefully in relation to his intentions about future contact with the child or parenting expectations, his physical and intellectual characteristics, his availability and his health.

After a pregnancy had been achieved and a baby born, the participants endeavoured to construct their roles and position in their family and their community. The lack of visibility of de novo families in society meant that essentially, there were few role models for constructing motherhood. In addition, lesbian mothers were sometimes excluded from the usual familial support that heterosexual mothers might experience, due to rejection by their biological family because of their lesbian identity. One of the major challenges the couples experienced was legitimising their family, and in particular, the position of the non-birth mother. The couples laboured to implement specific strategies to justify the non-birth mother’s position as a legitimate parent in their family.

During their interactions with healthcare providers and services, participants experienced various forms and levels of homophobia and heteronormativity. They often anticipated homophobia and implemented strategies to avoid interacting with
healthcare services and providers that they perceived as homophobic. Other participants met homophobia head-on and regarded it as a unique opportunity to teach others about themselves and their family and subsequently promote acceptance of diversity. Participants were challenged by heteronormativity and expressed frustration at heterosexual assumption and experiences of being excluded. To counter these sometimes stressful and devaluing interactions, participants implemented specific strategies to maintain their safety.

The findings of this study have revealed some interesting and significant aspects of lesbian mothering in the Australian context, some of which resonate with the literature while others represent new knowledge. In elucidating the experiences of lesbian mothers, a deeper understanding of the decisions made on their journey to motherhood, how they constructed *motherhood and family*, and strategies that promote inclusive healthcare have been identified.
List of publications and presentations

**Peer-reviewed publications**


**Presentations**


Acceptance letters for each of the published papers and papers *in press* are contained in Appendix 1.
Dedication

This thesis is dedicated to my beautiful family – Merryn, Jaimie, Chloe, Thomas, Mackenzie and Piper with all my love.
Acknowledgements

I am very grateful to all the people who have helped me complete this thesis. Here I acknowledge the support and contribution of my academic supervisors, my family and the women who participated in the study.

My supervisors, Professors Lesley Wilkes, Debra Jackson and Liz Halcomb have taught, mentored, supported, guided, encouraged and persevered with me despite the various challenges that cropped-up during my candidature. Together we negotiated three pregnancies, two babies, a miscarriage, a wedding, a diagnosis of chronic illness and sadly, the deaths of two special nannas and my beloved mother-in-law. Despite these challenges, I am so thankful that they stood beside me, cheering me on, believing in me (even when I didn’t) and ultimately, supporting me to write this thesis. I am not only appreciative for their genuine care and kindness, particularly when things got challenging, but also for their academic support. Reading my work and providing meticulous feedback on countless drafts of various papers and chapters, directing me to resources and engaging me in discussions about theory, methodology and philosophy consistently helped me make sense of what I was doing.

My family have also provided me with unwavering support. My extraordinary partner and our four beautiful daughters shared with me their infinite and unconditional love throughout my PhD journey. Their support and understanding
were especially appreciated during my intermittent absences from partnership and mothering, while I was busy thinking and writing.

Finally, I am tremendously thankful to the women who participated in this study. They gave me their time, emotion and their energy, and shared with me their stories – the stories that ultimately provided the foundation and the substance for this research. I was humbled to have the opportunity to talk with lesbian mothers who so openly shared both their joys and their struggles in creating their families. I hope the research findings do their stories the justice they deserve. Hopefully, together we have been able to increase understanding of the experiences of lesbian mothers.

I have had the opportunity to learn much about myself during this candidature. Mostly, I have been able to realise my own courage, tenacity and resilience and I am truly humbled by the support from my family, supervisors and the participants who helped me achieve my goal. To those acknowledged here and the countless other family, friends and academics who also supported me in numerous ways, please accept my unreserved gratitude for accompanying me on this adventure!

One isn’t necessarily born with courage, but one is born with potential. Without courage, we cannot practice any other virtue with consistency. We can’t be kind, true, merciful, generous, or honest.\[1\]

(Maya Angelou 1928-2014)

Statement of authentication

The work presented in this thesis is, to the best of my knowledge and belief, original except as acknowledged in the text. I hereby declare that I have not submitted this material, either in full or in part, for a degree at this or any other institution.

__________________________________________
Brenda Hayman
Chapter 1

Introduction

Introduction to the study

A *de novo* family is a constellation of kin that consists of a lesbian couple and the children they planned, conceived, birthed and are raising together (McNair, 2004). The literature also refers to these families as two mother families (Bos, van Balen & van den Boom, 2004) and lesbian-headed families (Hequembourg, 2009). In Australia, like other countries, there has been a significant increase in the number of *de novo* families in recent years (Australian Bureau of Statistics, 2009; Hequembourg, 2009). This has led to researchers increasingly using terms like the lesbian baby boom (Patterson, 1995) and the *gayby boom* (Spidsberg, 2007) to describe this modern family constellation. Lesbian mothering first emerged in the literature in the 1970s (Clarke, 2008; McCann & Delmonte, 2005) and, since then, lesbian families have been able to achieve growing visibility in society (Clarke, Kitzinger & Potter, 2004; Renaud, 2007). Despite this, there is a paucity of literature exploring the experiences of lesbian mothers in *de novo* families.
My story

The inspiration for this research project was generated out of my personal and professional experiences as a woman, a lesbian, a mother and a registered nurse. I often reflected on my experiences of being a lesbian woman in a heteronormative world and frequently considered the challenges faced by me, my family, my friends, my children and other lesbians, and in particular lesbian mothers. I share some of my story here for various reasons, but primarily out of genuine, unreserved respect for the remarkable lesbian mothers who participated in our study who gave their time, thought, energy and emotion through their words, pictures, art, photos and their stories. I am both grateful and humbled by their passion, unwavering positions on social justice issues and their willingness to share with me their story. Their stories were rich, detailed and emotive – they shared their determination to become mothers, their joys, their heartbreaks and their everyday lives. Their voices provided a narrative platform to help increase understanding of the experiences of lesbian mothers and will hopefully lead to change by raising our visibility in the community, reducing homophobia, eradicating discriminatory legislation and policy, increasing education that focuses on equality and inclusiveness and increasing awareness of the impacts of heteronormativity.

In my personal life, the challenges were not insurmountable primarily due to supportive family, friends and colleagues – the world however, was not ready to accept me as a lesbian, and much less a lesbian mother. I cautiously came out when I was 30 years old and by then I had two beautiful daughters aged three and four. Soon after, I met my life partner and we embarked on our journey of having two more delightful daughters together, now aged six and four. It was a
wonderful experience, but because of our lesbian orientation, there were many, many challenges – additional to those experienced by heterosexual couples. I wondered why it had to be so difficult, why people were harsh with their judgments and why some refused services. A donor, the law, schools, healthcare providers, homophobia – how would we negotiate all of these difficulties to meet our heart’s desire – to have and raise a family together. We longed to be mothers together – we wanted desperately to conceive, birth and raise our children as a family. We talked as a couple and with other lesbian women, who had chosen motherhood together. We researched, we made appointments with solicitors and healthcare providers and discussed options for sperm donors. We were excited but anxious.

We advertised for a sperm donor and had in excess of a dozen replies within a few days (most within hours!). While rather overwhelmed with the volume and rapidity of responses, we excitedly ploughed through information like age, health status, physical characteristics and photos and eventually, we found our guy! He ticked all our boxes – and we had quite a few! We met him several times over a period of three months and once we had discussed all the details of our arrangement, we proceeded with monthly donations via alternate (self) insemination at home.

After just three months, I was pregnant! The joy and excitement was immeasurable and uncontainable and we shared our news with everyone. Sadly, at 11 weeks – just as we started to feel safe, we lost our girls. It was … there are, no words – we grieved then and we still grieve now. Moving forward, we waited the three months advised by the midwife and tried again. After just a few months, I was pregnant again. We were cautious and apprehensive. The
pregnancy went well and our third daughter was born, one week early via caesarean. Love, joy, excitement and more love … she was perfect! Twenty-three months later, our fourth daughter was born after a fairly uneventful pregnancy. More love, more joy and more excitement! Then aged 41 years and after four caesareans, we felt our family was complete.

As a couple, we experienced many challenges during our pregnancies and since that time, related directly to our sexual orientation and our decision to be mothers in the context of our same-sex relationship. Homophobia, and the potential for homophobia, affects the decisions we make every day. Heteronormative attitudes, policies and practices mean we often have to come out over and over again and to frequently explain (and sometimes justify) our family constellation. These experiences are no different to the stories shared by the lesbian mothers participating in our study. Both my personal and professional experiences provided me with the opportunity to identify and reflect on the following question:

What are the experiences of lesbian women who choose motherhood in the context of a same-sex relationship?

**Background**

In Australia, there are over 33 714 same-sex couples (Crouch, McNair, Waters & Power, 2013). This represents less than one percent of all couple families (Department of Families, Housing & Community Services & Indigenous Affairs [FaHCSIA], 2008). It is estimated of that there are some 6120 children living in same-sex parented households (Crouch, 2013). It is important to note these
figures may significantly under-reflect the actual numbers of same-sex couples and their children (Mikhailovich, Martin & Lawton, 2001), and that these figures include; families where only one parent identifies as same-sex attracted, male same-sex attracted families and a variety of same-sex parented family constellations (for example, step-families, foster families and adoptive families). Due to continued stigmatisation (James, Harding & Corbett, 1994; Schwanberg, 1996; van Dam, 2004; Wilton & Kaufmann, 2001), some couples choose not to identify themselves as being in a same-sex relationship (Bjorkman & Malterud, 2007; DeBold, 2007; Doherty & Tilley, 2012; Khajehei, MacCallum & Golombok, 2004; Wojnar & Katzenmeyer, 2014). In 2008, Millbank estimated that up to 20 percent of lesbian women in Australia were mothers.

While lesbian mothers are becoming more visible in society, they remain a vulnerable group, marginalised by their non-heterosexual identity, particularly in the realm of mothering and family (Crouch et al., 2013; Renaud, 2007). Pacilli, Taurino, Jost and van der Toorn (2011) identified that marginalisation occurs because of attitudes that only heterosexual women are “naturally programed for reproduction and motherhood” (p. 581). Despite positive shifts in attitudes more recently, about the capacity and rights of lesbian women to be mothers, homophobia and heteronormativity continue to confront and challenge the way lesbian mothers negotiate and interact within the community. Lesbian women and their de novo families require safe environments that do not assume heterosexuality and where support and information are accessible.

Despite the increasing numbers of lesbian couple families, very little research has been undertaken with this group. In Australia, no studies have explored the
process of conception in *de novo* families, including donor decisions and methods of conception. In addition, while there is some literature that examines the role of the other mother in *de novo* families, the findings in this study provides a comprehensive description of her role, as well as the methods she employed, together with her partner, to legitimise her position as a genuine parent in her family.

**Aim**

To explore the experiences of lesbian couples in Australia who choose motherhood.

**Significance of the study**

The findings will provide information to encourage a deeper understanding of the experience under investigation. Seeking to understand the experiences of lesbian couples who choose motherhood provides many potential benefits to lesbian mothers, their children and families, the community and healthcare providers, including nurses.

Lesbian mothers participating in the research will have the opportunity to have their thoughts and feelings associated with their mothering heard and validated and also to gain a deeper understanding of their own experience by detailing these experiences together (as a couple) and with the researcher. The findings of the research may promote feelings of connectedness and community amongst lesbian mothers and provide opportunities for learning new or different
ways of mothering. Increasing knowledge about lesbian mothering may disrupt phobias and discrimination within, and outside of, the lesbian community. Increased knowledge and understanding about how lesbian couples go about planning, conceiving and parenting their children will benefit other lesbian couples (with or without children) and the community as a whole. The challenges and benefits of lesbian mothering may also be elucidated in the findings and this should further promote understanding and tolerance. Promoting understanding and tolerance in the community may reduce homophobia, increase equitable access to quality healthcare and increase validation of de novo families and lesbians as mothers.

The potential benefits of our study to the family include increased social and political recognition of the lesbian couple with children as a family. The generation of an in-depth understanding of the unique healthcare needs of lesbian couple and their families may improve the way in which healthcare services are offered and delivered to lesbian families. This in turn could improve the support offered to lesbian mothers and de novo families. Within the community, the findings of our study may facilitate the promotion of suitable support networks, encourage the effective utilisation of resources and provide a deeper understanding of the concept of mothering across the community.

The potential benefits to nursing and nurses include the gaining of a deeper understanding of lesbian mothering and therefore potentially improving the way nursing care is delivered and the quality of that care. This deeper understanding may in turn lead to the recognition of lesbian mothers as having specific healthcare needs. The findings may also lead to the development of ante, peri and post-natal healthcare processes that are inclusive and promote
access to quality healthcare services for all women. The research may also generate the implementation of inclusive healthcare services that support lesbian women to conceive.

This thesis will focus on the experiences of lesbian couples and in particular their choice to become mothers. How they decide to start a family, the processes they choose to conceive, their experiences of ante-natal and post-natal care and how they construct their family and mothering experiences will be explored. It is anticipated the research will: uncover valuable information in relation to the experience(s) of lesbian mothering, reveal challenges and benefits associated with lesbian mothering, increase understanding of the experience and identify clear strategies for supporting lesbian couples who choose to have children.
**Definition of terms**

Lesbian

A woman attracted emotionally and sexually to other women.

Lesbian mother

In the context of this study, the female parents; biological and non-birth of at least one child the couple have planned, conceived, birthed and parented within their relationship.

*De novo*

A family that is headed by a lesbian couple who planned, conceived, birthed and are raising their children in the context of their same-sex relationship.

Lesbian couple

Two women who identify as lesbian and are in a committed partnership or relationship.

Non-biological mother

The mother in a *de novo* family who is not genetically or biologically related to the child(ren).

Other mother

The non-birth mother in a *de novo* family.

Sperm donor (donor)

A male who donates sperm to the lesbian couple, and who may or may not be known to the prospective child.
Structure of thesis

This document fulfils the requirement of a ‘Thesis as a series of papers’ as defined by the University of Western Sydney Doctor of Philosophy policy (2012). It is structured as a series of six published, peer-reviewed papers (see List of Peer-Reviewed Publications and Presentations; pp. vi-vii) that are presented within an over-arching statement, combined to craft this thesis. Each paper is formatted according to individual journal requirements. Evidence of acceptance of each paper can be found in Appendix 1. As the primary author, I was responsible for data collection and analysis, preparing initial drafts of the papers, and my co-authors (doctoral supervision panel) provided critical review of each manuscript.

Three papers illustrated the methods of data collection that were used in the study; two papers explored story sharing (Papers A & B) and one paper elucidated journaling (Paper C). These papers described the methodological processes of story sharing and journaling, as well as offered insights into any challenges experienced by the researcher and strategies to overcome those identified challenges. In addition to the method papers contained in this thesis are three peer-reviewed, published papers that represent the findings of the study (Papers D, E & F). Each findings paper described and explored one of the themes generated from the data. Each of the six papers are presented within this thesis as chapters supported by additional chapters including an introduction, literature review, methodology, discussion, limitations and recommendations for future research.
Chapter One provides an introduction to the study. To contextualise the study, the position of the author in relation to the research is explained, and the concept of lesbian mothering is explored. To further frame the study, this chapter also describes the aim and significance of the study.

Chapter Two examines the literature on lesbian mothering. Social assumptions about de novo families, models of de novo families, becoming a mother in a de novo family and accessing healthcare are themes identified in the literature and are elucidated in this chapter. A summary of the literature concludes this chapter.

The next Chapter details the methodology used in this qualitative study. Initially feminism is explored, rationalised and justified as an underpinning philosophy. The recruitment strategies and data collection methods are explained in this chapter and are further detailed in Chapters 4, 5 and 6 (Papers A, B and C). Ethics, rigor and the position of the researcher as an insider are also detailed in this Chapter.

Chapter Four contains the first of the papers (Paper A) and is titled, Exchange and equality during data collection: relationships through story sharing with lesbian mothers. In this paper, story sharing is identified as a valid method of data collection in qualitative research and self-disclosure is acknowledged as a useful strategy in promoting trusting relationships that equalises power between the researcher and the participants, and subsequently improves the richness of the data collected.

The following Chapter contains the second paper (Paper B) titled, Story-sharing as a method of data collection in qualitative research. In this paper, story
sharing is justified as a valuable method of data collection that requires reciprocity between the researcher and the participants in the context of a qualitative research interview. The benefits and limitations of the method are offered in this paper.

Chapter Six presents paper C titled, *Journaling: identification of challenges and reflection on strategies*. This paper rationalises journaling is a valid method of collecting data in qualitative research and offers three potential challenges and six strategies to counter those challenges.

Chapter Seven contains an introduction to the study findings and Paper D titled, *Lesbian women choosing motherhood: journey to conception*. The paper detailed the decision-making processes and conception decisions that lesbian couples engaged when deciding to have a baby. As well as outlining the various methods of conception used by lesbian women, this paper also explores their decisions about the known or unknown status of the sperm donor. This paper offered a deeper understanding of how lesbian women in Australia negotiate the healthcare system and discriminatory legislation.

Paper E titled, *Marginalised mothers: lesbian women negotiating heteronormative healthcare services* is presented in Chapter Eight. While recognising lesbian women as vulnerable, this paper illuminated the unique experiences of lesbian women accessing healthcare and detailed strategies they used to maintain safety and avoid homophobia. It also offered suggestions for healthcare workers in regards to policy, inclusive language and education.

Chapter Nine contains the peer-reviewed, published paper (Paper F) titled, *De novo families: legitimizing the other mother* and an invited peer-reviewed (in
press) encyclopaedia entry (Paper G) that defines and describes the role and position of the other mother in de novo families. Paper F explored the role and position of the non-birth mother in de novo families, clarified her challenges and identified how the family worked to legitimise her role in their family as an authentic parent. The strategies implemented to legitimise the non-birth mother’s position are also identified in this paper.

The final Chapter (10) contains the discussion, implications and limitations of the study, as well as ideas about future research in the area of lesbian mothering. The discussion is presented in three sections; deciding and conceiving, negotiating health services and legitimacy of the other mother and the de novo family. The discussion explores the findings in relation to the existing literature and identifies new knowledge generated by this research.
Chapter 2

Literature review

Introduction

This literature review provides a broad, introductory overview of the issues affecting de novo families and compliments the focussed literature reviews contained in the published papers included in subsequent chapters of this thesis. The four main themes that emerged from the literature are: social assumptions about de novo families, models of de novo families, becoming a mother in a de novo family and accessing healthcare. Table 1 illustrates the four themes deduced from the reviewed literature.

Table 1: Themes identified in the reviewed literature

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<td>Theme 4</td>
<td>Accessing healthcare</td>
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Social assumptions about *de novo* families

Society as a whole assumes the norm is that children are born and reared within a heterosexual family home with the primary task or responsibility for care-giving, belonging to the mothers (Mercier & Harold, 2003; Tracey, 1999). While society assumes the heterosexual family as the norm, being a mother is an element of womanhood despite a woman’s sexual orientation (Potgieter, 2003). Contrary to the heterosexual family norm, some lesbian couples want to form families that include children they plan, birth and raise together, as a couple. In the literature, these families are referred to as *de novo* families (McNair, 2004). Like other women, Purewal and van den Akker (2007) identified that lesbian women chose to become mothers because of their biological drive, desire to make a family and to feel fulfilled. Lesbian mothers in *de novo* families negotiate hetero-normative spaces, are excluded from the usual mother traditions, construct their own family models including division of labour and develop ways of legitimising their *de novo* family.

Lesbian women in *de novo* families undermine the traditional gendered notions of division of labour in families (Dunne, 2000). Lesbian couples are less likely to employ gender role division than heterosexual families and lesbian parents are more likely than heterosexual parents to divide paid work and domestic labour, including childcare, more equally (Ciano-Boyce & Shelly-Sireci, 2002; Hadley & Stuart; 2009). Ben-Ari and Livni (2006) add that in the absence of traditional gender roles, lesbian mothers create their own roles according to the needs of their individual family. In Short’s (2007) study, lesbian participants defended their position stating both (mothers) take on an equal role and believe they
understood each other and communicated more effectively than couples in heterosexual families.

It is recognised within the literature that heteronormative spaces and institutions marginalise lesbian women (Dalton & Bielby, 2000). Thus, lesbian women exist in a space that does not fully accept their motherhood (Dalton & Bielby, 2000; Siegenthaler & Bigner, 2000). Gabb (2005) added that the home is the one space where lesbian mothers can reconcile their sexuality and their maternal role simultaneously – where they are free to be both a lesbian and a mother because they are hidden away from the “pernicious gaze of hostile others” (p. 426). In other places like streets and schools, lesbian mothers may hide their sexuality because, according to popular social beliefs, being a lesbian should be confined to marginalised spaces (Gabb, 2005; Skattebol & Ferfolja, 2007). They are indeed mothers but are left-out of the usual mother traditions and therefore have invented their own ways of being both lesbian and mother within these spaces, and this is particularly so for the non-birth mother in de novo families (Ben-Ari & Livni, 2006; Dalton & Bielby, 2000).

The marginalisation of de novo families is reinforced by exclusion from the usual birth stories, support and advice from older women in their families of origin that may be a consequence of their lesbian relationships (Erwin, 2007; Nelson, 2007). Since they do not conform to the institution of heterosexual family ideal, they are often isolated from other mothers and left outside of the mother-club. This was demonstrated by the participants in Nelson’s (2007) study who were reportedly met with disapproval from their family when they shared their news of being pregnant. Nelson (2007) further identified any celebration that did occur, was more likely to come from the birth mother’s
family, and this response often meant the non-birth mother’s impending parenthood was left unrecognised, and uncelebrated. Since heterosexual families are an existing institution, lesbian mothers – particularly non-birth mothers – must create their own identity and role and reconstruct the institution of mothering. Historically, there were few role models for lesbian women choosing motherhood to help guide the development of their roles within their families and “many of the cultural images of lesbians were pejorative” (Donaldson, 2000, p. 132). More recently, pop culture has provided some role models who have illustrated that lesbian identity and motherhood need not be at odds (Donaldson, 2000).

Models of de novo families

Lesbian de novo families construct their own unique model of family (Ben-Ari & Livni, 2006). The participants in Short’s (2007) study emphasised normalisation and similarity to heterosexual mothers’ experiences. Some families organised their family life so the non-birth mother was the stay-at-home mother. Other normalising strategies included choosing specific names (to be used by their children) for each mother that had meaning to them and in some families, children were given the non-birth mother’s surname. In the absence of traditional gender roles, lesbian mothers created their own roles according to the needs of their individual family (Ben-Ari & Livni, 2006) and as such, lesbian couples were more likely to divide childcare more equitably than heterosexual couples (Ciano-Boyce & Shelly-Sireci, 2002). Hadley and Stuart (2009) found lesbians are less likely to employ gender role division than heterosexual families and that lesbian parents are more likely than heterosexual parents to
divide paid work and domestic labour, including childcare, more equally. The disadvantage of this kind of normalisation, is that it suggests heterosexual family constructs are those against which all other family constellations should be measured (Hequembourg, 2007).

In order to establish de novo family models, these families need to be recognised as legal entities. Moves to recognise the de novo family in Australia are moving slowly with parts of the Sex Discrimination Act of 1984 overturned, providing lesbians with access to in-vitro fertilisation and donor insemination. In 2008, a further 85 pieces of legislation were amended to ensure recognition of same sex couples (National LGBTI Health Alliance, 2014) and, in particular, recognition of non-birth mothers in de novo families which has reduced their legal vulnerability. Despite these changes, lesbian women continue to face substantial inequality and social marginalisation (Rosenstreich, Comfort & Martin, 2011). Non-discriminatory laws are required to protect and sustain all mothers (Short, 2007; Smith, 2003). Lesbian mothers in de novo families need supplementary legal consideration given their especially vulnerable position (Hargreaves, 2006; Morrow, 2001) and as such validating the role and position of the non-birth mother was demonstrated as an important issue in many of the reviewed studies. De novo families employ various strategies to validate their family structure and the role of the non-birth mother within it. Dalton and Bielby (2000) stated that lesbian mothers in their study “shared a strong commitment to establishing the non-biological parent as a mother in her own right” (p. 50).

The concept of family to lesbians is extended beyond the blood ties that generally define families to include friends and other kin who are not necessarily connected by biology (Weston, 1991). Lesbian women tend to form
“extended networks of support that function like a large family … similar to those found in many Indigent cultures … who share socio-economic obligations regardless of a lack of biological relationship” (Donaldson, 2000, p. 122).

Biological mothers in Nelson’s (2007) study identified that they found ways to make it a pregnancy for two by sharing as much as possible of the experience in an attempt to alleviate the somewhat precarious position of the non-birth mother in her family. In some de novo families, the mothers attempted (successfully) to combat unequal biological ties by using one mother’s egg and the other mother’s body to conceive their child (Pelka, 2009) and were called “egg-mommy, womb-mommy families” (Ehrensaft, 2008, p. 163). This meant that one mother was the genetic mother and the other was the birth mother – giving them a perceived equal connection to their baby and this reduced potential for feelings of jealousy (Nelson, 2007). In addition, some non-birth mothers attempted to induce the production of breast milk prior to the birth of the baby, with a plan to breast-feed (Goldberg & Perry-Jenkins, 2007). This strategy was thought to support and encourage bonding between the non-birth mother and her child, and further validate her position as a legitimate mother to the world outside their family. While these strategies have been reported in the literature, there is little in the literature to suggest these practices are the norm.

Bergen, Suter and Daas (2006) reported that participants implemented three main strategies to symbolically construct equal parental identity between the two mothers and legitimise their family connections. These strategies included, giving the child the surname of the non-birth mother, terms of address for the non-birth mother and legal moves that asserted parental identity. Brown and Perlesz (2007) also identified that the names children used for each mother
were an important part of validating the non-birth mother’s identity – for her children, herself and to the outside world. Donovan and Wilson (2008) added that naming the non-birth mother was an important part of the creation of the de novo family. In some de novo families, both mothers were called Mummy, however Brown and Perlesz (2007), identified in their Australian study, that while there is a distinct lack of language to describe non-birth mothers in de novo families, they have adopted a variety of names that included nicknames and first names.

**Becoming a mother in a de novo family**

For some lesbian women, motherhood was not previously considered an option. This limitation was either self-imposed or considered in conflict with their lesbian identity (Herrera, 2009). Lesbian mothers in Herrera’s (2009) study identified that one of the major difficulties in creating a de novo family is the “world’s homophobia” (p. 38). However, as contemporary society has evolved, and the acceptance of de novo families has grown, more lesbian women are considering becoming a mother in the context of a de novo family. Lesbians become mothers in one (or a combination) of the following ways: partnering a woman who already had children (often referred to in the literature as lesbian step-families), conceiving via alternate insemination (AI) (also referred to as artificial insemination in the literature, however alternate insemination is the term preferred by most lesbians), intra-uterine insemination (IUI), in-vitro fertilisation (IVF), fostering, adoption and/or engaging in heterosexual sex to achieve pregnancy (Ben-Ari & Livni, 2006; Dunne, 2000; Hequembourg, 2004; Marina et al., 2010; Pelka, 2009; Renaud, 2007; van Dam, 2004).
Unlike fertile heterosexual couples, path to motherhood for lesbian women requires careful and deliberate consideration and decisions about which woman will be pregnant, sperm donation and the role of the non-birth mother (Herrera, 2009; O’Neill, 2012; Renaud, 2007). Lesbians also carefully and consciously consider decisions about parenting philosophies and the negotiation of roles and responsibilities within the *de novo* family (Chabot & Ames, 2004; Chapman et al., 2012; Renaud, 2009). Siegenthaler and Bigner (2000) state that “not all women are compelled to give as much thought to this process as lesbian women” (p. 79), and Herrera (2009) identified that children in *de novo* families were often “longed for intensely” (p. 40).

While many lesbian women desire children, they express fear about the effects of their same-sex relationship on their children. Lesbian mothers are acutely aware of the potential stigmatisation of their non-traditional families (Balsam & Mohr, 2007), in particular homophobia that targets their child(ren) (Stevens et al., 2003; Weeks, Heaphy & Donovan, 2001). They express a desire to protect their children from homophobia (Bos & Gartrell, 2010) and according to Litovich and Langhout (2004), lesbian mothers engage in conversations about homophobia and discrimination with their children, to help them develop the skills that are required to cope with homophobic bullying. In their longitudinal study, Bos and Gartrell (2010) identified that “growing up with loving, nurturing, supportive parents can counteract detrimental effects [of homophobia] … and enhances resilience” (p. 569).

Becoming a mother in a *de novo* family can occur in a variety of ways including with the use of Assisted Reproductive Technology (ART). While lesbian women choosing motherhood were faced with many decisions and challenges, the
increasing accessibility of ART has significantly reduced the complexity of conception for lesbian women (Glazer, 2001). The literature identifies three key decisions faced by lesbian women on their path to motherhood. Initially, they decided which of the women would carry the baby (Renaud, 2007). This decision was usually based on health and age of each of the women (Chabo & Ames, 2004) at the anticipated time of conception. Sometimes one member of the couple would exclusively take on the role of birth-mother in their family, and in other de novo families, the women take turns to conceive and birth the children (Renaud, 2007). While for most couples age and health were important factors when deciding which woman would carry a baby, for others the gender orientation of the women was also be an important factor when making decisions about conception and pregnancy. For example, in butch-femme dyads, it was highly unlikely that the butch-identifying partner would chose to be pregnant (Epstein, 2002; Pelka, 2009). As well as deciding who would carry the baby, lesbian women made decisions about the method of conception and the known or unknown status of the donor. These decisions were sometimes driven by preference for a known or unknown donor, health safety, fertility health and their desire to avoid technology in the process of conception. Sometimes these decisions were dependent on each other. For example, a couple choosing a known sperm donor had more options for methods of conception than a couple choosing an unknown sperm donor. In other couples, where fertility issues were, or became, apparent the method(s) of conception may have been limited. The main limitation was that a couple choosing an unknown donor could not use a method of conception that did not involve technology and any couple choosing (or using) technology were required to use
donor sperm that had been collected, tested and quarantined for a period of six months prior to a procedure to transfer the sperm or embryo to the potential mother.

Donor sperm can be used in a variety of procedures to achieve a pregnancy. Vaginal insemination (VI), sometimes also referred to as self-insemination (SI), occurs in a non-clinical environment (Markus, Weingarten, Duplessi & Jones, 2010). Some lesbian women prefer VI because there is no interference from outside authorities (for example, medical staff or social workers) and therefore offers autonomy and allows intimacy during insemination (Baetens & Brewaeys, 2001; Renaud, 2007). Intra-uterine insemination and IVF occur in a clinical environment and are considered a safer option because the donor sperm has been collected, tested and quarantined for a period of time, thus reducing the risk of transmission of infections (Baetens & Brewaeys, 2001). Both of these methods of conception were reportedly used by some lesbian women because they preferred an unknown donor or when AI had not been successful. Heterosexual intercourse, is described in the literature as unacceptable by most lesbian women because it is perceived as disrespectful to their lesbian identity (Baetens & Brewaeys, 2001).

Decisions about choosing a known or unknown sperm donor place an added burden on lesbian couples (Chapman et al., 2012; Hequembourg, 2004; Renaud, 2007). Most participants in Dunne’s (2000) study created their families by informal known sperm donor insemination. The benefits of known sperm donors was that the mothers felt they had a sense of what traits and/or attributes the child may inherit for example, level of intelligence or eye colour (Chabot & Ames, 2004). Choosing a known sperm donor was also important to
the lesbian mothers-to-be as they felt it was essential for their children to one day have the option to meet their donor if they desired, and for the mothers to be able to answer the child’s questions about their donor (Baetens & Brewaeys, 2001). For some of the participants in Dunne’s (2000) study, there was difficulty locating a donor who shared the same ideals about the amount of donor involvement in parenting (Donovan & Wilson, 2008) and this disagreement was the main reason potential donors were, sometimes after long negotiations, dismissed. Other studies report couples choosing an unknown donor because they fear uninvited contact or interference in the future (Baetens, Camus & Devroey, 2003; Chapman et al., 2012; Herrera, 2009). Fewer couples chose an unknown sperm donor fearing the donor would lay parental claim to the child in the future, subsequently threatening the “the integrity of their family” (Donovan & Wilson, 2008, p. 655) and an unknown sperm donor was perceived to reduce this risk.

Accessing healthcare

When lesbian couples decide to start their de novo family, they normally interact with health services and providers at some stage during conception, the prenatal period, birth and post-partum. At each interface with health care providers, lesbian women have to decide whether or not to disclose their sexual orientation. This decision is frequently difficult and consumes a considerable amount of “emotional energy” (O’Neill, 2012, p. 15) because the response from the healthcare provider may be homophobic or heteronormative. There is a considerable amount of stress associated with coming out repeatedly (Garcia, 2003; Neville & Henrickson, 2006; Polek, Hardie & Crowley, 2008) – often at
each and every healthcare interaction. Coming out can cause fear and create
distance between lesbian women and their families, the community and
healthcare professionals (Mc Nair et al., 2008). Conversely, lesbian mothers
and their children experience a healthier level of self-worth and reduced stress
levels when the mothers are out and there is no need to maintain secrecy
around their lesbian identity. Chapman et al. (2012) confirm that coming out
stress continues to be a deterrent to lesbian women seeking timely healthcare
and O’Neill (2012) and Dworkin (2000) add that homophobia and
heteronormativity lead to considerable stress in lesbian women.

Sexuality, and sexual orientation, are key determinants of health and therefore
important elements of health care (Hunter, 2001). Health professionals who are
homophobic can be detached and uninterested, and this attitude affects their
capacity to develop a therapeutic and professional relationship with the lesbian
woman seeking healthcare (Dahl, Fylkesnes, Sørlie & Malterud, 2013). The
attitude of nurses and other health care professionals is reported to frequently
affect the quality of care delivered to lesbian women and their children
(McManus, Hunter & Renn, 2006; Spidsberg & Sørlie, 2012).

In relation to healthcare service delivery, Renaud (2007) identified that lesbian
mothers (and mothers-to-be) require sensitive, lesbian-friendly health care
services. While laws are currently being scrutinised and updated to reflect
social change in some places, social judgment and heteronormative health
care service delivery unquestionably add stress to lesbians choosing
motherhood (Røndahl, Bruhner & Lindhe, 2009). Crouch et al. (2013) identified
that non-birth parents are often invisible and not acknowledged as legitimate
parents in healthcare environments and this also added to the stress
experienced by this parent. In addition, O’Neill (2012) found “… lesbian parents gained much support from having health professionals who acknowledged their relationship and recognised both the biological and non-biological mother were equally important” (p. 14). Further, healthcare providers may be unfamiliar with the specific healthcare needs of lesbian women (Fish, 2010). Locating a sensitive and knowledgeable health care provider can be challenging and can lead to a delay in lesbian women seeking healthcare (McNair, 2004). Finally, Barbara, Quandt and Anderson (2001) identified that when lesbian women can come out to their healthcare provider, they are more likely to increase their use of, and be more satisfied with, healthcare services. Therefore, lesbian women require a safe environment where disclosure of sexual orientation is encouraged (Chapman et al., 2012), and where invisibility is not perpetuated (O’Neill, 2012).

Summary of the literature

Lesbian mothers share mainstream existence with heterosexual mothers by virtue of their motherhood, but are marginalised by their non-heterosexual identity. Therefore, there are many challenges confronting lesbian women choosing motherhood via the creation of a de novo family. Lesbians who choose motherhood are a vulnerable yet emergent group within society, who require support in a safe environment that does not assume heterosexuality and accurately recognises their needs.

The literature demonstrates that despite apparent improvements in social policy that embrace the diversity of more contemporary family arrangements, homophobia (or fear of homophobia) continues to affect the way lesbian
mothers negotiate the wider community. It also reveals that, in light of few role models, lesbian mothers are constructing their own individual roles within unique family constellations. They implement a variety of strategies in an attempt to legitimise and validate their family and relationship status, and protect their children from negative judgment.

Further, accessible information about pregnancy options, equity in funding of pre, peri and post maternity-related treatment, recognition of lesbian mothers and their children as a legitimate family and reducing homophobia are issues that can enhance the mothering experience for lesbians. The literature identified that homophobia caused lesbian mothers to experience considerable stress, and also created barriers to positive interaction with healthcare providers. The fear of someone finding out about their sexuality is an emotion that is faced daily by some lesbian mothers. Therefore, increasing visibility and acceptance is important for the well-being of lesbian mothers and their children.

Finally, this literature review has demonstrated that further research is needed to fully understand the experiences of the growing number of lesbian mothers and de novo families. Specifically, future research that explores a deeper understanding of how de novo families are constructed, how mothering roles are created and sustained in de novo families, how mothering is affected by continual interface with heteronormative spaces and the experience of the non-birth mother would benefit lesbian mothers, healthcare and education providers and the community as a whole.
Research question

What are the experiences of lesbian women who choose motherhood in the context of establishing their *de novo* family?
Chapter 3

Methodology

Introduction

This chapter describes the philosophy which underpinned the methodology and the research design, as an adjunct to the details included in the published papers integrated in this thesis. This research was designed using a feminist approach incorporating story sharing via interviews and journaling as data collection methods. The feminist framework guided the development of the story sharing approach. It attentively integrated values such as reciprocity, respect, trust, cooperation, sensitivity to the role of power and politics and aimed to fundamentally value the individual woman’s perspective, experience, centrality and visibility.

Feminism

Feminism is both a philosophical framework and a practice concerned with the issues that are significant to women and the way in which women live their lives, the way they think, do and be (Jackson, Clare & Mannix, 2003). It explores emancipatory tradition that is socially accountable, politically essential and ethically imperative (Miraftab, 2004). Feminism embraces three basic ideologies: valuing women and their experiences, recognition of conditions that oppress women, and aspiration to generate social change (Hall & Stevens, 1991). Empowerment and self-determination are important components of
feminist ideology (Corbett, Francis & Chapman, 2007). Roberts (1981) defined feminist research as,

> Research concerned with not only making women visible, but with theoretical and methodological issues, with problems of sexual division in the research team, with language of the research findings and the ways in which these are used when they are published (p. 27).

Feminist research endeavours to understand, clarify and confirm women’s experiences and “recognises the intrinsic worth of women’s ways of being and knowing” (Jackson et al., 2003, p. 212). Reinharz (1992) concurs that feminist research should increase visibility of women, centralise women and recognise women as both competent and independent. Further, Speedy (1991) identified a variety of feminist approaches (liberal, Marxist, socialist, cultural and radical) that revealed methods for recognising and confronting women’s concerns and correcting injustices.

Feminism embraces values that collectively benefit women and focus on women and their experiences by working towards realisation of power and autonomy for women through a process of collaboration. It also involves critical examination of the source(s) of social power (Deutsch, 2006), while embracing activism and adopting the stance that advocacy and scholarship are not contrary (Baber, 2004). Feminism is sensitive and attentive to those conditions that oppress women and acknowledges that women’s experiences are genuine sources of knowledge. Feminist researchers are sensitised to voices and in particular, identifying the voices that may not be heard (Kralik & van Loon, 2008). This knowledge of women should illuminate diversity as well as
similarities and relationships in women’s experiences. It is through this knowledge that women’s experiences are validated (Esim, 1997; Stanley & Wise, 1993). Hence, a distinguishing feature of feminist research is that it employs women’s experiences as an indicator of reality (Harding, 1987).

Key ideological perspectives of feminist methodology are embodiment, empowerment and emancipation (Roberts & Taylor, 1998). According to Chinn and Wheeler (1985) feminist research also considers the processes of praxis, empowerment, awareness, consensus and evolvement. Alex and Hammarström (2004) identified the following characteristics of feminist research; an event that only women can experience with an emphasis on the woman’s context of the experience, aspires to benefit women, reveals the strengths of women, identifies the conditions that oppress women and contain non-hierarchical interactions. While there are a number of different considerations listed, the primary assertions of feminist methodology are the oppression (and exploitation) of women, the raising of the consciousness and the personal as political (Stanley & Wise, 1993).

More traditional research methodologies are frequently inadequate in reflecting the experiences (or context of those experiences) of women and can misrepresent the experiences of women (Cook & Fonow, 1986). Feminist frameworks used to conduct research do not require the researcher to use any specific research design. In fact, definite research designs can lead to simplification and minimisation of the important issues affecting women. More often than not, the questions feminists deem important to answer are not typically answerable within a scientific or conventional methodological framework (Tickner, 2005). Webb (1993) asserts the researcher should choose
the design that most fits the topic under investigation and Walker (2004) affirmed that feminists should use any methodology available as long as it is appropriate to the research question. Methodology should be determined based on its fit with the research question and its compatibility with the underpinning feminist principles. Whilst there are no prescriptive methods for feminist research (DeVault, 1996; Roberts & Taylor, 1998), it is suggested that feminist research is most likely to occur through qualitative processes and would include participant observation, small research numbers and in-depth interviewing (MacPherson, 1983).

While women may have shared similar life experiences, they are not a homogenous group and the interpretation of that experience will differ from woman to woman. Contextual factors like political and socio-cultural background, economic aspects, age and religion will individually shape values and the way women interpret experiences. Feminist research is not only about women, it is with women and for women (Cook & Fonow, 1990; Harding, 1986 &1987; Romyn, 1996).

**Justification of methodology**

The methodology for our research was naturally informed by feminist theory, with particular inclination toward a theoretical framework that valued women and their experiences, recognised conditions that oppress women and aspired to generate social change (Hesse-Biber, 2012). These underpinning feminist principles, fit the research question and the researcher’s desire to raise consciousness of the social and political issues faced by lesbian women.
choosing motherhood, as well as her own position as a researcher. It is “important to recognize the power and privilege invested in the role of researcher” (Jackson, 1997, p. 88). In keeping with these feminist ideals, a story sharing approach was implemented as it was predicted to reduce power inequality and move towards equivalence in relation to power and position of the participants and the researcher, while illuminating diversity and being sensitive and attentive to the position of the participants. Story sharing as a method of data collection (see Papers A & B) was congruent with feminist theory because it provided the opportunity for the researcher and the participants to work collaboratively to better understand the experience of lesbian women choosing motherhood. Story sharing promoted mutuality, and facilitated reciprocity to share ideas, experiences and information between the participants and the researcher (Bergum, 1991; Walters, 1994). This was achieved by the researcher, as an insider, and the participants sharing stories together of their journey to, and through, lesbian motherhood.

Rationale for the method

The development of the story sharing approach worked synergistically with the tenets of feminism primarily by eroding the perceived and actual power held by the researcher and recognised potential hierarchical interactions. Interviews were semi-structured and questions were constructed to guide the interview (Appendix 3). By sharing stories about lesbian mothering, the researcher and participants endeavoured collaboratively to expose the experience of choosing to be a mother in the context of a same-sex relationship in Australia. Additionally, the principles of feminism were applied to the journaling phase of
data collection by a similar process of story sharing. Sharing experiences of lesbian mothering dissolved power imbalances and increased the comfort of participants who were initially positioned as vulnerable. It was anticipated that as the interviews and journaling data collection phases unfolded, participants would become more comfortable to share more detailed stories of their experiences as lesbian mothers. The employment of feminist theory to guide data collection and analysis subsequently led to the gathering of rich data that aimed to increase their visibility and recognition and prompt social change that would benefit lesbian mothers.

Recruitment

The women were recruited via a flyer (Appendix 2) posted at women’s health services and by word of mouth. Participation was voluntary. Potential participants received an Information Sheet (Appendix 4) and a signed Consent Form (Appendix 5) prior to data collection. Details about the participants can be found in Papers D, E and F. The sample was 30 self-identified lesbian women, consisting of 15 couples \( (n=30) \).

Data collection

Data were collected using story sharing interviews, journaling and a demographic data collection sheet (Appendix 6) with each couple. Audiotaped interviews were semi-structured and tended to progress chronologically with the participant-couples and the researcher sharing stories about their experiences of becoming and being lesbian mothers. Journaling was completed within a private online forum, where participant-couples further
elucidated their mothering experiences. Additional details of story sharing and journaling as data collection methods are detailed in Chapters 4, 5 and 6 (Papers A, B and C) of this thesis.

Recruitment and data collection ceased once saturation of data had occurred. Data saturation was achieved after 13 couple interviews, when no new themes were identified in the data. Two further couple interviews were undertaken thereafter to confirm data saturation, before terminating the data collection phase of the study.

**Data analysis**

Transcripts from the interviews and the journal text data were analysed using constant comparative analysis (Thorne, 2000). Strauss and Corbin (1990) state constant comparative analysis requires the researcher to examine the data for recurring themes and this was done by reading, re-reading, making notations and developing codes. Text analysis and coding isolated patterns in the participant’s stories and generated three major themes; becoming mothers, constructing motherhood and legitimising our families. The richness of the data also exposed nine sub-themes that, along with the major themes, are identified in Table 2. In-depth descriptions of data analysis are included in Chapters 7, 8 and 9 (Papers D, E and F) of this thesis.
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<tr>
<th>Major themes</th>
<th>Sub-themes</th>
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<td>Becoming mothers</td>
<td>➢ Decisions, decisions: planning our pregnancy</td>
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<td>➢ Healthcare experiences of lesbian mothers-to-be</td>
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<td>➢ Homophobia: fear, anger and exclusion</td>
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<td>Constructing motherhood</td>
<td>➢ Where do we fit? In and out of motherhood</td>
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<td>➢ Lesbian mothering in a heteronormative world</td>
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<td>Legitimising our families</td>
<td>➢ We are both the mother</td>
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<td>➢ Inclusive language</td>
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<td>➢ Symbols of connection</td>
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<td>➢ Other mothers – role and position</td>
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### Ethics

In pursuing this study, care was taken to maintain justice and beneficence that is, causing no harm to participants, and was conducted under the premise of the *National Health and Medical Research Council [NHMRC] Code of Ethics* (2014). As described below, this was assured by establishing principles of confidentiality and anonymity. Prior to commencing data collection, ethics approval was gained from the relevant institutional Human Research Ethics Committee (Appendix 7).

An information sheet was given to each participant (Appendix 4) that detailed the aim of the research, the activities that would be included, for example, journaling and an interview, and the contact details for the doctoral candidate. At the time of sending the information sheet, potential participants were encouraged to contact the doctoral candidate to discuss any questions or concerns.
Participation was voluntary and all participants provided written consent (Appendix 5) prior to data collection. Participants were informed that they had the right to withdraw from the study at any time without providing a reason for withdrawal.

Confidentiality of the data was maintained by saving files on a password protected computer. All participants were assigned a pseudonym in publications and presentations to protect their privacy and anonymity. Given the sensitive nature of the research, and the very private information provided, in addition to the allocation of pseudonyms, careful consideration was given to the sharing of other personal information like specific (and uncommon) family constellations (for example, two mothers, with twin girls aged 5 and twin boys aged 8) and occupations that were unusual, and therefore may have jeopardised confidentiality.

Researcher safety, both physical and emotional was also considered. As some of the face-to-face interviews took place in the participant's private home, there was considered to be a level of risk to the researcher conducting the interview. To counter this, several strategies were put in place. For example, the researcher left a copy of her itinerary with her supervisors or partner that included the address of the interview she was attending. Where possible interviews were conducted in public locations, for example, on the grounds of the University. The researcher also carried a mobile phone and called the designated contact person once the interview was completed. At times, the researcher was exposed to participant stories that evoked strong emotional responses. This was managed by debriefing with either the research supervisors or the University counselling services.
The emotional well-being and safety of the participants was considered an important ethical aspect of the project. It was anticipated that, during data collection, participants may have shared personal and very sensitive information that evoked strong emotional responses. To manage this possibility, each participant was provided with the contact details of local, free, confidential and lesbian-friendly counselling services (Appendix 8).

**Position of the researcher**

An insider is defined as a researcher who studies a group of which they are a member (Breen, 2007; Kanuha, 2000). Insiders therefore have intimate knowledge of the characteristics and experiences of the group and are sometimes referred to as *native* or *Indigenous* researchers in the literature (Wilkinson & Kitzinger, 2013). It is important to acknowledge insider status so that assumed objectivity and the researcher’s position is clarified (Corbin Dwyer & Buckle, 2009). While some insider-researchers might choose to minimise their familiarity with the group being researched, and silence their own voice or ignore/negate their experience, this is inconsistent with feminist theory that is embedded within this research (Wilkinson & Kitzinger, 2013).

A high degree of familiarity with study participants can present methodological challenges. Blythe, Wilkes, Jackson and Halcomb (2013) identified four challenges potentially experienced by an insider-researcher, namely; assumed understanding, ensuring analytical objectivity, dealing with emotions and participants’ expectations. Anticipating these potential challenges in our study, it was initially important to recognise the insider status of the researcher, and then consider how relationships between the researcher and the participants
might be affected. To counter these challenges, strategies like: reflexivity, probing and review of data analysis by a non-insider, were implemented in our research. These strategies moderated potential disruption to the integrity of the research findings.

Some benefits of insider status were also identified in the literature. Being an insider affords the researcher added understanding of the experiences of the community or group (Unluer, 2012). Utilising the insider status can be useful in gaining access to otherwise invisible or hard to reach groups (Wilkinson & Kitzinger, 2013; Yakushko, Badiee, Mallory & Wang, 2011). Breen (2007) adds that insiders have a superior understanding of the politics of the group being studied. Being an insider allowed the researcher to establish trusting relationship with participants more readily than outsiders, and therefore participate more spontaneously in open discourse that leads to the generation of more in-depth and detailed data (Corbin Dwyer & Buckle, 2009). The identified benefits and challenges and ways of managing reciprocity as an insider-researcher are further addressed in detail in Chapter 4 (Paper A) of this thesis.

Rigor

To establish rigor, researchers are required to demonstrate that their findings are justifiable and valuable (Polit & Beck, 2013; Rose & Webb, 1998) and that they have taken action to reduce bias and promote reliability (Mays & Pope, 1995). Rigor is described as the trustworthiness of the method and findings of a qualitative study (Polit & Beck, 2013; Smith & Liehr, 2012; Thomas & Magilvy, 2011) and the extent of rigor can be evaluated in a variety of ways. The
trustworthiness of the method and findings can be measured by evaluating elements such as credibility, dependability, confirmability and transferability (Lincoln & Guba, 1985). These elements of the current study are detailed below.

Credibility

Credibility is established when the findings clearly and accurately reflect the perspective of the participants in the study (Hall & Stevens, 1991). In our study, these perspectives were demonstrated to be credible by using reflexivity, peer review and rich descriptions.

A reflexive approach, promoted through reflection, journaling and discussions, helped raise consciousness in relation to the researcher’s beliefs, biases and patterns of thinking and identified how they could affect interpretation of the data. Ackerly (2000) suggested feminist researchers should engage in repeated reflection and critical examination of the methodology process to ensure accurate expression of the experiences being studied. To this end, feminist researchers are encouraged to develop relationship with the participants and to interact throughout the process (Oakley, 1981).

In addition to reflexivity, peer review is also used to establish credibility in qualitative research (Guba & Lincoln, 1981). Of particular importance was the consideration of the insider status of the doctoral candidate and the potential for misinterpretation and/or misrepresentation of the analysed data. To manage this, it was important for non-insiders to read and check the data. Peer review, or member checking, was used in our study by research supervisors reading
and checking, and therefore validating, the context and interpretation of the data.

Finally, credibility can also be established by the inclusion of rich description (Welch, 2011). Consistent with the story sharing nature of data collection in our study, there were many detailed descriptions of various experiences offered by the participants. To promote credibility of the findings, direct quotes have been included in published papers and conferences presentations and posters. Additionally, the acceptance of peer-reviewed papers adds to credibility.

Dependability

To demonstrate dependability, a study must be transparent in relation to the research process (Ryan-Nicholls & Will, 2009). Transparency can be demonstrated by an audit trail. Audit trails are generated to establish trust and confidence in the research process and the findings as genuine and credible interpretations of the data (Sandelowski & Barroso, 2002). An audit trail was generated that documented the: reading of transcripts, checking of thematic analysis by the supervisory panel and the doctoral candidate’s reflective journal. In addition to this, ethical issues like dependability, are embedded within feminist research and difficult to separate, that is, the nature of feminist research aligns with the tenets of research ethics and it is difficult to achieve one without the other.
Confirmability

Confirmability is the degree to which the study findings can be confirmed by others (Tuckett, 2005). The use of the transcripts, journal and demographic data sheets as well as the audit trail are available to demonstrate confirmability in our study.

Transferability

The transferability of a study can be established by considering to what extent the findings can be applied to an alternate context (Guba & Lincoln, 1989). The findings of our study are transferable to various contexts as demonstrated by the contemporary literature that indicates similar findings around the world.
Chapter 4

Exchange and equality during data collection:

Relationships through story sharing with lesbian mothers

Story sharing as a valid method of data collection in qualitative research is presented in this paper. The advantages and challenges associated with the method are also addressed. Self-disclosure is identified as a useful strategy, as it promotes trusting relationships that aims to equalise power in the relationship between the researcher and the participants and subsequently improves the richness of the data collected. Together the participants and the researcher were able to share their stories of becoming and being lesbian mothers, and the participants stated that knowing the researcher was also a lesbian mother made them feel comfortable to discuss their stories in detail. Prior to engaging in story sharing, careful planning is required to promote the safety of the researcher, and this issue is also addressed within the following paper.
Exchange and equality during data collection: relationships through story sharing with lesbian mothers


Accepted: February 24, 2011

Abstract

Aim To explore how reciprocity is achieved through a method of self-disclosure, namely story sharing.

Background Self-disclosure through story sharing promotes trusting relationships between researchers and participants that support the collection of high quality data, particularly when participants are members of a marginalised group and may feel especially vulnerable when sharing sensitive information.

Data sources A qualitative study that examined the experiences of lesbian mothers.

Review methods Strategies were carefully and deliberately implemented to engage in story sharing with the participants.

Discussion Participants said that it made a positive difference to how safe and comfortable they felt once they knew at least some of the researcher's story.

Conclusion The collection of rich data is improved by using story sharing as a means of establishing reciprocity in qualitative research.

Implications for practice/research Story sharing has the potential to improve the quality of the data collected in qualitative studies. However, strategies that promote the emotional safety of the researcher in this context will need further exploration.

Keywords Reciprocity, story sharing, storytelling, self-disclosure, data collection, qualitative research

Introduction

DRAWING ON experiences of collecting data for a study that explored lesbian mothers, this paper examines the role of reciprocity in gathering high quality and authentic qualitative data. Given that lesbian mothers are a marginalised and perhaps stigmatised group (Gottschalk 2007, Weber 2010, Goldberg and Smith 2011), it was especially important to consider approaches that captured authentic and rich data without further marginalising the participants.

Reciprocity can be achieved in various ways. This paper focuses on reciprocating through story sharing, a method that can be used during qualitative data collection to strengthen co-operative researcher-participant relationships (Lennon et al 2009) by fostering rapport and removing power imbalances, improving the quality of data collected and conveying value for the stories and life experiences of participants (Heller 2007). In our study, we used story sharing as a method of establishing reciprocity to create co-operative research relationships.

In this paper, we will provide an overview of the study, examine reciprocity, discuss story sharing as a means of reciprocating and explore how we achieved reciprocity using story sharing.

The study

Purpose To identify how lesbians in partnerships approach mothering.

Sample We sought a purposive sample of lesbian mothers who had planned, conceived, given birth
and were raising their children as a couple. We anticipated that it might be challenging to recruit an adequate number of participants to the study because of perceived stigmatisation, judgement or homophobia and because lesbian mothers are largely a group open unrecognised in the community. Considering the distinct barriers that exist in accessing lesbian mothers, we implemented various recruitment strategies. We enlisted some participants by advertising in ‘lesbian-friendly’ publications or websites. We recruited others using a flyer distributed as hard copy and electronically to Women’s Health Centres. Some snowballing also occurred as couples who had been interviewed told their friends about the study.

When we began data collection, five couples had consented to participate. Over time, we recruited additional participants but after we had collected 17 sets of data, we achieved data saturation.

Data collection Gathering data involved the participants completing a brief demographic data sheet, a semi-structured, in-depth interview with their partners and keeping a journal. We used the demographic data sheet to collect the following information about the participants:

- Age.
- Location.
- How long they had been in their relationships.
- Time spent cohabiting.
- Number and gender of children.
- Children from previous relationships.
- Level of education.
- Job.
- Cultural background.
- Religion.
- Housing.
- Combined family incomes.

This information was intended to provide context for the study. All participants completed the demographic data sheet.

We used five different ways to carry out the semi-structured interviews. We interviewed seven couples using Skype, a computer program that allows people to hear and see each other in real time using the internet. We interviewed six couples in person in their homes, two using an online instant messaging service, one by phone and one face to face in an office at the university at the couple’s request. The aim was to collect in-depth data that would strengthen understanding of the experiences of lesbian mothers. We developed a list of concepts based on BH’s own experience as a lesbian mother, the literature and the research question and we used this list to guide the interview. Holloway and Freshwater (2007) stated that ‘when eliciting a story from a vulnerable person, researchers should ask a trigger or stimulus question, where the answer is of personal and significant importance to the participant’. There are two benefits to this strategy: it enables participants to tell their stories and it allows the researcher to contribute to the conversation in a meaningful way.

We created individual journals for each couple as closed and private personal or social networking site Facebook. Five couples did not participate in the online journal and two couples engaged in an email journal because they were either not confident with the security of the website or had limited internet access.

The interviews and journaling yielded stories, pictures, music and artwork that represented mothering and, in particular, lesbian mothering for the participants.

Exchange and equality Reciprocity in research is also called the ‘dyadic’ or ‘mutual’ effect (Barak and Gluck-Off 2007) or self-disclosure. There are two main ideas central to reciprocity: exchange and equality (Matter et al 2008). Reciprocity aims to foster a genuine relationship between the researcher and the participant and contains two categories of content: ‘personal information facts and experiences, personal thoughts and feelings’ (Barak and Gluck-Off 2007). Gittis et al (2008) defined “strong” reciprocity as the inclination to cooperate with others in a shared social setting or on a task and it provides benefits for participants and researchers (Finney and Rishbeth 2006). The definition of reciprocity that will be used in this paper is described by Matter et al (2008) as “an ongoing process of exchange with the aim of establishing and maintaining equality between parties”.

A concerted effort is required to establish reciprocal relationships in qualitative research (Kihlmeier 2005). A commitment to reciprocity by the researcher reduces the potential for harm or negative impact (Fry et al 2005). Qualitative inquiry ‘enables and promotes social justice, community, diversity, civic discourse and caring’ (Lincoln 1995). Trusting researcher-participant relationships can develop through mutual learning, embracing diversity and creating emotional associations (Simmons 2001, Phillips et al 2009). The forging of reciprocal relationships confers trust (Denning 2004).
Reciprocity can be achieved by self-disclosure, which means revealing personal information about oneself (Rotenberg and Chase 1992). Self-disclosure can lead to the development of trust and gives permission for deeper discussion of relevant topics. Co-operation can be achieved when reciprocity is practiced and people are more likely to engage co-operatively in response to friendly interaction (Engel et al 2010). Qualitative data collection is improved through participant-researcher reciprocity (Watson et al 1994, Flachzer and James 1997) and it contributes to the depth and value of the data (Daly 1992). Reciprocity can also create self-understanding and self-determination (Lather 1986) for the participants.

Self-disclosure is an important strategy to implement in particular when researching marginalized groups that seldom have the opportunity to have their voices heard because of social disengagement (Flanery and Richethier 2006, Weber 2010) and because of their socially devalued position (Chaudhur and Quinlan 2010). Reciprocity promotes social engagement and provides participants with the potential to ‘regain the power to shape their own world and identity’ (Holloway and Freshwater 2007). Reciprocity is more likely to occur when the researcher and participants share common experiences, such as being a woman, a lesbian or a mother (Kvale 1996, Eddins and Riley-Eddins 1997, Borton et al 2005). Unequal relations between the researcher and participants are problematic and one method of overcoming inequality is to foster reciprocal sharing (Junqueira 2009).

Reciprocity involves ‘privileging the discourses of those at the margins and engaging in activities that aim to move their issues toward the center’ (Kihwa-N'dunya 2005). It offers an opportunity for participants to be heard by someone who is genuinely interested in their stories. A lack of reciprocity can threaten a relationship (Roberto and Scott 1996), distort or ignore participant experiences (Kihwa-N’dunda 2005) and fortify stereotypes, theoretical presuppositions and superficial understanding of participants’ stories.

While most of the literature confirms the benefits of reciprocity, including Stanley and Wise (1991) and Cotterill (1992), Master et al (2006) claimed that reciprocity is not habitually featured as a fundamental part of health-related research because traditional medical research experts researchers to be impartial to avoid affecting participant responses. However, it is unrealistic to believe that a qualitative researcher has no effect on a participant, or the nature and quality of the data obtained, so self-disclosure is advocated by most as good research practice (Rainie 1992). Successful collaboration is determined by the amount and type of reciprocity (Gachter and Herrman 2005); the perceived sensitivity of the area of research determines the level of disclosure (Lee 1993); disclosure is more likely to occur when there are strong personal ties and people share expertise in practice (Waxler 1998).

Before revealing personal information, you must establish rapport (Dickson-Swift et al 2010). You need to exercise caution and be aware that the participants have not formally agreed to maintain your privacy. Some of the questions you might ask yourself are:

- What stories am I comfortable telling?
- What is most relevant?
- What is appropriate?
- Is my story going to help the participants feel safe?
- If the participants tell my story to a third party, how might I be affected?

Reciprocity through story sharing
Reciprocity can be achieved by sharing stories during qualitative data collection. The exchange of stories promotes equality and trust and builds co-operative research relationships. Creative approaches such as story sharing that nurture reciprocity lead to shared benefits for participants and the researcher (Sandercock 2009).

Story sharing helps reduce power imbalances. Mutual story sharing is a way of deepening understanding and validation, and can promote a sense of caring by the researcher (Heikkinen 2007). Mallory et al (2002) identified that participants in their study said that uneasiness diminished as they established reciprocal relationships with the researchers and they felt more at ease about sharing their stories. Some participants felt cared about as the researcher asked questions about their lives.

Story sharing promotes non-hierarchical relationships between researchers and participants. Qualitative research in which researchers and participants are able to establish rapport through reciprocity is especially empowering to the members of marginalized groups (Dismantling and Ezzy 2009). Solberg (2006) identified that reciprocity is one of seven important strategies for recruiting and sustaining participants, and used reciprocity to promote a sense of collaboration between the researcher and the participants by first initiating an understanding of ‘mutual obligation’.

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Story sharing with lesbian mothers

Self-disclosure can result in the researcher achieving ‘insider’ status which can help create co-operative research relationships. Being an insider is explained as ‘ever-shifting and permeable social locations that are differentially experienced and expressed by community members’ (Naples 1996). Researchers can be insiders in changing situations but, despite feeling some indigenous kinship or knowing relevant information, their status as researchers excludes them (at least partially) from the group.

In our study, insider status meant the researcher understood terminology, had knowledge of organisations, processes and experiences and was not a complete stranger to the phenomenon under investigation. We used insider knowledge to promote connectedness and comfort.

Considering the demographic of the participants in this study – women who were mothers and lesbians – we anticipated that most, if not all, would have experienced some form of discrimination at one time or another and they would be conscious of this prospect when engaging in the study. It was therefore important to foster trust by negotiating co-operative relationships.

The strategy that we implemented in our study had two stages. Initially, the primary researcher [BH] revealed that she was a lesbian mother. This helped to promote security and comfort for the participants. Most of them stated that it made a positive difference to the information they chose to disclose, the language they used and how they felt during the interviews.

Then, BH shared experiences of being a lesbian mother through careful and deliberate story sharing. She chose three stories because of their relevance – we anticipated other lesbian mothers may have had similar experiences – their humour and because she felt comfortable sharing them. This strategy often generated more stories from the interviewees and this made for a relaxed interview process. This ‘triggering’ of additional stories increased the richness of the data collected.

Laughter at the humorous stories further broke down the barriers and power imbalance that may have otherwise persisted. Lynch (2002) said that humour permeates social boundaries – it broadens the margins, opens or delimits the social interaction (before humour was introduced to it) and empowers people to engage in a more comfortable, equitable and co-operative exchange.

On three occasions, the participants shared sad stories. Although we had not planned it, BH shared her own sad story. Sharing humour and these sad stories aided in developing collaborative research relationships and in promoting deeper understanding of lesbian mothering experiences.

Other strategies we used to make participants feel comfortable included providing reassurance about confidentiality, questioning sensitively and using inclusive language. At the start of each interview, we gave each couple information about the study and the measures that we would take to maintain their anonymity. BH asked questions cautiously, watching for cues from each participant, particularly with sensitive topics. Sometimes, the content of the interviews was upsetting to one or both participants. When this happened, BH encouraged the women to take some time, offering to stop or delay the interview and ensuring they knew that both options were acceptable.

On each occasion, the participants chose to continue but by encouraging them to stop or delay the interview, BH demonstrated empathy and potentially extended her relationship with the participants.

Strengthening the relationship

Immediately after each interview, we emailed the participants a list of free, lesbian-friendly counselling services should they feel the need to debrief or discuss any issues that arose for them during or after the interview. This strategy, while ethically responsible and required, also expressed care and may have worked to strengthen further the relationships with the participants. Using inclusive language was important for a cohort familiar with experiencing exclusion based on their sexuality, motherhood, femininity or other personal characteristics. To promote co-operative relationships further during story-sharing, we asked participants at the outset the terms of address they found most comfortable. The researcher then sought permission to use these terms (usually names for the non-birth mother) during the interview.

A potential pitfall of story sharing and the development of this type of insider relationship is that assumptions or misinterpretations about the data are possible. Knowing this, we gave careful and conscious consideration to ensuring that we avoided assumptions and that we clarified any information that was unclear. During each interview, BH asked the participants if it would be acceptable to revisit Facebook or email any of the interview data at a later time using the journal or email, and they all agreed.

After each interview, we reviewed the audio recording; there were several instances where we realised that clarification was needed. We used the
Nurse Researcher

participant journal to clarify information obtained from the interview by leaving questions for the participants to consider and answer.

Conclusion

Story sharing can be an effective type of reciprocity that promotes access to quality data. Co-operative relationships between researchers and participants can be established through story sharing and, in this particular study, the participants stated that once they understood Efi’s story, they felt more comfortable sharing more stories.

While many of the benefits of sharing stories have been discussed in this paper, one main limitation is apparent: researchers need to be cautious in sharing their stories. Since participants are not obliged to maintain confidentiality, there is the potential for them to pass on private information to others in ways that could potentially harm the researcher. Strategies that promote the emotional safety of the researcher in this context need further exploration. However, story sharing is a beneficial method of reciprocity that promotes trusting and co-operative researcher-participant relationships and has the potential to improve the quality of the data collected in qualitative studies.

References


Chapter 5

Story sharing as a method of data collection in qualitative research

Story sharing as a valuable method of data collection requires reciprocity between the researcher and the participants in the context of a qualitative research interview. Judicious and strategic self-disclosure on the part of the research can counter power imbalance, creating a safe environment to engage participants. The benefits and limitations of the method are offered in this paper.
RESEARCH IN BRIEF

Story-sharing as a method of data collection in qualitative research

Brenda Hayman, Lesley Wilkes, Debra Jackson and Elizabeth Halcomb

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Aim
The aim of this article is to demonstrate the use of story-sharing as a practical and valuable method of data collection in qualitative research interviews. The benefits and limitations of the method will be evaluated and discussed.

Design
This article does not report on a study that collected primary data, but instead describes a method of data collection with a definite focus on the technique.

Background
Story-sharing is the reciprocal exchange of relevant stories between the participant and researcher in qualitative research for the purpose of engaging the participant in a genuinely mutual experience that yields superior quality data because of that relationship. There is little documented in the literature about story-sharing. The use of story-sharing as a method of data collection is a technique used to achieve reciprocity that incorporates the processes of self-disclosure to reveal insider status and story-telling (ST). The primary purpose of self-disclosure is to make known the insider status of the researcher and ST permits participants to share their account thus legitimising their experiences, allowing them to reclaim power and (re)shape their identity (Holloway & Freshwater 2007). Story-sharing adds to ST by promoting an authentic relationship based on mutual understanding and experience of a specific phenomenon. Sharing relevant stories during data collection weakens the participant/researcher power imbalance, creates a safe environment, promotes trust and understanding and simultaneously establishes a cooperative researcher/participant relationship that has greater potential to yield more accurate and rich data.

Methods
Story-sharing is a method of data collection that can be used during qualitative research interviews. It involves a two-way sharing of stories central to the research topic. The researcher deliberately and strategically discloses relevant stories that promote safety for those who might otherwise feel threatened or at risk when sharing personal information. Reciprocity is achieved through story-sharing, and Maiter et al. (2008) assert that there are two main ideas central to reciprocity: exchange and equality. Gittis et al. (2008) add that strong reciprocity is the inclination to cooperate with others in a shared social setting or task. This strategy is of particular interest when interviewing marginalised groups about sensitive topics. Marginalised, stigmatised and fundamentally invisible groups in the community (for example, lesbian mothers) require approaches that attain authentic and rich data without further disempowering the participants.

Results
Story-sharing is a data collection method that enhances the depth and amount of data collected in qualitative interviews. However, there are three limitations of story-sharing.
that have been identified. First, the researcher is put at risk of exposure by sharing stories that the participants are not obliged to keep confidential. The researcher could experience harm as a consequence of the stories being shared outside the research interview context. To combat this, carefully chosen stories that are least likely to cause harm if disclosed outside the researcher/participant relationship should be shared. Second, the method can only be used effectively and realistically by an insider. Insiders have the authentic stories to share that convey genuine understanding and promote the development of collaborative researcher/participant relationships. Finally, because the researcher has some understanding of the phenomenon owing to their insider status, they need to be cautious about making assumptions based on their own experiences. A careful and conscious balancing act is required to make known the insider status and at the same time allow the participants' stories to unfold naturally, minimising the influence of the disclosure.

The benefits of story-sharing as a method of data collection far outweigh the limitations. When used deliberately and strategically, richness of the data is augmented. Carefully chosen stories help participants feel a legitimate sense of safety and promote the telling of deeper, more detailed experiences and value is conveyed for their stories and life experiences by the researcher reciprocating a relevant story. When stories are shared, the participant/researcher power imbalance is weakened and a safe and trusting environment is created. Heliker (2009) states that story-sharing can be used to strengthen cooperative researcher/participant relationships by fostering rapport and dissolving power inequities. Power is typically held by the researcher over participants and story-sharing is one method of dissolving power imbalance and levelling the playing field. Interrupting power imbalance is thought to liberate participants in the expression of their experiences and therefore extend the amount and depth of data collected.

Conclusions

Story-sharing is a method of data collection that occurs within a qualitative research interview. It requires the researcher to strategically share relevant stories. The use of story-sharing during interviews is achieved initially by judicious use of self-disclosure. The major benefit of story-sharing in qualitative data collection is that it simultaneously engages the participant in a safe and power-balanced interaction while sharing rich data.

Relevance to clinical practice

Story-sharing can be used effectively to access information when undertaking research about nurses and nursing practice and experiences. Second, it can also be used in the clinical environment when interviewing clients about sensitive topics. Again, there is a need to engage in story-sharing cautiously and consciously to ensure that professional/therapeutic relationships are not crossed. For example, story-sharing could be effectively used during data collection by a registered nurse researcher who is examining the experiences of other registered nurses working in an area where the researcher is an expert. Sharing their nursing stories would likely promote all of the benefits identified in this article.

Key words
data collection, qualitative research, reciprocity, self-disclosure, story-sharing, storytelling

Contributions

Study design: BH, LW, DJ; data collection and analysis: BH and manuscript preparation: BH, LW, DJ, LH.

Conflict of interest

None of the authors have any conflicts of interest to declare.

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Journaling: identification of challenges and reflection on strategies

Journaling is a valid method of collecting data in qualitative research. During our study, the participants were able to share their mothering experiences in the context of their lesbian relationship, by including text, pictures, lyrics, music, photos and poetry in their journals. Three potential challenges and six strategies to counter those challenges, are presented in this paper.
Journaling: identification of challenges and reflection on strategies


Accepted: December 8 2010.

Abstract
Aims To identify the challenges associated with using journaling as a method of data collection and to offer strategies for effectively managing those challenges.

Background While journaling can be used for a variety of reasons, in the context of this paper, journaling refers to the process of participants sharing thoughts, ideas, feelings and experiences through writing and/or other media. Journaling is used in phenomenological research studies to record participant experiences in their natural contexts.

Data sources The findings are based on the experiences of the researchers during a qualitative study that explored the experiences of lesbian mothers and used journaling as one method of data collection.

Review methods This is a methodological paper.

Discussion Three main challenges affect journaling as a method of data collection: poor participation, feeling exposed and staying on track. Six strategies to promote participation in journaling are: coaching participants, limiting the journaling period, providing follow-up contact, promoting comfort, ensuring safety and providing clear content expectations. Each strategy is discussed and methods of implementing the strategies are offered.

Conclusion Journaling as a method of data collection has long been accepted as a valid method of accessing rich qualitative data. By acknowledging the common challenges associated with the process of journaling that are experienced by the participants, researchers employing this data collection method can promote constructive and valuable participation.

Implications for future research Further research examining participants' experiences of journaling as a method of qualitative data collection would be useful in determining challenges, barriers and benefits of the method.

Keywords Journal, journaling, data collection methods, qualitative research

Introduction
QUALITATIVE RESEARCHERS use a variety of methods of data collection under the umbrella of 'personal document research'. Personal documents can include: autobiographies, diaries, letters, journals, oral histories or other raw material authored by a single person' (Holbrook 1995). Verbrugge (1989) first identified journaling as a primary source of data collection; Smith and Hunt (1997) later stated that journaling is used least frequently in phenomenological research for data collection, but that it is still a useful tool to document specific experiences and feelings associated with them.

While data collected from journaling can be used to successfully examine specific experiences in natural contexts and frameworks (Simmons-Mackie and Damico 2001), there are challenges when using journaling as a method of data collection. This paper will use the literature and researchers' experiences to describe these challenges and will provide strategies that promote participation and the collection of quality data.
Background
In the literature, the terms journal, log, and diary are used interchangeably. However, there are some subtle differences. A log is an objective report of definite events and a diary is a continuous, unstructured and private record that includes thoughts and feelings (Redlund et al. 1989). A journal is a diary and a log in that it blends personal reflections, accounts of events and descriptions of experiences (Chabon and Lee-Willerson 2006). In this paper, we will discuss journaling, which can take a number of forms. In particular, we will focus on the use of the internet for journaling, since it provides a convenient, accessible and secure environment.

The literature describes various reasons for journaling. Since the 1950s, healthcare providers have frequently used client journaling to keep records of health events, such as food intake and pain experiences (Hager and Brockopp 2009, Stein 2010). The main purpose of journaling is to document and reflect on experiences as a way of thinking, understanding and learning, such as in the cases of English and Gillen (2001), Darozewski et al. (2004), Cusley et al. (2007), Horowitz (2008), Van Horn and Freed (2008), and Waldo and Hermans (2009). Deep learning, problem solving and clinical reasoning are outcomes of journaling when used as a learning strategy for nursing students (Chabon and Lee-Willerson 2006). Less often, journaling is used for telling a story for therapeutic purposes (Ullrich and Lutgendorf 2002, Davidson and Robison 2008). Journals have the capacity to provide detailed information that can determine specific and individualized healthcare interventions.

Journaling as part of research can be used in two ways: as a means of documenting and reflecting on the practice of research (Bank-Wallace 2009) or of data collection that records information for later analysis (Vilamaki et al. 2007). Vilamaki et al. (2007) argued that journals can be used as primary sources of data in nursing research and Swenson (2004) added that journaling as a method of data collection can be used with other data collection methods to enrich information gathered from interviews.

The challenges associated with journaling as a method of data collection will be the focus of this paper. Additionally, we will identify six strategies to overcome these challenges, derived from a research study that required participants (lesbian couples) to journal their mothering experiences for a month. Journaling was the final phase of data collection for the study, with participants first completing demographic data sheets and participating in in-depth, semi-structured interviews. The aim of the journaling was twofold: to collect data that would enrich and confirm the data already collected during interviews and to clarify data and seek responses to questions inadequately explored during the interview.

Identification of challenges
While researcher challenges have been identified in the literature, they are associated specifically with data analysis – as opposed to data collection – and therefore have been excluded here. There are three main challenges in journaling that are central to respondents:

- Poor participation.
- Feeling exposed.
- Staying on track.

These challenges and potential solutions are illustrated in Table 1 and will be discussed in relation to the literature and researchers’ experiences during the study.

Poor participation
Poor participation in journaling has been identified as a common barrier to the success of the method (Richardson 1994, Stone et al. 2002, Taylor et al. 2006, Vilamaki et al. 2007). Failure to participate can be attributed to participants lacking the confidence to write, the length of time it takes to complete a journal compared with a single interview, and anxieties associated with the participant writing his or her feelings and experiences as possible permanent records.

The three strategies for promoting participation are as follows:

- Coaching.
- Limiting the journaling period.
- Follow-up contact.

Coaching
Participants need to be enthusiastic about journal-keeping if they are to engage with the task and report useful data (Taylor et al. 2006) and most participants will require ‘coaching’ in journaling (Stopka et al. 2004). Coaching can take various forms, Mackrell (2007) and Van Horn and Freed (2008) suggested that guided questions promote participation and confidence in the depth of information being shared. Clarity of terms and ease of use will promote participation in journaling activities (Hager and Brockopp 2009).

In our study, when we started to collect data using an online journal, we consciously gave participants little guidance because we held the
somewhat naive and misconceived notion that we did not want to be prescriptive, stiff or limit participant contributions, or place value on any particular aspects of participants’ mothering. However, with no guidance or direction, the participants did not contribute at all.

Consequently, we decided to provide explicit direction about the types of information participants might want to include in their journals and even presented some examples. These strategies gave participants a better sense of what was expected and, as a consequence, they began to contribute more readily. As the recruitment of participants to this part of the study progressed, we became more confident in giving instructions that gave participants a sense of direction and expectation without restraining their creativity or imposing our values on what was important to them.

A more effective strategy than adding large amounts of information and instructions to individual journal pages is to add small amounts of information frequently. When we created journal pages following interviews, we adjusted the length of the instructions to see if we could increase participation. We found that small amounts of information led to longer, more frequent and more detailed contributions to the journals.

Our initial post to the journals was as follows: ‘Art, pictures, music, poems – add anything here that defines you as a mother or relates to your experiences of being a lesbian mother. There are no requirements about how frequently to add – just whenever you want to. At least ten posts within the month would be good if you can manage it.’

We added further random questions and statements, occasionally including our experiences as stories. For example, one of the aspects of mothering that the participants were asked to share was about their brightest mothering moment and I (RIH) shared my story. This strategy generated numerous entries about experiences resulting from things their children did or said.

Additionally, we avoided using technical terms apart from well-known computer jargon and abbreviations. The participants were using a social networking website to which they already belonged so we included some online text language, such as btw (by the way) and lol (laugh out loud), on the journal pages to promote a sense of comfort and convey that the standard of writing was relaxed.

After we implemented these strategies, all the participants, except one couple, contributed multiple entries to their journals and the entries came to include pictures, photos, songs and lyrics as well as text. These outcomes demonstrate that the strategies proved successful in promoting participation in journaling as a method of data collection.

Limiting the journaling period
Providing a limit for the journaling period can promote participation (Norman et al 1992) because, when participants can see the end, they are more likely to participate. In our study, participants expected to journal for one month. Given that these couples were all mothers whose children were mostly aged under six years, their time was limited and we realistically expected only a few journal entries, probably in the initial period. Providing a time limit had two benefits: it gave a clear expectation to the participants of how long it would take for data to be collected; and it may have encouraged some to participate as the perceived deadline approached.

Table 1 Overview of challenges, strategies and strategy implementation methods

<table>
<thead>
<tr>
<th>Identified challenges</th>
<th>Six strategies for the researcher</th>
<th>Methods of implementing the strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor participation</td>
<td>1. Coaching. 2. Limiting the journaling period. 3. Follow-up contact.</td>
<td>- Provide examples. - Add questions, statements or stories. - Do not use technical terms apart from well-known computer jargon and abbreviations in text (if appropriate). - Provide a time limit for the journaling. - Regular contact, reminders and trigger comments or questions will help the participants engage in journaling.</td>
</tr>
<tr>
<td>Feeling exposed</td>
<td>4. Promoting comfort. 5. Increasing safety.</td>
<td>- Provide ongoing support for the journalers by ‘dropping by’ their pages. - Promote a sense of safety and privacy by adding privacy clauses to each journal page</td>
</tr>
<tr>
<td>Staying on track</td>
<td>6. Clarity about content expectations.</td>
<td>- Provide direction about the types of information participants should include. - Be clear about the required content of the journal.</td>
</tr>
</tbody>
</table>
Follow-up contact
Follow-up contact with participants will also trigger participation and enhance motivation (Vigliaski et al. 2007), particularly in the latter stages when journaling tends to become inconsistent. Regular contact, reminders, and trigger comments or questions will help the participants engage with journaling and keep the content on track, drawing out useful information and supporting the participant-researcher relationship. In our study, comments posted weekly to the journal pages were the catalysts for rapid escalations of contributions on most occasions.

Sometimes a barrier might be motivation and at other times it may be a lack of confidence in writing, difficulty in getting started or feeling confronted by writing down personal information. Youngren (2008) said that it could be ‘verifying to take the first step’ when journaling; some participants might feel unsure about getting their thoughts, ideas and feelings down on paper, and getting started sometimes presents an extra difficulty. Others may be concerned with maintaining privacy, particularly in an online environment.

Promoting comfort
Some participants may feel vulnerable or anxious documenting sometimes intimate details of their lives. They may also worry about being judged negatively based on their journal contributions. Others may feel less comfortable with their literacy and writing skills (Stopka et al. 2004), which can be countered by using oral (audio-recorded) journals (Neal and Neal 1994).

One method of alleviating fears associated with journaling is to provide clear instructions, identify specific objectives, and provide ongoing support and guidance (Taylor et al. 2006). In our research project we:

- Identified specific objectives – we provided the objectives of the study during interviews but, in hindsight, there may have been some benefit to restating the objectives later to provide further guidance.
- Offered ongoing support – we ‘dropped by’ participants’ journal pages a couple of times a week and left notes or comments about posts or photos they had added. Providing participants with positive feedback validated the content of their journal entries and encouraged ongoing participation.
- Provided ongoing guidance – after each interview couples were sent an invitation to join a lesbian mothering research web page that provided study updates.

Increasing safety
Another strategy to increase participants’ sense of safety is to use blogs or dedicated web pages for journaling. This offers some degree of security and should support effective participation (Dilling 2006). Stone et al. (2002) found that patients in their study were more likely to complete an online journal than a paper one – this could also be true for participants in research projects.

In our study, participants could journal using either the social networking site or a paper journal, with most choosing the online option. We found no problems in accessing these journals created as closed and private social network pages. We added privacy clauses to individual journal pages to promote a sense of safety and to guarantee privacy further, some participants used pseudonyms.

There is a risk the journal will diverge from the intended topics. Occasionally, this can benefit the researcher in terms of the information gained. However, sometimes it can lead to rich and important data being compromised with copious amounts of unusable information. For these reasons, it is important that participants receive clear instructions and guidance from the outset.

Clarity about content expectations
Researchers need to be clear about the required content of the journal and ensure that the participants keep to the topic. Participants are giving up valuable time to contribute, so researchers need to ensure that this results in useful, usable data. Richardson (1994) argued that journaling instructions need to be broad and flexible or participants will have to unnecessarily narrow their thinking; as a result, the information their journals yield may be superficial.

In our study, this strategy was not relevant, as the participants needed to ‘drive’ the content of their journals. Striking a balance between allowing creativity and expression, and keeping the content of the journal on track is a challenge that is more readily achievable when the researcher and the participants are clear about the purpose of the journal. The purpose may need to be reassessed at specific stages of the journaling process.

Conclusion
Journaling as a method of data collection has long been accepted as a valid way of accessing rich qualitative data. By acknowledging the common challenges that participants experience...
when journaling, researchers can promote constructive and valuable participation.

The challenges experienced by the participants in relation to journaling have been identified in this paper as poor participation, feeling exposed and staying on track. To promote participation, help the participants feel secure with their disclosures and keep the journal content relevant to the study, six strategies were implemented. These are:

- **Coaching.**
- **Limiting the journaling period.**
- **Providing follow-up contact.**
- **Promoting comfort.**
- **Increasing safety.**
- **Ensuring clarity of expectations.**

The strategies proved helpful in managing the identified challenges and subsequently promoted a journaling experience that yielded useful and rich data.

### Online archive

For related information, visit our online archive of more than 6,000 articles and search using the keywords.

### Conflict of interest

None declared.

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### References


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Chapter 7

Findings

Introduction

The following Chapters (7 – 9) contain three peer-reviewed, published papers (Papers D, E & F) and one invited encyclopaedia entry (Paper G) that is currently under editorial review. These papers examine the three major themes identified in the data. Table 3 illustrates the relationship between the themes and the publications. Each paper presents new knowledge which emerged from the data which promote understanding of the experiences of lesbian mothers in Australia.

Table 3: Major themes in relation to published papers

<table>
<thead>
<tr>
<th>Theme</th>
<th>Becoming mothers</th>
<th>Constructing motherhood</th>
<th>Legitimating our families</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paper title(s)</td>
<td>Lesbian women choosing motherhood: the journey to conception</td>
<td>Marginalised mothers: Lesbian women negotiating heteronormative healthcare services.</td>
<td><em>De novo</em> families: Legitimiizing the other mother and Community other mothers</td>
</tr>
</tbody>
</table>
Lesbian women choosing motherhood: the journey to conception

(Paper D)

This details decision-making processes that lesbian couples engaged when deciding to have a baby as well as the processes they used to achieve a pregnancy. It explored the various decisions concerning the status of donors and various method of conception. This paper offered a deeper understanding of how lesbian women in Australia negotiate the healthcare system and discriminatory legislation.
Lesbian women choosing motherhood: the journey to conception

Keywords: lesbian, mother, *de novo* family, conception, alternate insemination, artificial insemination, self-insemination, in-vitro fertilisation, intra-uterine insemination, pregnancy, donor sperm

Introduction

Worldwide, more lesbian women are choosing to have children in the context of a same-sex relationship than ever before (Australian Bureau of Statistics, 2009; Buchholz, 2000; Gabb, 1999; Hequembourg, 2009; McCann & Delmonte, 2005; Wilton & Kaufmann, 2001). Thus, the terms ‘mother’ and ‘lesbian’ are no longer mutually exclusive identities (Reed, Miller, Valenti & Timm, 2011). The journey to conception and on to motherhood involves a range of decisions that are unique to lesbian couples (Renaud, 2007), for example, deciding which partner will become pregnant. Two additional key decisions to be made during this time include deciding on a known or unknown donor and choosing a method of conception. This paper will draw on the findings of an Australian study that explored the experiences of lesbian mothers creating *de novo* families to gain an insight into the issues and describe their decisions around conception.

Background

The conventional ideology of ‘family’ is shifting from the traditional two-parent, heterosexual family to include varying permutations of individuals, including lesbian women and their children. Today, lesbian women have more options to create families than in the past (Ryan & Berkowitz, 2009). Subsequently, the decision to embark on motherhood is being made by increasing numbers of lesbian women in Australia (Rawsthorne, 2009). Lesbian families, sometimes referred to as *de novo* families, consist of a same sex female couple and the children they have planned, conceived, birthed and are raising together. *De novo* families challenge the conventional idea of who constitutes a ‘family’ (Haimes & Weiner, 2000).

Lesbian women wishing to achieve pregnancy have several options available to them (McNair, Dempsey, Wise & Perlesz, 2002; Yager, Brennan, Steele, Epstein & Ross, 2010). The increasing accessibility of assisted reproductive technology makes conception for lesbian women far less complicated than ever before. Donor sperm can be used for various alternate modes of insemination,
including vaginal insemination, intra-uterine insemination or invitro-fertilisation (IVF). Vaginal insemination can be undertaken either in a medically supervised procedure in a clinical setting or as self-insemination in the home. Both intra-uterine insemination and IVF take place in a clinical environment. Whilst heterosexual intercourse is another option, this alternative is deemed unacceptable by most lesbian women as it viewed as disrespectful to their identity (Baetens & Brewaeys, 2001).

The study

The findings presented in this paper focus on choosing which partner would be pregnant, donor decisions as well as methods of conception used by lesbian women participating in a larger qualitative study that examined the experiences of lesbian mothers in Australia. This paper is not intended to be interpretive, but rather a description of the processes engaged by participants. Fifteen lesbian couples participated in the study. Recruitment occurred via lesbian publications, word of mouth and women’s health services. The main purpose of the study was to explore the ways lesbian mothers construct mothering. Data were gathered between March and August 2010. Participants provided demographic data and participated in: a) in-depth semi-structured interviews that employed a story-sharing approach (Hayman, Wilkes, Jackson & Halcomb, 2012) and b) journaling (Hayman, Wilkes & Jackson, 2012). Demographic data included; age, length of time in their relationship and cohabitating, occupation, number of term pregnancies, the age of their child(ren) and their combined annual income. Interview data were transcribed verbatim and then analysed and coded using a process of constant comparative analysis (Thorne, 2000). During data analysis, four themes emerged: becoming mothers, constructing motherhood, legitimising our families and raising our children. This paper explores the theme ‘becoming mothers’.

Prior to commencing data collection, ethics approval was gained from the relevant institutional Human Research Ethics Committee. Participation was voluntary; all participants provided informed consent and have been assigned a pseudonym in reports and publications to protect their privacy and anonymity.

The findings

While there is no comparative demographic analysis, this data provided context to the study. There was a convenient sample of 30 self-identified lesbian women, consisting of 15 couples, was recruited to the study. The age of the
participants ranged from 28 to 58 years (mean 39.8 years). The couples had been in their relationship between 3 and 18 years (mean 9.6 years) and had been living together between 2.5 and 17 years (mean 9.0 years). Collectively the women had achieved 18 term pregnancies, producing 21 children, including three sets of non-identical twins. At the time of the study, the children were aged from two months to 10 years (mean 2.58 years). The couples combined family income ranged from $AU23,000 to $AU400,000 (mean $AU118,000).

This paper focuses on the theme ‘Becoming mothers’ and specifically the three topics that emerged from that particular theme: deciding to be mothers, sperm donor decisions and methods of conception.

**Deciding to be mothers**

While most participants had always thought they would become mothers at some stage in their adulthood, others initially thought that their status as lesbian women would exclude them from motherhood. Tina shared, “I knew I was a lesbian from a fairly early age ... I assumed that children weren’t part of that identity”. Preclusion from motherhood based on sexual orientation was both internal and external. Participants generally excluded themselves from the prospect of motherhood believing that it was not possible for lesbians to have a family that included children or were unsure of how conception could occur given the obvious lack of spermatozoa available within the dyad. For this reason, lesbian couples trying to conceive were required to engage in careful and deliberate planning and decision-making.

Social expectations, both within and outside the lesbian community, also placed perceived reproductive restrictions on lesbian couples and essentially positioned them as childless. Jane said, “I’d built myself up as this lesbian who wasn’t going to have children because that’s not what lesbians do ... it was my [lesbian] identity I was going against [by choosing to have a child]”. The lesbian community can also be harsh in its judgement of lesbians choosing motherhood because lesbian motherhood can be regarded extraneous to authentic lesbian culture (Bos, van Balen, van den Boom, 2004). Sam confirmed this stating “there are a proportion of the lesbian community who are very anti-children”. Some participants discussed their experience of rejection from parts of their local lesbian community because of their choice to have children.

Families of origin sometimes struggled with their daughter’s disclosure of sexual orientation and subsequently assumed they would not be provided with grandchildren (from their lesbian daughter). Petra shared that her “...family were a bit more different and a bit wary and I think it was more about what
other people would think”. Those outside the family of origin also made assumptions about the lesbian couple, speculating that they would be childless. Sometimes these suppositions were made based on history (previously lesbian women were less likely to have children in the context of their lesbian relationship) and on other occasions, the assumptions were derived from negative judgements about a lesbian couple’s ability to successfully parent their children. Dana shared that “We did talk about how is the child going to be received, like socially? Like is the child going to suffer because we want to have kids”?

Despite external and internal expectations about lesbian motherhood, participants in our study chose to become mothers in the context of their same-sex relationship. All participants disclosed lengthy discussions, sometimes over several years, prior to making the decision to have a child together. Jane stated, “We talked about it for a year or a year and a half with them [their potential donor and his partner] before we decided to go ahead. It would be part of everyday conversation; every time we saw them and we’d discuss different things”. Another couple described discussing the possibility of having a child together for over ten years. The topics for discussion were concerned with, who would become pregnant, the role of the non-birth mother during conception, pregnancy and her future parenting role, known and unknown sperm donors, accessing sperm, and method of conception.

While some of the decisions that lesbian couples make are not dissimilar to those made by heterosexual couples, one of the most obvious differences is the choice about which partner will be pregnant. This decision was made by participants based on the age and health status of each woman as well as the individual desire to be pregnant and ability to conceive. Billy, who embraced a butch lesbian identity said, “I’m not the feminine or maternal one”. This was predominantly experienced by participants who identified their relationship as a butch-femme dynamic where each partner is essentially more masculine or feminine according to the commonly accepted social expectations of male and female gender roles (Rosario, Schrimshaw, Hunter & Levy-Warren, 2009). For these couples, the femme-identified woman was identified as the natural choice for child bearing within the relationship. Gemma said that her more feminine partner “had expressed more of a desire to carry the child. I said I would if she couldn’t, but I didn’t have that strong desire to actually carry the child, for it to have my biological make-up”. Women identifying as butch did not recognise child bearing as part of their role within their relationship and some completely rejected the idea despite their physiological capacity to conceive.

Participant dyads that did not identify butch-femme roles or identities tended to make their decisions about conception based on factors such as age and
health status. Some participants were aged over 45 years and felt that pregnancy was too risky for themselves and the child. Other younger couples identified that while their age was not necessarily a barrier to a healthy pregnancy, the younger partner would be less likely to experience health problems associated with pregnancy. However, one couple decided that the older partner (Jessie) would TTC as she was reaching menopause and felt that her “time was running out”.

The health status of each partner was a major factor in deciding which woman would try to conceive. For example, in one dyad, the older partner had a history of cervical cancer and had been told that she would not be able to carry a pregnancy to term. Subsequently, it was decided that the other partner would try to conceive. On the other hand, one participant aged in her twenties had experienced severe health problems and had been told by her doctor that a pregnancy was a significant health risk for her. She proceeded with trying to conceive as her partner was in her late fifties and therefore unable to conceive and she had expressed a deep desire to be a mother.

Finally, the decision to establish which woman in the couple would try to conceive was sometimes determined by ability to conceive. For two couples, one partner had tried to conceive on many occasions and had not been able to achieve pregnancy. Fran stated that “We had a lot of failed attempts and stuff in the beginning ... so it took us quite a while”. In this situation, the participants decided that the other partner should try to conceive.

These findings demonstrate that when deciding to have a baby, lesbian women negotiate expectations from both the general and lesbian communities, their families and may even find themselves challenging their own previously held ideas about their lesbian identity and how that fits with motherhood. Further, it has been shown that gender identities can also be a substantial consideration for lesbian women deciding to have a baby. Finally, lesbian women choosing motherhood have diverse thoughts, ideas and desires about their journey to motherhood.

Sperm donor decisions
Participants explained that they engaged in meticulous research to identify ways of accessing sperm, discussed the pros and cons of known and unknown (to the women) sperm donor status and various methods of conception. One participant stated that she researched these areas “within an inch of my sanity” (Lilly). Information was accessed via a combination of; conversations with friends, internet websites and medical consultations. Participants spent time talking with lesbian friends, and in particular, friends who had conceived
children in the context of their lesbian relationship. Websites were accessed as a resource for finding information about donors and methods of conception. Several couples made appointments with general practitioners, specialists and fertility clinics to seek information about methods of conception. Sam stated that, “the clinic gave us a very comprehensive package on what we’re about to go through”. Such extensive research allowed participants to be well equipped to decide which woman would try to conceive. The next decisions focussed on choices about sperm donation and subsequently methods of conception.

Choosing a known or unknown sperm donor was a major decision for the participants. Together, the couples deliberately and purposefully debated the benefits and limitations of either a known or unknown donor. Participants choosing a known donor \( (n = 16) \) fell into two groups. The first group consisted of participants who initially chose a known donor that they engaged for the sole purpose of sperm donation (i.e. no ongoing relationship with the mothers or the child) \( (n = 10) \), while the second group chose a donor with whom they had regular contact and an ongoing friendship/relationship \( (n = 6) \). In this latter group, the participants chose friends or relatives. Where a relative was chosen, he was the brother of the non-birth mother \( (n = 3) \). Where friends (rather than relatives) were chosen, the father engaged in a parenting role \( (n = 3) \). Participants choosing the brother of the non-birth mother stated they made this choice to establish a biological link between the child and non-birth mother. This was considered important as it was viewed as a means to strengthen and validate the position of the non-birth mother as a legitimate parent and promote social recognition of her maternal identity. One participant of a couple who chose a known donor who was a relative of the non-birth mother said that, “I think the idea that this child is related to both of us is very important”. Another couple (Kelly and Rosie) who also chose a relative of the non-birth mother as their donor, expressed the importance of their child having the non-birth mother’s genetics. This represented a need to promote a biological tie between the non-birth mother and the child.

All participants choosing a known donor did so because they felt it was important that the child be able to make contact with their donor in the future. Jade said, “we did want it to be someone who I guess we could point to and say that’s where I’ve [you’ve] come from ... so it wasn’t for us that we made the decision for a known donor. But just for him, if that was ever to be an issue, he could easily find out where he came from”. Most participants \( (n = 16) \) choosing a known donor also expressed that the importance of their child having the option of contacting their donor in the future was an important factor in knowing the donor.
Participants choosing an unknown donor \((n = 2)\) did so because they felt strongly that they wanted no donor involvement in the parenting of the child. Participants expressed concern that a known donor could stake a claim to the child in the future and by choosing an unknown donor, this was less likely to occur. Sally shared that, “a fear of mine is having a known donor because I feared that the gentleman in question may come back say 12 or 13 years down the track and say, “Oh, he’s a lovely young boy, he’s my son”... and have any sort of right of ownership. That was a big fear from me”. One couple went so far as to deliberately choose a donor from overseas, as this was perceived as further limiting potential donor access to the child and the likelihood of unwanted contact. Jane said, “We wanted to make sure that he knew that it was going to be our child, not part of – like not his child. That any decisions that were made were ours”. This decision was made primarily to protect the parental position of the women and in particular, the non-birth mother. Further, Annie expressed a definite preference to use an unknown donor as the option of a known donor (particularly a friend) made her uncomfortable and stated that, “I think for us there was just a little bit of uncomfortableness about friends or acquaintances offering sperm, and I just said, that’s too messy for me”. Additionally, choosing an unknown donor meant that conception would occur in a clinical environment and with this came increased health safety. Participants choosing self-insemination assumed some risk of contracting sexually transmitted infections, while couples using intra-uterine insemination or IVF were afforded the peace of mind that semen had been tested and quarantined for six months prior to use, thus significantly reducing the risk of disease transmission.

While some donors were unknown to the women, all participants expressed the importance of accessing information about a prospective donor. Firstly, participants tried to choose a donor that matched the non-birth mother’s physical characteristics, for example blue eyes. Unlike birth mothers who are privileged with automatic mother status, non-birth mothers are often excluded from their maternal position and identity because they do not always have a biological tie to their child (Hayman, Wilkes, Jackson & Halcomb, 2013). Choosing a donor with similar physical characteristics to the non-birth mother offered the possibility of the child having similar physical features (for example, blue eyes) as the non-birth mother and was perceived as a way of emulating a biological tie and was subsequently perceived to strengthen her mother position (Hayman et al., 2013). Second, the participants explained that it was important to be able to access medical information about a potential donor and his family. In particular, participants preferred a donor who was healthy and whose family did not have any known serious, hereditary health conditions. Participants opting to use an unknown donor engaged a process of donor selection that included examining the profiles of potential donors. Profile information included age, race, education and occupation, health and physical characteristics.
Methods of conception

The decision to use a known or unknown donor was also important in terms of its impact upon the method of conception. This is primarily because choosing an unknown donor limited the method of conception options to intra-uterine insemination or IVF. Choosing a known donor broadened the options because it meant that vaginal insemination (self-insemination or medically supervised), intra-uterine insemination or IVF could be used for conception. Couples choosing a known donor tended to opt for vaginal insemination initially at least, while couples preferring unknown donor status used intra-uterine insemination or IVF.

Vaginal insemination

The participants talked at length about how they planned to inseminate at home and researched the process of vaginal insemination via the internet and through discussions with friends – primarily lesbian friends who had previously had children together, or were also planning a pregnancy. Participants trying to conceive then charted their menstrual cycle and some measured and recorded vaginal temperature and most started pre-natal supplements to prepare for pregnancy. Lilly said “I had been checking my cycle beforehand so testing with the thermometer and stuff so that when we did decide to begin that I knew when was the right time”. Of the 18 women who had conceived, 12 chose vaginal insemination as their first preference for conceiving. Of those women, six achieved pregnancy, all conceiving on the first attempt. The other six women had a total of 60 attempts at conceiving via vaginal insemination - one was successful, and the others moved onto IVF (n = 4) or intra-uterine insemination (n = 1).

Three participants inseminated on their estimated ovulation day as well as the day before and after, while all others inseminated only on their ovulation day. The participants who inseminated multiple times in one cycle anticipated this would increase their chances of conceiving. Jane shared, “... we did it a day or two days before and [on] the day and the day later [after ovulation] ...” On most occasions, the non-ovulating partner travelled to collect the sperm from the donor at his home. Fewer participants organised for the donor to deliver the sperm to their home and one couple lived in the same home as their donor. Ellie said, “[Josie] jumped in a car and went, drove, picked it up, put it in her bra to keep it warm! And it’s in a sock, he put it in a sock because he thought it would keep the specimen jar warm! Then she put it in her bra and drove it back and we put it in a 10ml syringe ...”
Inseminated participants engaged in post-insemination activities such as leg and buttock elevation for thirty minutes to promote movement of sperm into the uterus. About half the participants waited until the first day of a missed period to do a pregnancy test. The others started testing as soon as five days after insemination and Patty shared that, “We bought pregnancy tests in bulk and just about every time I went to the toilet I was using one” and Erin added, “I could never wait for their [the clinic] results. I was always too eager to know”. The participants, who did not conceive on the first attempt, described a roller-coaster of emotions. They expressed feelings of guilt, disappointment, frustration and sadness each time they discovered they were not pregnant. Renee shared that the process was “very draining ... became mechanical in the end ...living fortnight to fortnight [and] ... in the end we had given up”. Most participants were trying to conceive without people close to them knowing and this meant that they had limited options for sharing these feelings and accessing support. One of the benefits of trying to conceive with the assistance of a fertility clinic was seen to be the access to support and information that may not have been as available to participants using vaginal insemination at home.

**Intra-uterine insemination**

Of the couples who were not able to conceive using vaginal insemination, one then tried using intra-uterine insemination and was successful after six attempts. Five participants chose intra-uterine insemination as their first preference of method of conception. Of those, three conceived and two then attempted IVF. The three participants who conceived using intra-uterine insemination had a total of five attempts (range = 1 - 6). Of the participants choosing intra-uterine insemination as their first choice of method of conception, four ($n = 80\%$) used sperm from a known donor.

Participants choosing intra-uterine insemination as their preferred method of conception, whether using a known or unknown donor, were interviewed by healthcare staff and counsellors in a fertility clinic. As a couple, their perceived ability to parent children was assessed and the woman trying to conceive had various blood tests and health checks. Jill shared that, “before they would see us and start taking the initial tests and screenings ... all the ethical dilemmas came up in the counselling session to make sure we were 100% knowing what we were doing and what we were in for”. For participants choosing an unknown donor, the sperm had already been collected, tested and stored at the clinic. Where participants chose a known donor, arrangements were made for the donor to visit the clinic to donate the sperm and have some blood tests. Millie said their donor “went to the clinic and had tests and donated sperm and dah, dah, dah. Waiting time!” In this situation, the sperm was quarantined for six months, after which time, the donor returned to have further blood tests to exclude infections that may not have been evident in the initial blood tests. The
participants stated that waiting the six months was often difficult and that once they had made the decision to have a baby and chosen a donor, they were really keen to start the process. While increased health safety was achieved by using intra-uterine insemination, the disadvantage was waiting the mandatory six months to start insemination. Toby confirmed “in that time, the IVF clinic in [city] allowed us to store the father’s sperm ... it has to be stored for six months to be able to be used”. Fertility clinic staff monitored the participant trying to conceive to identify ovulation and carried out intra-uterine insemination at that time. Pregnancy testing was carried out two weeks later to determine the success or failure of the insemination.

In vitro-fertilisation

None of the participants chose IVF as their first preference for method of conception. This is largely because of local regulations governing women who are eligible to access fertility services. At the time of data collection, women had to have a medical diagnosis that reduced their capacity to conceive to qualify for fertility treatments such as intra-uterine insemination and IVF. Some participants were precluded from fertility clinics because they were deemed ‘socially infertile’ rather than having a genuine, or medically-caused, fertility problem. Jane confirmed, “… it’s only been since January that you can be a fertile lesbian and get access to IVF in [city]. Before that you couldn’t be socially infertile which is what they called it, to access it”. Three couples travelled interstate, where local laws allowed lesbian women to legally access fertility treatment. The remaining participants attempted pregnancy via vaginal insemination or intra-uterine insemination at first to demonstrate a fertility problem that would in turn make them eligible for medicare-subsidised treatment via a fertility clinic. Three participants were able to establish a diagnosis (polycystic ovary syndrome) which meant they were able to access fertility treatment locally on medical grounds. For example, Kelly and Sam had been unsuccessful using vaginal insemination, so their doctor diagnosed infertility, giving them access to IVF on medical grounds. Kelly explained, “We had tried at home for a little while, just artificial insemination at home and that hadn’t been successful ... he [obstetrician] just said yeah you’ve been trying it hasn’t worked, you’ll have to go straight onto IVF.”.

The seven participants who conceived using IVF had a total of 32 embryo transfers. Whilst two participants conceived on the first attempt at IVF, the range of attempts was 1-10 to achieve a pregnancy. Of the participants who conceived using IVF, five (71.4%) used sperm from a known donor.

Discussion
Creating a *de novo* family is burdened with decisions. Choosing to be parents was a deliberate and conscious decision made by lesbian women participating in our study. Choosing to be mothers in a heteronormative societal context poses many challenges for lesbian women. Heteronormativity marginalises and silences lesbian women in many aspects of their lives including their reproductive choices (Osche, 2011). The journey to conception for lesbian mothers is “multilayered and complex” (Chabot & Ames, 2004, p. 348), fraught with challenges (Oswald, 2002) and requires “a great deal of planning and preparation” (Kranz & Daniluk, 2006, p. 17). While there are many options available to lesbian women who want to have children (Kranz & Daniluk, 2006), the initial decision to become parents was not always easy for participants. Of equal difficulty were decisions about which woman in the partnership would try to conceive, sperm donors and methods of conception. Every stage of the journey was debated and discussed and each decision was made deliberately (Chabot & Ames, 2004; Kranz & Daniluk, 2006; Touroni & Coyle, 2002).

A circumstance unique to a lesbian couple is the option of choosing which partner would try to conceive. This decision was generally made based on the age and health of each woman as well as desire to be pregnant. For some participants, pregnancy was not at all appealing and furthermore they did not see it in any way as part of their role in terms of their gender identity within their lesbian relationship. This was particularly so for the participants identifying as butch lesbians. Likewise, Chabot and Ames (2004) revealed that participants in their study of lesbian mothering decided which woman of the couple would try to conceive based on a variety of factors and in particular, the age of each woman. These authors uncovered an additional factor that was not identified by participants in the current study, that is, whether the women were ‘out’ to their families of origin. Chabot and Ames (2004) identified that if women were not ‘out’ about their sexual orientation to their families, then it would be more difficult for them to be pregnant. This added another layer to the already complex process of decision-making for lesbian women wanting to conceive using donor sperm. All participants in our study were ‘out’ about their sexual orientation with their families.

Vaginal insemination is a method of conception that has been used by lesbian women since the 1970s (McNair, Dempsey, Wise & Perlesz, 2002) and it was the preferred first choice of MOC for most participants in our study. Vaginal insemination was chosen by participants primarily because they wanted to use a known donor. McNair et al. (2002) identified that participants in their study chose a known donor so that the child could have the option of finding out about their “biogenetic heritage” (p. 44), it met their desire to have a non-medicalised conception and allowed the non-ovulating participant to be involved in conception. These factors were also voiced by the participants in our study as reasons for choosing vaginal insemination. One of the challenges
of vaginal insemination that was identified both in our study and by Nordqvist (2011) is the need to access and use sperm in a timely fashion, that is, while it is still mobile. Participants in our study were acutely aware of the urgency required to increase the likelihood of successful conception, and as such shared that they hurried to inseminate as soon as possible after the sperm was obtained. The participants in our study also identified that the non-medicalised nature of vaginal insemination meant that participants were not required to interact with healthcare providers and this subsequently meant that they avoided anticipated homophobia and heteronormativity (Hayman, Wilkes, Halcomb & Jackson, 2013).

In our study, fewer participants chose a method of conception that required medical intervention (for example, intra-uterine insemination or IVF). Participants made this choice because they preferred an unknown donor, had been unable to conceive using other methods of conception and/or valued the health safety afforded to them by the clinical environment. McNair et al. (2002) found the participants in their study expressed the same reasons for choosing intra-uterine insemination or IVF. Similarly, Nordqvist (2011) highlighted the health risks associated with vaginal insemination. Choosing which woman should try to conceive, whether to have a known or unknown donor and which method of conception to use are all important decisions that participants consciously and deliberately made on their journey to motherhood.

Implications and conclusion
Lesbian women participating in the study had to make at least three important decisions before they could try to conceive. Which woman in the partnership would attempt pregnancy, the status of the donor and method of conception were all decisions that the women researched vigorously. This demonstrated commitment to ensuring the health and wellbeing of each other and their prospective child. While most women who conceived did so by vaginal insemination, this may well have been because of the restrictive laws in some states and territories of Australia that prevented lesbian women from access to fertility services at that time. The change in laws that now permit lesbian women to access these services may well see a rise in the number of lesbian women opting for intra-uterine insemination or IVF. Providers of healthcare services who deliver services to lesbian women should be informed of the decision-making processes and the reasons lesbian women make certain decisions in order to offer effective and sensitive healthcare.

Conflict of interest statement
There are no conflicts of interest to declare.
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Chapter 8

Marginalised mothers: Lesbian women negotiating heteronormative healthcare services

Marginalised mothers: Lesbian women negotiating heteronormative healthcare services (Paper E) identified lesbian mothers in Australia as a vulnerable population. This paper illuminated the unique experiences of lesbian women accessing healthcare, detailing strategies they used to maintain safety and avoid homophobia and offered suggestions for healthcare workers in regards to policy, inclusive language and education.
Marginalised mothers: Lesbian women negotiating heteronormative healthcare services

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ABSTRACT: Lesbian mothers share mainstream existence with other mothers by virtue of their motherhood, but remain marginalised by their non-heterosexual identity. This paper will draw on the qualitative findings of a recent Australian study that examined the experiences of lesbian mothers. Using a story-sharing method, data were collected using three methods: a demographic data sheet, in-depth semi-structured interviews and journaling. The findings demonstrated that participants experienced various forms of homophobia when interfacing with healthcare services and providers and included exclusion, heterosexual assumption, inappropriate questioning and refusal of services. Strategies used to avoid homophobia included screening and crowding.

KEYWORDS: lesbian, mother, healthcare, nursing, heteronormative, homophobia, vulnerable populations, story-sharing

Until recently, lesbian health has been considered equivalent to women’s health, and this thinking has led to misunderstandings about the unique health risks experienced by lesbian women (AIDS Council of NSW [ACON], n.d.). Fundamentally, the distinctive healthcare needs of lesbian women go unnoticed, are deemed unimportant or are simply ignored (DeBold, 2007; Weisz, 2009). However, evidence has shown lesbian women have a higher morbidity rate in a range of health related conditions including breast, uterine, colon and ovarian cancers, heart disease, stroke, mental health problems (Wagner, 1997), polycystic ovary syndrome, obesity, substance abuse disorders including tobacco smoking, and exposure to significant stress (US Department of Health and Human Services Office on Women’s Health [USDH], n.d.). In Australia, Mulligan and Heath (2007) reported similar issues in relation to stress, depression, anxiety and self-harm and McNair (2009) demonstrated that lesbian women were more likely to smoke and inject drugs and were also more likely than heterosexual women to have experienced abuse.

While sexual orientation is not specifically the cause of any of these conditions, it can be considered a social determinant of health as is gender, socio-economic status or ethnicity (ACON, n.d.). Coupled with the morbidity data, lesbian women experience homophobia when interfacing with heteronormative healthcare services and providers (HS&I), subsequently increasing the potential health risk to this already vulnerable population. Bjorkman and Malterud (2009) highlight the ‘unique challenges’ lesbian women face in seeking healthcare (p. 238) and add that lesbian women experience some health problems more frequently than their heterosexual peers, due to marginalisation. Marginalisation occurs when a person exists in two cultures but does not feel entirely connected to either one (Barber & Vega, 2011), can result in low self-esteem and vulnerability to emotional stress (Johnson et al., 2004; Stonequist, 1937). Furthermore, being marginalised generates feelings of isolation and exclusion (Moharty & Newhill, 2011; Santucci, 2011). In this paper we explore lesbian women and de novo family experiences of homophobic marginalisation as they negotiated health services in relation to conceiving and birthing their children.

BACKGROUND

A de novo family is a family that comprises a lesbian couple and children they planned and birthed within the context of their same-sex relationship, and are raising together (McNair,
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Hequembourg (2009) refers to de novo families as ‘lesbian-headed’ while Bos, van Balen, and van den Boom (2004) use the term ‘two mother’ families. Lesbian mothering first became visible in the 1970s (Clarke, 2008; McCann & Delmonte, 2005) and since that time, de novo families have been able to realise growing recognition, acceptance and visibility in the broader socio-cultural milieu (Clarke, Kitzinger, & Potter, 2004; Renaud, 2007). The number of de novo families is increasing in Australia and internationally (Australian Bureau of Statistics, 2009; Hequembourg, 2009) and this is demonstrated in the literature that is increasingly using terms like the lesbian baby boom and the ‘gayby’ boom (Spidsberg, 2007) to describe this phenomenon (Bergen, Suter, & Daas, 2006; Irwin, 2007).

Lesbian mothers share mainstream existence with other mothers by virtue of their motherhood, but remain marginalised by their non-heterosexual identity (Ben-Ari & Livni, 2006). The passage to motherhood can be particularly demanding for lesbian mothers as they navigate the usual challenges of motherhood alongside the challenges of birthing and raising children in a heteronormative social context that can have disabling features such as stigmatisation, discrimination, and homophobia (Goldberg & Smith, 2008; Webber, 2010). Homophobia is defined as the ‘explicit fear or hatred of homosexual people and activities’ (Higgins, 2007, p. 283). The characteristic heteronormative nature of the healthcare environment precipitates distinguishing patterns of homophobic behaviour and results in ‘overt discrimination, violation of rights and social ostracism’ (Christensen, 2005, p. 60), acts as an impediment to the delivery of holistic and individualised care and hinders the development of therapeutic relationships (Christensen, 2005; Goldberg, Ryan, & Sawchyn, 2009). The loss of control, isolation and vulnerability that a person typically experiences when they are hospitalised are emphasised for lesbian mothers accessing HS&P (Christensen, 2005). Homophobia in HS&P can reinforce ‘isolation and alienation’ and further marginalise lesbian mothers (Irwin, 2007, p. 73).

This paper will draw on the qualitative findings of a recent Australian study that examined the experiences of lesbian mothers. On analysis of the data from the larger study, it became apparent that despite increasing visibility and social acceptance of lesbian mothering, heteronormativity and homophobia continue to permeate health service delivery. Subsequently, negative attitudes toward lesbian mothers affect the way in which they access healthcare. It is important that heteronormativity is recognised and strategies to provide quality healthcare to lesbian mothers are developed and practised. This paper presents findings generated from the larger study and in doing so, will identify and discuss the types of homophobia experienced by lesbian mothers when interfacing with HS&P and offer strategies for implementing more inclusive healthcare.

**Method**

Lesbian couples who had planned, conceived, birthed and were raising their children together participated in this qualitative study. A convenience sample of 15 self-identified lesbian couples (N = 30) was recruited through women’s health care services, lesbian publications and word of mouth. Recruitment continued until data saturation was achieved. Participants were aged between 28–58 years (mean 39.8 years). Couples had been in their relationships for between 3–18 years (mean 9.6 years) and had been co-habiting between 2.5 (one couple co-habitated prior to entering into a relationship) and 17 years (mean 9.0 years). Collectively the families had achieved 21 pregnancies, producing 23 children consisting of 11 boys and 12 girls, including two sets of non-identical twins. The age of the children ranged from 2 months–10 years (mean 2.58 years). Most (N = 26/30) of the participants had tertiary qualifications. The combined family income ranged from $223,000–$490,000 (mean of $AU118,000).

Using a story-sharing method (Hayman, Wilkes, Jackson, & Halcomb, 2012), data were collected using three methods: a demographic data sheet; in-depth semi-structured interviews; and journaling. Participants were interviewed as couples between March–August 2010 and at that time a demographic data sheet was completed by each participant. Journaling took place soon
after each interview and continued for a period of 1 month.

The interviews were semi-structured, in-depth interviews that were either audio recorded ($N = 13$) or captured as text via an online messaging programme ($N = 2$). Story-sharing was the method used during the interviews. Story-sharing is the reciprocal exchange of relevant stories between the participant and researcher during qualitative interviews with the purpose of generating rich data (Hayman et al., 2012). The interviews took place face-to-face ($N = 7$), via an internet web camera programme ($N = 5$), an instant messaging programme ($N = 2$) or over the telephone ($N = 1$). The interviews lasted between 45 minutes–2 hours.

Journaling is a 'valid method of accessing rich qualitative data' (Hayman, Wilkes, & Jackson, 2012). Journaling was accomplished online via a popular social networking website for ten of the 14 couples who had internet access. One couple who did not have reliable internet access engaged in an email journal with the principal researcher. Participants were encouraged to share their mothering experiences in their journal. Participants included text, music with lyrics, photos and drawings. The participants were later asked to interpret the non-text contributions to their journals in words to ensure that interpretations made by the research team were authentic and reflected the meanings of the women.

Constant comparative analysis of interview and journal data was used to identify and isolate patterns in the participant's stories (Thorne, 2000). Patterns in the analysed text exposed major and minor themes. Rigour was established by an audit trail and checking of the thematic analysis by all members of the research team. Further, reflection, journaling and discussion of the data promoted a reflexive approach and helped raise consciousness in relation to the researchers' beliefs, biases and patterns of thinking.

**ETHICS**

Ethnic approval was sought and approved from the University of Western Sydney Human Research Ethics Committee prior to commencing data collection. Pseudonyms have been used for all participants in reports and publications to protect the privacy of participants.

**FINDINGS**

The analysed data used in this paper describes the perceptions of homophobia as experienced by the participants during their interface with HS&P. Homophobia was perceived by participants and took various forms including: exclusion; heterosexual assumption; inappropriate questioning and refusal of services. Strategies used to avoid homophobia included screening and crusading. Each of the types of homophobia described by participants will be explored further below. Later, we will identify and discuss the strategies implemented by participants to avoid homophobia and offer some strategies to promote acceptance of diversity in healthcare.

**TYPES OF HOMOPHOBIA**

Four types of homophobia were experienced by participants during their interface with the healthcare services: exclusion; heterosexual assumption; inappropriate questioning and refusal of services. Each of these is explored in detail below.

**EXCLUSION**

Several participants experienced homophobia in the form of exclusion. In particular, non-birth mothers were not accepted as genuine or legitimate parents and were essentially prevented from participating in various health-related procedures. Lucy explained, 'my partner was not allowed into recovery after IVF – male dads were allowed and Phoebe added ' [Name of Hospital] gave us a pack and it was a book for the father and a book for the mother. They didn't have anything else and just said 'sorry, that's all we have". Further, inappropriate terms (like sister, friend and mother) were reportedly used by healthcare providers to identify non-birth mothers in de novo families. Exclusion experienced by lesbian mothers led to feelings of anger, sadness, frustration and the need to frequently legitimise the parental role of the non-birth mother. For some participants, these experiences meant that in the future they made decisions not to disclose sexual orientation, relationship status or method of conception.
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During HS&P interactions, homophobia essentially generated a barrier between lesbian mothers and HS&P.

Heterosexual assumption
Frequently the women were presumed to be heterosexual and this made them feel ‘embarrassed’ (Mia), ‘uncomfortable’ (Ellie) and ‘self-conscious’ (Grace). Miett explained ‘... there are always assumptions made – especially since we have the same last name, people think we are sisters’. Holly added another example of heterosexual assumption when she said, ‘We were having a tour [of the birth centre] and this woman who was giving us the tour said, ‘Well where’s the father?’ We don’t want to be somewhere that thinks there should be a father hanging around’. These stories demonstrate how the heterosexual assumptions of HS&P generated negative feelings and experiences when dealing with the healthcare system. These heterosexual assumptions made by healthcare providers further excluded and marginalised an already vulnerable population.

Inappropriate questioning
The participants articulated that they were asked what they perceived as inappropriate questions that they felt were asked of them only because they were a lesbian couple. Such questions were asked during various stages of maternity care, including immediately after the birth. Questions about how the couple conceived were most common. Phoebe recalled, ‘People ask us odd questions at times which aren’t entirely appropriate, but for the most part I think it is genuine curiosity’. One couple shared that, immediately after the delivery of their baby, healthcare staff asked them about their method of conception and joked about how conception may have occurred. The participants said this made them feel embarrassed and uncomfortable. Many of the participants interpreted the questioning (however uncomfortable or inappropriate) as an opportunity to educate healthcare providers about their families, healthcare needs and preferred terminology. In relation to terminology, Holly remarked that ‘I think every form we filled in was like that [heteronormative], so there is a kind of systematic or institutional homophobia’. She was referring to the forms at the hospital for example, where lesbian couples and mothers did not ‘fit’ into the set responses provided. This led to feelings of exclusion and vulnerability. Jane also identified filling in forms as a problem when she discussed the admission of their child to hospital and there was no space for the non-birth mother on the form to be identified as a parent. She relayed that she crossed the ‘father’ section out and added the words ‘other mother’ to the form – to make it fit her family. Inappropriate questioning, whether verbally or via forms, can make lesbian mothers uncomfortable in a healthcare setting and this discomfort could amplify reluctance to access HS&P in the future.

Refusal of services
The fourth type of homophobia experienced by participants was refusal of services. On several occasions, participants were denied health services solely because of their sexual orientation and/or same-sex relationship. Refusal of services was not a personal choice on the part of individual healthcare providers, but instead one enforced by legislation. Melanie said ‘You couldn’t be socially infertile which is what they called it, to access it [IVF]’ and Lilly added, ‘Anyway there was a female doctor [there] who was very nice … but she refused to give Kate a referral. I think she said she was Catholic …’ Phoebe and her partner experienced refusal of services on more than one occasion and said, ‘...we were rejected by the first two [hospitals] because they said it was unethical for them to assist a single woman because they don’t recognise same-sex couples as being a valid couple’. In this situation, Phoebe and her partner were forced to travel interstate to access fertility services not legally available to them as a lesbian couple in their home state. Since the time of this incident, the laws have changed and in all States and Territories of Australia, lesbian couples have access to fertility services comparable to heterosexual couples.

The four types of homophobia demonstrate behaviours that operate to distance lesbian mothers from HS&P. With the increased morbidity rate of some illnesses and conditions experienced
by lesbians, disengagement and marginalisation from healthcare services will only serve to escalate the already vulnerable health status of this population.

**Strategies to avoid homophobia**
When interfacing with HS&P, lesbian mothers anticipated heteronormativity. Accordingly, they formulated strategies they thought would circumvent homophobia. Conceivably, the reason some participants did not experience homophobia was because of these particularly deliberate approaches. Lesbian mothers implemented two clear strategies to protect themselves and their children from homophobia: screening and crusading.

**Screening**
Screening was an activity often engaged by participants prior to physical contact with HS&P. They explained that they would contact the service, usually by phone, and ask questions about the service philosophy. In some instances, they asked the service or provider, "How do you feel about having lesbian clients?" (Billie). Essentially, screening was used to evaluate services for their attitude to the sexual orientation and same-sex relationship status of potential clients. The response determined whether participants accessed that particular service and an affirmative response meant the participants were likely to utilise the service. Any intimation of homophobia rendered the service unsuitable. This strategy was not as useful for participants living in outer urban areas where fewer services were available. In some instances, participants were told that the service was unable to meet their needs due to legal restrictions. This did not necessarily represent homophobia by the individual service or healthcare provider, but rather systemic homophobia by the community — a community represented by the government making decisions that precluded access to fertility services by lesbian couples.

Many participants also screened healthcare services and providers via the internet, searching blogs and forums for positive or negative comments and some participants sought referral from lesbian friends. Screening was a successful strategy that was used to reduce the risk of exposure to homophobia when interfacing with HS&P.

**Crusading**
Some participants stated that they were always out about their sexual orientation and that if HS&P were not comfortable or accepting, then they would access an alternate service. Participants said they thought of themselves as 'crusaders' and considered it their responsibility to educate people and to normalise their sexual orientation and same-sex relationship, in the context of accessing healthcare. They recognised that some healthcare providers may not have had exposure to lesbians and de novo families and it was an ideal opportunity to educate them.

Participants expressed that it was important for them to stop being invisible. Charlie summed this up adeptly by saying, 'as consumers and as women we just have to keep voicing our needs and make sure that we don't go back; we keep going forward and empowering ourselves in the system'. In the spirit of raising visibility and not standing for less than equality, two couples made formal complaints directly to HS&P's about the homophobia they experienced while accessing healthcare.

**DISCUSSION AND RECOMMENDATIONS**
Participants in this study were a highly educated and articulate cohort with effective communication skills and access to resources. Despite this fact, many experienced and were adversely affected by homophobia when accessing HS&P. This finding is consistent with other literature (McManus, Hunter, & Renn, 2006; Larsson & Dykes, 2009; Lee, Taylor, & Raitt, 2011). It is known that homophobia and hetero-centrism can affect the health and well-being of lesbian women (Victorian Government Department of Health, 2009). Despite this, lesbian women continue to experience negative, homophobic and hetero-centric interactions with HS&P.

Lesbian women continue to experience distinctive challenges and significant health disparities when interfacing with HS&P in comparison to the heterosexual community (National Academy of Sciences, 2011; Tjepkema, 2008), particularly when accessing maternity services because of the very nature and characteristics of their same-sex relationship. Hence, lesbian couples are reported to be vulnerable when interfacing with HS&P (Spidsberg
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Other studies demonstrate that lesbian women feel fearful about accessing healthcare and disclosing their sexual orientation to healthcare providers (Platzer & James, 2000; Wilton & Kaufman, 2001). This was evident in this study when the participants felt embarrassed, uncomfortable and self-conscious. Hutchinson, Thompson, and Cederbaum (2006) add that lesbian women are less likely to access preventative healthcare due to a fear of homophobia, and the fear of homophobic HSP& is has been shown to influence lesbian women’s decisions to access healthcare services generally. This is important as World Health Organisation (WHO, 1986) stated that, reduced access to quality healthcare is a predictor of poor health outcomes for all people, including lesbian women.

One of the prominent findings in this study was the extent of homophobic exclusion in health services and by health professionals. These exclusions incorporated levels of interaction with the non-birth mother during pregnancy and birthing and in the heteronormative language of assessment forms and health promotional materials. This echoes the findings of others, particularly in relation to maternity services (Dibble, Eliaison, DeJoseph, & Chinn, 2008; Erlandsson, Linder, & Häggström-Nordin, 2010; Renaud, 2007).

Exclusion was again illustrated by inappropriate questioning and refusal of services and while this is not new, it was reiterated in the voices of the participants in this study. It reinforces that HS& need to be more inclusive in their language and actions. It has been previously reported that assumptions of heterosexuality lead to communication barriers between lesbian women and healthcare providers (Bonvicini & Perlin, 2003; Rondahl, 2009). Communication barriers inevitably affect the quality of health service delivery and poor outcomes can occur.

Like lesbian women in other studies, the participants in this study used resourcefulness to counteract the negativity of inappropriate communication (Mulligan & Heath, 2007; Renaud, 2007). As proposed in these other studies, participants in this study chose services where they believed they were less likely to be discriminated against and also requested exclusion of staff that were homophobic. Lesbian women participating in the study were more likely to choose a healthcare worker who was accepting of their sexual orientation and to facilitate this, they engaged in screening to determine attitudes of HS& about sexual orientation. The authors above further stated that lesbian women interview health services to assess their attitude to homosexual people. Renaud (2007) also identified that lesbian women shared experiences of various healthcare services and advised each other about positive experiences and cautioned each other about services they evaluated as homophobic. The lesbian women in this study also shared positive and negative experiences of various HS& via internet blogs and word of mouth.

In order to overcome heteronormative services, participants in the current study reported that they negotiated the healthcare system cautiously to identify the services and practitioners most likely to deliver culturally sensitive or ‘lesbian-friendly’ healthcare. This highlights the need to recognise that homophobia represents a major hazard to lesbian health (Wagner, 1997). Measures need to be taken in order to assist lesbian women to equitably access healthcare. It is evident that the healthcare environment could be improved by inclusive policy development for de novo families. These policies should include health promotional materials, health assessment forms and education for staff that recognises the unique needs of the de novo family during the pre-natal, peri-natal and postnatal period. The restructuring of health assessment and interviews that use gender-inclusive language should be part of this reform. Additionally, heteronormative health promotional resources should be reviewed and designed in a way that includes lesbians and lesbian health issues. The generation of a database that identifies lesbian-friendly healthcare environments will help endorse utilisation of those services and subsequently promote the health of lesbians.

This study has shown that whilst society is moving forward, homophobia is still evident in the health service and with health personnel. When heteronormative practices, attitudes and policies are modified lesbian women and their de novo families will be better able to access equitable healthcare services. Nurses are in a unique position to advocate for lesbian women within the healthcare
environment by engaging in culturally sensitive practice. Cultural sensitivity in this context might include increasing consciousness of heteronormativity as well as the use of inclusive language and will help promote feelings of comfort and safety for lesbian women interfacing with HS&Ps and subsequently generate positive healthcare experiences.

CONCLUSION

It is evident from this study that de novo families are vulnerable group when accessing health care particularly during the pre-natal, peri-natal and postnatal period. While the lesbian women in this study were able to use their own resourcefulness to achieve appropriate care, other less educated or socially able couples may need to be guided through a system which is often harsh and not meeting their needs. In order to do so, the health environment needs to address the issues around homophobia exclusion, inappropriate language and refusal of treatment to vulnerable de novo families.

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Marginalised mothers: Lesbian women negotiating healthcare services


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Chapter 9

De novo families: Legitimating the other mother

This study revealed that the non-birth mother in de novo families faces a unique experience. De novo families: Legitimating the other mother (Paper F) clarifies the challenges experienced by the non-birth mother and the de novo family, and distinguished how the family worked to legitimise her role as an authentic parent. The strategies implemented to legitimise the non-birth mother’s position are identified and explained in this paper.
De Novo Lesbian Families: Legitimizing the Other Mother

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This study aimed to explore the experiences of other mothers in de novo or planned lesbian-led families in Australia to elaborate on one theme: legitimizing our families. Little is known or understood about how lesbians construct mothering within their families. Even less is understood about the experiences of the often marginalized and invisible other mother, that is, the non-birth mother in lesbian families. Fifteen self-identified lesbian couples participated in semistructured, in-depth interviews (as couples) using a story-sharing approach, undertook journaling, and completed a demographic data collection sheet. To be included in the study, participants had to have planned, conceived, birthed, and be raising their children together. A process of constant comparative analysis was used to analyse the data and generate themes and subthemes.

Legitimizing our families was described by participants in terms of several subthemes, including the following: the role of the other mother in planning, conception, pregnancy, and birth; symbols of family connection; and negotiating health care. Other mothers participating in the study were acutely aware that people in society generally did not perceive them as genuine parents. This finding was consistent with the concepts of Others and Othering. To this end, other mothers sought to legitimize their role within

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their families by establishing symbols and using ceremonies, names, and other methods of formal recognition to justify their role as an authentic mother and signify legitimate de novo family connections.

**KEYWORDS** lesbian, de novo, lesbian mother, lesbian parenting, other mother

**INTRODUCTION**

*De novo* is a term that was first used by McNair (2004) to describe lesbian-couple families. *De novo* families, and in particular *other* mothers, have encountered invisibility and exclusion and experience fear of homophobia (Lee, Taylor, & Raitt, 2011) because their sexual orientation and family construction were incongruent with social norms and expectations. The term “*other* mother” has been chosen here as there is no universally acceptable alternative term to describe non-birth mothers in *de novo* families. Increasing visibility and acceptance of homosexual orientation has encouraged more gay and lesbian couples to consider parenthood (McManus, Hunter, & Renn, 2006). Subsequently, mothering in the context of a lesbian relationship has also become increasingly prevalent (Goldberg & Perry-Jenkins, 2007). Little is known or understood, however, about how lesbians construct mothering within their families. Even less is understood about the experiences of the often marginalized and invisible *other* mother; that is, the non-birth mother in lesbian families (McNair et al., 2008). *Other* mothers challenge dominant and heteronormative family ideologies that affirm biological relatedness as critical to the establishment of legitimate and genuine families (Ryan & Berkowitz, 2009).

**Background**

Over the past decade there has been a distinct increase in literature examining the experiences of lesbian mothers (for example, Bergen, Suter, & Daas, 2006; Brown & Perlesz, 2008; Dondorp, De Wert, & Janssens, 2010; Millbank, 2008; Pead & Butterfield, 2011). This is not surprising, given shifting social attitudes and the growing availability of assistive reproductive technologies that has led to a significant increase in lesbians choosing motherhood (Lee et al., 2011). Much of the literature focuses on homophobia (see, for example, Lindsay et al., 2006), outcomes for children of lesbian mothers (see, for example, McNair, Dempsey, Wise, & Perlesz, 2002, and Bos, van Balen, & van den Boom, 2007), health care (see, for example, Webber, 2010, and Lee et al., 2011), and division of labour (see, for example, Patterson, 1995, Tasker & Golombok, 1998, and Dondorp et al., 2010) in *de novo* families.

*Other* mothers are positioned as Others—that is, outside what is socially accepted and expected in relation to family construction and in particular
mothering—and because of their Other position, are “perceived as different or marginal” (Jackson et al., 2011, p. 103). Marginalization locates the other mother outside the normal, or heterosexual, family construct, and relocates her as powerless and vulnerable, essentially excluding her from the position of a legitimate mother in de novo families. This concept of “Other” and “Othering” can be used to explore the other mothers identified here. While “Other” has been primarily discussed in the literature in relation to gender, more recently, the phenomenon has been used to understand additional marginalized and vulnerable groups—for example, those from minority groups based on race, age and socioeconomic status. It would be reasonable to add sexual orientation to this list of groups who are consigned to the position of “Other.” Essentially, “Others” are those who are not ourselves (MacCallum, 2002), and are those who represent difference (Weis, 1995). While it is not the purpose of this paper to problematize the concept of Other and Othering, it is important to recognize the phenomenon in relation to the other mothers referred to in this paper as a way of understanding their resistance to social (heterosexual) expectation and simultaneously striving to achieve recognition as a member of the motherhood collective.

Other mothers can be seen as disconcerting the socially accepted and expected binary family structures that consist of one male and one female parent (Padavic & Butterfield, 2011). The unsettling of the binary gender roles by de novo families can cause social discomfort, which could lead to attitudes and behaviors that render other mothers invisible, vulnerable, and excluded, particularly in social and health care settings (Dalton & Bielby, 2000; Brown & Perlesz, 2008; Markus, Weingarten, Duplessi, & Jones, 2010; Gartrell et al., 1999). The other mother is legally disenfranchised and this can lead to her feeling “jealous, devalued, excluded and confused” (Morrow, 2001, p. 64) and socially invisible (Dalton & Bielby, 2000). Other mothers have reported exclusion and neglect by health care providers (Stevens, 1995; Dalton & Bielby, 2000) and some other mothers have found themselves essentially excluded during health care interactions (Wilton & Kaufmann, 2001).

Millbank (2009) identified the importance of validating the other mother in de novo families in a societal environment where biological motherhood is privileged over social motherhood (Almack, 2005). A social mother is not a biological mother but a mother because of the relationship she has with a child’s biological parent (Bos, van Balen, & van den Boom, 2004; Braeeways, Ponjaert, Van Hall, & Golombek, 1997) and particularly because of the mothering relationship she has with the biological children of her partner (Brown & Perlesz, 2007). Ehrensaft (2008) described the balancing act that is sometimes experienced by the other mother, who may struggle with the debate of genetic ties versus legitimacy of her role as mother, and adds that “blood ties trump social bonds” (p. 173). Other mothers must strive to develop a social mothering relationship with their child in the absence of a biological bond and genuine role models.
While other mothers experience a destabilized parental position, they are compelled to justify their motherhood more so than heterosexual fathers are required to justify their fatherhood (Bos, 2004). Other mothers may not have had lesbian mother role models from which to construct their social mothering role (Vanfraussen, Ponjaert-Kristoffersen, & Braeeways, 2003) and they are required to continually “justify their family structure” (Padavic & Butterfield, 2011, p. 17). As revealed in the literature, the invisibility of the other mother is a challenge as she struggles to legitimize her role as an authentic mother in a hetero-centric society.

Research Aim

This article explores one of the four themes generated during a study that examined the experiences of lesbian mothers in Australia. The theme that is the focus of this article pertains specifically to the experiences of the other mother in de novo families and is titled Legitimizing Our Families. Exploration of the other themes will be published elsewhere, and will include, for example, lesbians accessing health care and the journey to motherhood for lesbian couples.

METHOD

Data were collected in three ways; demographic data sheet, in-depth semistructured couple interviews, and journaling (Hayman, Wilkes, & Jackson, 2012). Interviews were the primary source of data and a story-sharing approach was employed (Hayman, Wilkes, Jackson, & Halcomb, 2012). The interviews were constructed around a framework that has, embedded within it, feminist values such as receptivity, trust, listening, subjectivity, cooperation, collaboration, and connection (Kvale, 1996). During the interviews, participants were asked to describe their mothering stories and were encouraged to share in detail their experiences. A list of questions was developed to guide the interviews; however, the couples tended to share their story chronologically once the interview began. The list was then used primarily at the end of each interview, by the interviewer, to double check that each topic had been sufficiently addressed.

Participants

A convenience sample of 15 self-identified lesbian couples who had planned, conceived, birthed, and were raising their children together was recruited through women’s health care services, lesbian publications, and snowballing. Participants were between ages 28 and 58 years (mean age 39.8 years) and 13 couples resided in urban areas. Couples came from New South Wales ($N = 9$), Victoria ($N = 4$), South Australia ($N = 1$), and Canberra ($N =$
1. Most participants identified as Australian ($N = 11$), with one Italian-Australian, one Dutch, one Filipino, and one Lebanese-Australian. They had been in their relationship for between 3 and 18 years (mean 9.6 years) and had been cohabitating for between 2.5 and 17 years (mean 9.0 years). Collectively the couples had achieved 21 term pregnancies, producing 23 children. The 11 boys and 12 girls included three sets of non-identical twins. The children’s ages ranged from 2 months to 10 years (mean age 2.6 years). Each couple’s (combined) annual income ranged from $AU23,000 to $AU400,000 (mean income $AU118,000).

Data Collection

Semistructured, in-depth interviews were conducted with participating couples between March 2010 and August 2010. The interviews were either audio-recorded ($N = 13$) or captured as text via an online messaging program (MSN instant messenger) ($N = 2$). Seven interviews were undertaken face-to-face ($N = 7$), with others undertaken via an Internet webcam program (Skype) ($N = 5$), instant messaging ($N = 2$), or via telephone ($N = 1$). The interviews lasted between 45 minutes and 2 hours (mean 81.5 minutes).

At the time of interview the demographic data sheet also was completed by each participant. This sheet collected information about the participant’s age, general geographic location, length of time in her current relationship, duration of cohabitation, employment and income, religion/spirituality, and number, ages, and gender of children.

Couples also commenced a diary, or journal entry system, after their joint interview and journaling continued for up to one month subsequently. Journaling has been described as a valid data collection method that can document specific experiences and the associated feelings (Hayman, Wilkes, & Jackson, 2012). Journaling was undertaken online via a popular social networking website (Facebook) where closed and secure pages were generated for individual participants. All but one couple had regular Internet access, so that couple engaged in an e-mail journal with the principal researcher. The frequency of journal entries varied and contributions included text, music, lyrics, photos, and drawings.

Ethical Considerations

All potential participants were provided with an information sheet that detailed the study and a consent form. All participants provided written consent prior to data collection. Ethics approval was gained from the University of Western Sydney Human Ethics Research Committee. Confidentiality has been maintained with the use of pseudonyms.
Data Analysis

Data were analyzed and coded using a process of constant comparative analysis of the interview and journal data to identify themes in the participants’ stories (Thorne, 2000). To ensure rigor, a reflexive approach promoted through reflection, journaling, and discussion within the team facilitated the raising of consciousness in relation to the researchers’ beliefs, biases, and patterns of thinking and identified how they could influence interpretation of the data. An audit trail was established to provide a clear pathway leading from the data to the themes.

FINDINGS

Role of the Other Mother in Planning, Conception, Pregnancy, and Birth

Planning

Prior to conception, most couples held lengthy discussions about who would conceive or, if both women hoped to conceive, which one would attempt pregnancy first. Jane confirmed this, stating: “Children is [sic] always something that I wanted or intended to have. So it was a conversation that we had very early on.” Decisions were negotiated based on age, health, and roles within the family. Lilly stated: “...the only reason why I thought I'd be the best one is because of my age,” and Jenny added, “[her partner] had expressed more of a desire to carry the child. I said I would if she couldn't but I didn't have that strong desire to actually carry the child.” Several couples identified as butch-femme dyads, and for those couples it was essentially unthinkable that the self-identified butch woman of the dyad would prefer to be pregnant.

Extensive dialogue also reportedly transpired between the women and their friends, potential sperm donors, and family about ovulation (patterns/cycles), sperm donor options (known or unknown), methods of conception, and pregnancy. These conversations occurred over a period of years for several of the couples, and involved substantial research, primarily via the Internet. Fran stated:

We talked a lot in the early stages about the pros and cons of what would it mean to have a child in a same sex relationship and what that would mean for a child, like would it be a fair thing to do from the child's point of view, how that might impact having two mothers and not the usual nuclear family of a mother and father, so we got literature.

Most couples also sought out other lesbian mothers to discuss their experiences.
One of the focal points of pre-pregnancy discussion was around what constituted a "suitable" sperm donor. Donor considerations included willingness for health screening, contact/role with prospective children, availability during ovulation, age, ethnicity, physical characteristics, intellect, and family health history. These were all identified as equally important issues when considering a donor. Six couples opted for a donor who had similar physical characteristics to the other mother in an attempt to produce a physical likeness between her and the child. Participants expressed that society often (from birth) made judgments about the child based on their physical characteristics. Optimizing the similarity of physical characteristics between the child and the other mother was deemed to enhance perceived familial connection and ties. This is also evidence of the couples strategically promoting connectedness and kinship between the child and the other mother.

A further consideration around sperm donation was whether to opt for known versus anonymous donation. The main concern in choosing a known sperm donor was that he might be able to lay claim to the child at a later date, could want to influence parenting choices and decisions, or could want a relationship with the child that was unacceptable to the mothers. This concern was juxtaposed with the perceived importance of the child wanting or needing to have knowledge of the sperm donor at some point. Some of the other mother participants felt very strongly about not choosing a known donor who could potentially intrude on their parental role; nevertheless most participants (N = 14, 82.3%) opted for a known donor. The rationale for choosing a known donor was described by Brooklyn in the following way: "We had to have a known donor for the child's sake. I believe he now has a choice. Just knowing where he really comes from and having that option available if he [their son] wants it." Meanwhile, Ellie stated, "We only wanted a registered donor, so that when the kids turn 18, they are able to contact him."

Conception

De novo families engaged in various strategies to achieve a pregnancy. Participants either used Assisted Reproductive Technology (ART) via fertility clinics (N = 9) or Alternate Insemination (AI) at home (N = 8). Several couples tried both AI and ART. For those who used ART, the fertility clinic arranged sperm collection and storage, as well as providing pre-conception counseling and information/education sessions, preparation for conception (for example, stimulating ovulation), insemination, as well as follow-up pregnancy testing and support. In contrast, participants described AI as a process where sperm collection and storage was negotiated privately, collected at ovulation time, and used soon after at home to inseminate the woman. For all couples choosing AI, the prospective birth mothers were inseminated by their partners.
The choice of conception method was either based on personal choice or was necessitated because of limitations like health concerns, age, availability of donor sperm, cost, and legal restrictions/reservations. Couples choosing to conceive via AI generally had no known medical (particularly gynecological) conditions that could complicate conception, pregnancy, and/or delivery, were comfortable with a known donor, had access to the donor sperm, or could not afford ART. Two couples articulated that they used AI because ART was cost prohibitive. Whatever method of conception, it was important to both mothers that the other mother was involved as much as possible in the process.

The couples choosing ART created a shared experience by attending appointments together. The other mothers collectively agreed that this was a special time that they wanted to share. The importance of both women being involved in ART conception was expressed by Kristie, who stated, “We were together, so it was so nice. It felt kind of like a joint thing we were doing” and also by Jessica, who stated, “It was nice to have someone to share it [insemination] with.” The shared experience facilitated a sense of involvement for the other mother that aimed to fortify her parental role. For most couples, the other mother was present during intrauterine insemination (IUI) or embryo transfer. However, some (N = 2) other mothers were excluded from procedures by clinic staff because they were not male partners. Exclusion was perceived by the other mothers to be based on homophobic values. Homophobia experienced by participants is addressed in more detail later.

The role of the other mother in the process of AI was determined, by all women, to be an important one in legitimizing the other mother’s role. In all cases the other mothers collected sperm and performed the inseminations. Lyn described her involvement, saying, “… I set up the room with candles and... with pillows, I did it with a syringe given to us by Jamie’s doctor. And then we did the deed and laughed a lot. And then Jamie lied [sic] there for a while with her legs in the air.”

PREGNANCY

Once a pregnancy was achieved, the other mother participants expressed a sense of connectedness with their pregnant partners. Amanda said, “We were close, I think I was supportive, we both went through it together.” The other mothers watched over their pregnant partner; made sure she ate and drank adequately, was comfortable, and rested sufficiently. The other mothers described taking on extra household chores during the pregnancy to reduce workload and stress for the pregnant partner. Eden stated, “I went into looking-after mode, so did a bit more of the cooking and stuff around the house but I certainly didn’t mind doing that. I felt it was my contribution being supportive.” Both women engaged in the preparation
stage prior to the birth. Together they purchased clothing, furniture, and baby equipment.

Birth
It was important to both partners that the other mother was present at the birth. All birth mothers gave birth in a hospital. Ten mothers had a vaginal delivery and eight delivered their babies by cesarean section, four of which were elective cesareans. All but two partners were present for the delivery. One other mother (Abbie) missed the delivery because her partner went into labour rapidly and delivered much quicker than anticipated. Abbie later said, “We’re still really disappointed, and it was seven months ago.” Another couple was separated during the delivery because the maternal grandmother (mother of the birth mother, who did not approve of her daughter’s same-sex relationship) insisted on being present for the cesarean delivery. The other mother in this dyad respectfully but regrettably allowed her partner’s mother to be present. Ellie was preparing for her cesarean delivery and had been separated from her partner during her epidural procedure. At this time she expressed anxiety about her partner missing the delivery and wondered if the staff would not try too hard to ensure Phoebe was there because they are “only a lesbian couple.” She said, “I was a bit anxious in all of that, because there’s no dad, do they just go, oh well stuff it.” Phoebe expressed that because they were a lesbian couple, the staff might not attribute the same importance to both parents being present during the delivery as they would to a heterosexual couple, in which a “dad” was available.

Participating in the labor and delivery was very important to the other mothers as it sought to justify their position as a legitimate parent. In relation to cutting the umbilical cord, Ellie said, “traditionally there is this whole thing that that’s what the other parent does, and I was the other parent, so I wanted to do that.” Lyn (birth mother) stated that she was “very happy when she saw Jamie there, she was right with me. She was scrubbed up. She was just on the other side of the door when he was getting born.” Some participants recounted that sharing in the birth of their child connected them in a new way and deepened their union. The other mothers expressed “joy” and “amazement” with the birth of their child. Brooklyn said that when she saw her son for the first time she felt “instant love.” Holly said, “He was just beautiful, and perfect and ours.”

Symbols of Family Connection
While diverse families are becoming more prevalent and socially acceptable, acknowledgement of the legitimacy of de novo families was a challenge that
participants expressed repeatedly. Conventional heterosexual-couple families benefit from assumed and socially accepted family connections while de novo families have to actively construct and then work to preserve those family connections. This burden is intensified for the other mother in de novo families, as she is often not seen by society, or even her own family, as a legitimate mother. To facilitate legitimacy, participants established symbols using ceremonies, names, and methods of formal recognition to affirm the other mother as an authentic mother and symbolise legitimate de novo family connections.

CEREMONIES

The lesbian couples were precluded from many formal ceremonies such as engagement and marriage ceremonies that legitimize their relationship. As de novo families, the women participated in ceremonies such as naming days for their children and commitment ceremonies in an attempt to symbolize their relationship and family.

NAMES

Choosing surnames for children and their other mothers was another significant strategy that de novo families used to justify their authenticity as a family. Most participants (N = 10) gave their child(ren) the surname of the other mother. Other participants opted for a double-barrelled surname consisting of both mothers' surnames. One couple used the other mother's surname as the child's middle name. Choosing names that connected the other mother and the child represented a public and tangible connection and commitment to the relationship between the two. Phoebe said that it was important for her children to have her partner's surname so that "they're always attached to her in a symbolic way." Four participants had taken on their partner's surname prior to having children and the children were subsequently given the same surname. Beth's family all share the same surname. She stated, "that way she is connected to both of us." Mae (other mother) was concerned about how she would create ties to her children. She stated, "I started to feel like I would have no connection with them and like there's nothing of me that's part of them, and I said to her really, the only thing I can think of to give them that's mine, is my surname." So Mae and Lilly's babies were given Mae's surname.

Couples also carefully considered what the child(ren) should call their other mother. The name mum or mummy was essentially assigned to the birth mother and there was a desire to not cause confusion. Therefore, names like mama, ma, daddy, first names, and non-English words for mummy/daddy (for example, "tatay," which is Tagalog for daddy and "mutti," which is German for mummy) were used. The choice of the word "daddy,"
or its alternative in another language, represents conformation to heterosexual ideals and norms. Though potentially problematic because “daddy” is used traditionally to represent a biologically male parent, the use of the word “daddy” in the *de novo* context clearly signifies a parental role that allows differentiation of two female parents. Others chose “mummy/mum” for the birth mother and “mama” for the *other* mother. Debbie and Gemma encouraged their children to use their first names to differentiate each mother. These names gave meaning and value to the *other* mother and also provided differentiation between the two mothers.

**Methods of Formal Recognition**

In recent years, Australian *de novo* families have benefited from changes to the laws allowing both birth and non-birth mothers’ names to appear on the child’s birth certificate. In 2008, the Miscellaneous Acts Amendment (Same Sex Relationships) Act 2008 (NSW) was established. The act specified that children born through ART to lesbian couples will have two legally recognized mothers. Given the retrospective nature of the act, participants were also able to have birth certificates amended (for children born prior to 2008) to reflect both mothers as legal parents. This was important to ensure both the birth mother and *other* mother had equal legal parenting rights to their children. Ellie (*other* mother) stated, “symbolically, it [having both mothers’ names] was important to me. It is public recognition that I am as much the parent as Phoebe.” This could be important if one mother (in particular the birth mother) dies or becomes significantly incapacitated, that the *other* mother is recognized as a mother and the legal guardian of her child(ren). Formal recognition is particularly important also in relation to a non-birth mother’s interface with school and health care providers for her child(ren).

**Negotiating Health Care**

When interacting with health services, participant *other* mothers reported experiencing homophobia and feeling stigmatised. The reality of negative societal attitudes caused participants to think and behave in a self-protective manner. Strategies to avoid homophobia were often a daily consideration. Some *other* mothers experienced homophobia in the form of exclusion and refusal of services. One couple described being refused fertility assistance because they were deemed to be “socially infertile” and did not have a “genuine” fertility problem. Other participants reported being excluded from fertility clinic procedures because they were not male. Another was excluded from the neonatal intensive care unit because she was “not the real mother.” The *other* mothers reported finding this frustrating and upsetting. One couple recounted being told they should try another hospital when booking in for
antenatal care because the religious ethos of that private hospital did not condone homosexuality.

Heterosexual assumptions about the women’s relationships, and identifying their partnerships as mother/daughter, niece/aunty, friends or sisters in health care environments, were considered unacceptable by participants. Jenny and Blair described a situation where hospital staff assumed they were sisters because they had the same surname. Despite regularly correcting the staff, several participants identified that health care providers would persist with calling the other mother anything but a partner; much less the child’s other mother. One couple described being shown around the labour and delivery ward of a hospital where they were planning to have their baby when the midwife asked, “Where’s the father?” The women found this question offensive because, again, it assumed heterosexual orientation. Given the assumption of heterosexual orientation, the other mother was essentially disqualified and excluded from being a legitimate partner and parent.

Heterosexism ostracizes the other mother and reduces her role from that of a mother to the equivalent of someone outside the immediate family. It minimizes her position in the de novo family and excludes her from important events that heterosexual couples expect without question. Participants identified that the joy and thrill of the new baby was sometimes obscured by the other mother’s experience of heterosexism. In all its forms, heterosexism creates barriers to effective health care for de novo families.

DISCUSSION

Essentially, other mothers participating in the study revealed that they felt a constant need to justify their position as a legitimate parent. Together with their partners, they made decisions around conception, pregnancy, and birth that promoted connectedness and familial ties. In addition, they described experiences—in particular when interfacing with health care services—that sought to dismiss societal judgment that the other mother is extraneous to her family and simultaneously resist being relegated to the vulnerable outsider or marginalized Other. Other mothers, supported resolutely by their partners, implemented conscious choices to position themselves as a genuine part of their families with legitimate parental ties with their children.

Some of the decisions participants made were done so deliberately with the express purpose of protecting and/or enhancing the parental position of the other mother and consequently resisting their positioning as the marginalized Other. Choosing a known or unknown sperm donor, actively seeking out a donor who had similar physical characteristics to the other mother, including the other mother as much as possible in the planning, conception, pregnancy, and birth of her child, choosing particular names (also identified by Almack, 2005), engaging in ceremonies, and using methods of formal
recognition where available were all decisions made by the couples to fortify the parental position of the other mother and were consistent with the findings of Bergen and colleagues (2006). In many ways, these decisions may have taken part in attempting to legitimize their families to the outside world.

Study Limitations

The main limitation of this study is the small sample size. However, the depth of data compensated for the small sample size. This limitation was anticipated by the researchers, and subsequently deliberate and careful decisions were made by the research team about when to cease data collection. Data collection was only considered complete when we were certain that data saturation had been achieved. The retrospective nature of stories means there is possibility the content or context of the story may have changed over time for the storyteller. This limitation is outweighed by the richness of the stories that allow comparison of similarities and differences across a number of participants and provide detailed description of the phenomenon under investigation.

CONCLUSION

The findings of this study have significant implications for health care providers. To achieve acceptable and inclusive health services, two strategies are required: examination of the current heteronormative social environments, and most significantly education for all service providers. Heteronormativity, for example assumed heterosexuality, limits the way health care providers are able to interact with clients and can create barriers between lesbian women and health care providers. Education for health care providers about issues specific to lesbian health care (similar to those identified by McNair et al., 2008) and methods of providing inclusive services would potentially increase the quality of health care received by lesbian women. Raising awareness of the concept of Otherness and how this phenomenon affects the way health care is delivered is another important consideration.

Like Short (2007), we found that most of the other mothers participating in the study described feeling anger at having to constantly justify their parental position but had also accepted it as part of their path to parenthood in the current social environment. Participants expressed hope that in the future, society's attitudes would change to become more inclusive and tolerant of diverse family structures.

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Community other Mothers

The following invited encyclopaedia entry (Paper G) defines and describes the role and position of the other mother in *de novo* families.
Family/Household

Community Other Mothers

Brenda Hayman/University of Western Sydney, Australia/ b.hayman@uws.edu.au

Word count 958

Main text

The term Other Mother is used to describe the non-biological female parent in de novo lesbian families in academic literature. Alternate phrases include: non-birth mother, lesbian co-parent, lesbian co-mother and social mother. Notably, the term ‘social mother’ has been used more accurately in the literature when referring to the step-mother in lesbian-headed families where the children were born during the partner’s previous heterosexual relationship. In the social context, as a child attempts to differentiate two female parents in de novo families, a variety of words and phrases are used to describe Other Mothers. For example: mum/mummy, ma, the woman’s first name, ‘daddy’, a name made-up by their child or a word that means ‘dad/daddy’ in an alternate language that is culturally significant to the family.

A de novo lesbian family refers to a family constellation that consists of two partnered women and the child(ren) they planned, conceived, birthed and are raising together in the context of their lesbian relationship. Since the 1970’s, de novo families have become more visible in society. However, language (like, Other Mother) to name various aspects, types and members of de novo families continues to emerge and therefore, a unique opportunity exists for Other Mothers and their families, to construct their own identity, role and title through language.

Other Mothers challenge hetero-normative ideologies about family and the need for biological connectedness to create a genuine family and despite increased visibility, they are often required to justify their position as a legitimate parent. Other Mothers, together with the biological mother and their children often work together to create symbols of connectedness and relationship, to gain recognition as a genuine family and the acknowledgement of the Other Mother’s position. Symbols of de novo family connection include the use of names, ceremonies and other formal means of recognition. Lesbian parents choose names for their children that demonstrate a relationship between the Other mother and the children. For example, the children are often given the Other Mother’s surname. Parents also engage in ceremonies, like baby naming days and commitment ceremonies (where same-sex marriage is not permitted by law), which also attempt to show familial connectedness. Finally, any means of formal recognition, for example official documentation on birth certificates where the Other Mother is listed as a parent, is also used.

There is some contention about the use of the term Other Mother as it may not accurately or adequately describe the existent role and position of the non-biological mother in de novo families, and in fact it may further position the Other Mother outside of the family. Use of the word ‘other’ may further marginalise her from the socially acceptable and hetero-normative construct of ‘family’ and detract from her role and position. ‘Others’ are essentially defined as not ourselves, generally represent difference and subsequently are vulnerable, excluded and invisible. Use of the term ‘Other Mother’ is not meant to infer exclusion or otherness in the context of academic literature, but in the absence of a more suitable term or until a more
appropriate word or phrase is generated, this seems to be the term most reflective of the role
and position of the non-biological mother in de novo families.

There is an abundance of research that has explored the outcomes for children of lesbian
mothers compared to the outcomes for children raised in heterosexual families. Likewise
there is a significant amount of research that has explored the role of women in de novo
families and more recently research exploring how lesbians make decisions about method of
conception and donor status. Fewer studies have been reported how lesbian women negotiate
hetero-normative spaces, for examples healthcare services and schools. Much of this
literature refers to the non-biological mother in de novo families as the Other Mother.

SEE ALSO: family, household

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Further reading

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Chapter 10

Discussion, implications, limitations and future research

Introduction

The aim of this discussion is to explain the findings of this study in relation to previous research, identify the clinical relevance of the findings, acknowledge study limitations and make suggestions for further research in this area. The following table illustrates the significant findings in relation to the identified themes, existing knowledge and extant literature. Other characteristics that make this study distinctive are that lesbian women were interviewed as couples and that a unique story sharing method for data collection was used.

Table 4: Study findings, related theme, extant literature and contribution to knowledge

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<th>Significant finding</th>
<th>Related theme</th>
<th>Extant literature</th>
<th>Contribution to knowledge</th>
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<td>Deciding and conceiving</td>
<td>Becoming mothers</td>
<td>Lesbian women carefully and</td>
<td>Confirmed that coupled lesbian women engage in many</td>
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A qualitative approach with an underlying feminist philosophy to explore the experiences of lesbian women creating *de novo* families in Australia, was used for this study. A number of data collection methods, including story sharing interviews, journaling and demographic data collection sheet were used to
illuminate the women’s experiences. Within the context of data collection, story sharing was applied and discussed in Chapters 4 and 5 (Papers A and B). Interviews provided one avenue for this story sharing. Another source of sharing stories, which enriched the interview data, was journaling by the participants. Journaling provided a means through which women related their stories and experiences of becoming and being mothers (detailed in Chapter 6 [Paper C]).

Three papers and an invited encyclopaedia entry have presented discussion of the main findings that relate to the experiences of lesbian women as couples (see Chapters 7, 8 & 9 [Papers D, E, F & G]). These papers illuminated the trajectory of decision-making processes that lesbian couples engage prior to having a child; the conception and negotiation of health services; and, provided an insight of roles within the partnership by examining the of the other mother and the *de novo* family. These findings have added to the growing literature on *de novo* families and provided recommendations that policy makers, health services and government can utilise to facilitate lesbian couples to achieve their goals of creating a family in a non-judgemental and respectful inclusive environment.

Deciding and conceiving

This study has provided the first comprehensive description of how lesbian women decide to become mothers and travel the path to conception in Australia (see Chapter 7). This journey to conception involved conscientious and careful decision-making and planning. Complex choices about which partner will conceive, the status (known, unknown or registered) of the sperm
donor and method of conception are decisions made by lesbian women embarking on motherhood. These decisions resemble those made by heterosexual women (or couples) who experience infertility (Goldberg, Downing & Richardson, 2009), however are dissimilar because lesbian women also need to determine which partner will conceive. While challenging the restrictive and rigid expectations from within some sections of the lesbian community that presumes members will not be parents, and harshly judges those who choose motherhood, lesbian women are increasingly using assisted reproductive technology.

Although the expectation that lesbians will not choose motherhood is gradually shifting as more lesbian women openly have children, there is still significant resistance to lesbian motherhood both within and outside the lesbian community (Bradford, Ryan, Rothblum & Honnold, 2013). This is juxtaposed with the ideal that all women should have children, that a woman’s worth is measured by her child-bearing capacity (Barrett, 2003) and that she is invisible in a society where the expectation is motherhood for all women. Regardless of their sexual orientation, women who choose not to have children often have to defend their decision, as they are judged as selfish, incomplete, unnatural and a disappointment (Barrett, 2003). For lesbian women, they grow-up with the expectation that, as they mature, they will follow the traditional trajectory into motherhood. This ideal is disrupted when she comes out as a lesbian, and her course is then modified to childlessness. For lesbian women choosing motherhood however, this expectation changes again, and it can be difficult for families and society to understand, accept or adjust their expectations to unanticipated motherhood.
The resistance from outside the lesbian community is based on negative suppositions about the capacity of two women to raise a child together in the context of a family, and they are often judged harshly for bringing a child into a hostile (that is, homophobic) environment. Lesbian mothers have also been criticised for choosing to have children without a father in the family. Despite this, Pacilli et al. (2011) identified that a “deviation from the traditional nuclear family does not constitute an obstacle per se to creation of a healthy family environment” (p. 581). There are actually few, if any, differences in outcomes for children raised in de novo families when compared to children raised in heterosexual families (Bos et al., 2004) and children do not experience atypical gender development as a consequence of not having a sufficient male role model (MacCallum & Golombok, 2004).

Parts of the lesbian community contemplate lesbian mothers with disdain because they consider that motherhood is inconsistent with a genuine lesbian identity that assumes compulsory childlessness (Crawford, 1987). Pacilli et al. (2011) state that while “heterosexual women are programed for reproduction and motherhood” (p. 581), lesbian women who choose motherhood, may have their true sexual orientation questioned. Siegenthaler and Bigner (2000) add that, “her lesbian community may question the authenticity of her true sexual orientation because of the presence of children in her life” (p. 80). In addition to resistance from within and outside of the lesbian community, lesbian women often struggle with their decision to become mothers because they are “… acculturated to believe that being a lesbian runs counter to being feminine, nurturing, or in a word, a mother” (Donaldson, 2000, p. 124).
Consistent with the literature most of the women participating in our study chose VI (Baetens & Breuwaey, 2001; Ben-Ari & Livni, 2006; Dunn, 2000; Marina et al., 2010; Markus et al., 2010; McNair, Dempsey, Wise & Perlesz, 2002; Pelka, 2009; Renaud, 2007; van Dam, 2004). However, other participants like those in the Nordqvist (2011) and the McNair et al. (2002) studies chose IVF or IUI because they preferred an unknown donor and/or to limit the chances of the transmission of infections. Highlighted in this study was that participants primarily preferred a known donor and to use non-medicalised procedures to conceive. While choosing an unknown donor meant that potential unwanted future contact from a donor was significantly limited and that there was much less risk of transmission of infections (because of the quarantining and testing of donor sperm prior to use) some couples were limited to IUI or IVF to conceive. These procedures were much more costly than VI which was done at home. In addition, to access IUI or IVF, some couples were required to be diagnosed as medically infertile to participate in the program. This meant that some couples did not qualify for IUI or IVF because they were socially (not medically) infertile. Conversely, choosing a known donor meant that couples, regardless of fertility, were able to choose from the three conception methods available. Interestingly, IVF and IUI were no more successful in achieving pregnancy than VI at home. This is probably representative of the women using VI being less likely to experience fertility challenges (for example, polycystic ovary syndrome or being older than 35 years).
Consistent with our findings, the literature demonstrates ongoing discrimination, in the form of homophobia, against lesbian women who seek fertility and maternity services (Herrera, 2009; Irwin, 2007; McManus et al., 2006; Spidsberg & Sørlie, 2012). In particular, Herrera (2009) found homophobia was one of the most significant challenges identified by lesbian women when interacting with health care services. Further, Dahl et al. (2013) identified that lesbian women experience difficulties when interfacing with healthcare services and professionals who feel awkward communicating with lesbian women and because their professional relationship is influenced (negatively) by their personal attitudes towards homosexual people in general. To counter homophobia in their everyday lives, Short (2007) stated lesbians construct their de novo families in a way that is meaningful to them. Lesbian women experience several types of homophobia during their interface with healthcare services and individual healthcare professionals (McNair et al., 2008). Four types of homophobia were experienced by participants in our study, namely, refusal of services, inappropriate questioning, heterosexual assumption and exclusion. While some participants readily recognised homophobia and recounted their stories, others stated initially that they did not experience homophobia. The women identified that they had in fact experienced the more subtle forms of homophobia. For example, participants were more likely to identify and share their experiences of homophobia when they were overt experiences, for example, when excluded from healthcare services because of their sexual orientation. Subtle homophobia, like intrusive questioning, was also reported by Khajehei et al. (2012) in their study of lesbian
mothers experiencing post-natal depression in Australia. More subtle experiences, like inappropriate questioning or heteronormative assumptions were less likely to be recognised as homophobia. For example, some participants may have been so emotionally invested in the birth of their child that their awareness of the attitudes of people around them was clouded or their joy allowed them to overlook inappropriate behaviour or attitudes. Other participants may have been exposed to homophobia so regularly, that they have simply become accustomed, or desensitised to it.

In addition to external homophobia displayed by others toward homosexual people, lesbian women can also experience internalised homophobia (Goldberg & Smith, 2011), referred to by Sharfstein (2012) as self-stigma. This type of homophobia represents an irrational fear or hatred of homosexuals that is instilled or inculcated by homosexual people themselves (Lewis, Derlega, Clarke & Kuang, 2006; Lingiardi, Baiocco & Nardelli, 2012; Szymanski & Chung, 2002). Experiencing self-derogatory feelings can lead to “shame, hostility, self-blame and anxiety” (Chapman et al., 2012, p. 1129) and lesbian women may have negative ideas about their capacity to be parents, due to their internalised homophobia (Pacilli et al., 2011).

Legitimacy of the other mother and the de novo family

The finding that some de novo families felt they were not perceived as being proper families is consistent with other literature (see Chapter 9) (Ben-Ari & Livni, 2006; Dalton & Bielby, 2000; Herrera, 2009). The literature also identified that being accepted as a genuine parent was particularly challenging for the
non-birth mother in de novo families and that non-birth mothers remain in a vulnerable (Cloughessy, 2010) and invisible position (Goldberg & Smith, 2008). Non-birth mothers described being excluded at times and this is consistent with Hargreaves (2006) and Morrow (2001), who identified that non-biological relationships were judged by society as being less important than biological connections within families. Further, non-birth mother participants explained that they often felt exposed, and not completely valued as a proper parent.

This study has filled a gap in the literature around how lesbian couples legitimise the non-birth mother’s role and position within the family. Legitimising the position of the non-birth mother was an especially important activity for the partnered lesbian women within this study. Strategies, such as the use of ceremonies, symbols and special names, were implemented to legitimise the non-birth mother in de novo families and demonstrated connection between children and their non-birth mother.

Our study confirmed these findings, demonstrating that the participants used such strategies to legitimise their family and in particular, the role and position of the non-birth mother. Since the 2008 legal changes in Australia, that now allow the non-birth mother to be recognised on her child’s birth certificate (McNair et al., 2008), identifying herself as the child’s legitimate parent is no longer as problematic.

**Implications of the study**

For the lesbian women who participated in this study, the journey to parenthood was laden with complex decisions and often met with negative attitudes from
their families, other lesbians and society. Despite this, the women’s stories demonstrated that lesbian women in Australia are successful in creating their much-desired de novo families. Lesbian women participating in the study had their voices heard. They were able to share their stories in a meaningful way and indeed their stories clearly demonstrated the challenges they faced when choosing motherhood, as well as the successes they experienced in creating their de novo families. These findings have established an alternate context of mothering within the community and highlighted the need for acceptance by society. Through their stories, clarification about the unique health needs of lesbian women when interfacing with healthcare services and providers were elucidated.

The need for ongoing education of health care providers and continuing policy review to promote the implementation of sensitive health care in the future will benefit lesbian women seeking healthcare. Strategies that will most benefit lesbian women are the use of inclusive language and the challenging of heteronormative attitudes and practices. Policies that require healthcare providers to be accepting of diverse family structures and education that encourages examination of heteronormative attitudes would reduce the incidence of homophobia in the healthcare environment.

Limitations of the study

In the current study, the doctoral candidate identified as a lesbian, a mother and a nurse. These identities positioned her alongside participants as an insider or native – in this case, to lesbian mothers participating in our study.
Dual identity as researcher and insider requires careful consideration and management, particularly during qualitative data collection and analysis. While this may be considered a limitation by some researchers, in this study, it was central to the story sharing method.

The major advantage of insider status was that the researcher understood the participants; the shared stories, experiences and language. The participants subsequently expressed a higher degree of comfort than if they had been interviewed by someone who was not a lesbian mother. Furthermore, knowing the interviewer was also a lesbian mother meant participants did not anticipate homophobia and this reduced overall stress and increased feelings of safety. This level of comfort meant participants felt confident to share more detailed information about their experiences, increasing the overall depth of our study findings.

Conversely, insider status also confers some potentially undesirable consequences that can significantly affect the quality of the findings. When participants are aware of the insider status of the researcher, they can unconsciously develop inaccurate expectations of what information they should, or should not, share with the researcher during data collection. For example, a participant might assume the knowledge of the researcher. Assumptions about what the researcher already knows can lead to participants omitting details from their stories. To avoid collecting cursory explanations that lead to superficial data and deficient findings, qualitative researchers who identify as insiders need to be conscientious about seeking details and explanation during interviews and other data collection activities. Additionally,
interpretation of the data was rigorous using techniques outlined in Chapter 3 of this thesis.

The sampling method in this study may have led to the recruitment of particularly vocal participants. While this may demonstrate representation of only a portion of lesbian women, their experiences would be reasonably characteristic of the population in general. Similarly, during the couple interviews, one member of the dyad may have been more vocal than the other. Caution to ensure both members of the dyad were heard during the interviews was taken by directing questions to each participant directly.

**Future research**

More research into lesbian couples creating families in Australia is needed. Research that examines how lesbian women construct motherhood would benefit lesbian women in the future by providing a better understanding of lesbian women’s needs as mothers. Further research about the experiences of the non-birth mother’s experience of becoming and being a parent and, exploration of resilience and coping in *de novo* families would provide a better understanding of these families in Australia. Finally, research that explores the experiences of children in *de novo* families and provides understanding from the perspective of the child, would create opportunities to better support children growing up in alternate family models.

From a broader perspective, examination of other non-traditional family models like foster families, adoptive families and male same-sex parented families
would be beneficial to provide a deeper understanding of the ways various types of families can be supported.

**Conclusion**

The findings of our study demonstrate that, in Australia, homophobia continues to be an influence on lesbian women and the decisions they make in regards to choosing motherhood, and their mothering experiences. Furthermore, the findings strongly indicate that lesbian women work hard to justify their family as a valid family, and in particular, seek to legitimise the role of the non-birth mother. Finally, we explored the various methods of conception that these lesbian women employ on their path to motherhood.

Strategies that promote tolerance and inclusivity need to be implemented in order to protect and meet the needs of this vulnerable population, especially in healthcare environments. The planning of health and community services needs to be sensitive to both overt and subtle homophobia. Challenging heteronormative thinking about individuals and families is important as it will reduce assumptions about a person’s sexual orientation and moderate preconceived ideas about lesbian mothers and their families.

Despite criticism from the wider community; inclusive of healthcare providers, the stories recorded in this thesis have shown the strength and resilience of the lesbian women participating in our study. While the complexity of decision-making and the experiences of homophobia and heteronormativity generated challenges, the women effectively formed their *de novo* families. They successfully negotiated a variety of choices about method of conception and...
donor status, and engaged in activities that legitimised the role of the non-birth mother in their families. Finally, the lesbian women participating in our study implemented strategies that were perceived to promote safety when interfacing with healthcare providers and some identified as crusaders and took opportunities to educate the community about their families.
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and constructed meanings of biological and non-birth lesbian mothers. 

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Appendices

Appendix i: Acceptance letters

Paper D
Lesbian women choosing motherhood: the journey to conception

Paper G
Community Other Mothers
03-May-2014

Dear Ms Hayman:

Ref: Lesbian women choosing motherhood: the journey to conception

Thank you for submitting your revised manuscript. I am pleased to accept your paper in its current form for publication in the Journal of GLBT Family Studies. I will now forward the manuscript to the publisher for copy editing and typesetting. I have attached the copyright form for your to complete and return to the email address listed in the signature.

You will receive proofs for checking in due course. The publisher requests that proofs are checked through the publisher’s tracking system and returned within 48 hours of receipt.

Congratulations on your publication and thank you for your contribution to Journal of GLBT Family Studies. We look forward to receiving further submissions from you.

Sincerely,
Dr M. Paz Galupo
ETC. Journal of GLBT Family Studies
glbtfamilystudies@towson.edu
Dear Miss Hayman:

Your revised entry entitled "Community other mothers" by Hayman, Brenda, has been successfully submitted online and is presently being given full consideration for publication in The Wiley-Blackwell Encyclopedia of Gender and Sexuality Studies.

Co-authors: Please contact the Editorial Office as soon as possible if you disagree with being listed as a co-author for this manuscript.

Your entry ID is GSS-0253.R1.

For your reference: the entry number of the PREVIOUS manuscript version is: GSS-0253.

Please mention the above entry ID in all future correspondence. If there are any changes in your street address or e-mail address, please log in to Manuscript Central at http://mc.manuscriptcentral.com/gendersexualityencyc and edit your user information as appropriate.

You can also view the status of your entry at any time by checking your Author Center after logging in to http://mc.manuscriptcentral.com/gendersexualityencyc.

Thank you for submitting your entry to The Wiley-Blackwell Encyclopedia of Gender and Sexuality Studies.

Sincerely,
J. Michael Ryan
Managing Editor
The Wiley-Blackwell Encyclopedia of Gender and Sexuality Studies

Date Sent: 11-Mar-2014
Appendix ii: Flyer
Research: Lesbian mothering

Lesbian mothers who have planned, conceived and are raising children together are required for a study that aims to identify how lesbian couples construct mothering. Participants will be asked to participate in an interview with the researcher, journal (online) their mothering experiences over a one month period and complete a demographic data collection sheet. ALL information collected will be kept strictly confidential. Participants will be over the age of 18 years and be able to speak and read English. If you AND your partner are interested in participating in this study, please contact Brenda Hayman on 0407 845 995 or via email at b.hayman@uws.edu.au Ethics approval for this study was sought and approved by the UWS Human Research Ethics Committee. The approval number is H7472
Appendix iii: Interview guide
Appendix 3: Data instrument - Interview questions

The questions will begin by asking the couple about their mothering journey, for example:

When did you start to talk about having a child?
What was the content of that conversation?
How did you both feel about being a mother at that time?
What expectations did you both have at that stage?
What experiences had you both had of mothering at that stage?
If you could have defined mothering then – what would you have said, how is that different to now?
What were the topics of discussion in regards to having a child?
What were the ‘hot’ topics for both of you and individually?
What plans (if any) did you make in order to prepare for pregnancy?
Were there any challenges at this stage?
How did you feel once you had decided to go ahead and have a baby?
How did you go about conceiving?
What was the process?
What did you learn about the process, pregnancy, your bodies, your partner etc along the way?
Tell me about the experience of pregnancy for you both.
What was antenatal care for you both?
What was the brightest moment?
How do you feel about being a mother?
What is the best thing about being a mother?
What is the most challenging thing about being a mother?
What is the most challenging thing about being a lesbian mother?
Do you interact/socialise with other lesbian/non-lesbian mothers?
Is your mothering different to heterosexual mothering? If so, how?
What makes you a mother?
Are you both comfortable with the term mother? If not – what is your preference?
Is one parent the primary carer?
How do you divide paid and unpaid work in your family?
How do you organize your family and roles within your family?
Do you both interact in similar ways with your child(ren)?
Are your relationships with your child(ren) different – what the strength and challenges of each relationship and what makes them strengths and challenges?
Do you have an awareness of how other mothers perceive you? If so, what do you think they think?
How do you relate to other mothers?
Are you always 'out' about your relationship and family? Why or why not?
Do you experience any challenges with schooling or accessing healthcare for your child(ren)?
Are there any other challenges?
Appendix iv: Participant information sheet
Participant Information Sheet (General)

An information sheet, which is tailored in format and language appropriate for the category of participant - adult, child, young adult, should be developed.

Note: If not all of the text in the row is visible please 'click your cursor' anywhere on the page to expand the row. To view guidance on what is required in each section ‘hover your cursor’ over the bold text. Further instructions are on the last page of this form.

Project Title: Choosing parenthood: a collective case study of lesbian mothering

Who is carrying out the study?
You are invited to participate in a study conducted by Ms Brenda Hayman, PhD candidate at the School of Nursing and Midwifery at the University of Western Sydney. Brenda is supervised by Professors Lesley Wilkes and Debra Jackson.

What is the study about?
The aims of this project are to: illuminate the concept of ‘family’ for lesbian couples, identify the processes by which lesbians conceive, understand their experiences with health-care services pre and post-natally and describe their mothering journeys. Case study design will be used and the method of data collection will be via in-depth, semi-structured interviews, field notes, journaling and questionnaire. Data will be examined for recurring themes and the themes analysed in the contexts of lesbian mothering and the local health-care system.

What does the study involve?
Participation in the study involves three things:
1. A audio-taped interview with the researcher that will last between one and two hours. The interview will take place in a mutually agreeable location for the you and the researcher,
2. Completion of a demographic data collection form and
3. Contribution to an online journal to describe your mothering experiences.

How much time will the study take?
The interviews will take between one and two hours and will include completion of the demographic data collection form. The online journaling can take up to several hours depending on the quantity of individual contributions.

Will the study benefit me?
Lesbian mothers participating in the research will have the opportunity to have their thoughts and feelings associated with their mothering heard and validated and also to gain a deeper understanding of their own experience by detailing these experiences together (as a couple) and with the researcher. The findings of the research may promote feelings of connectedness and community amongst lesbian mothers and provide opportunities for learning new or different ways of mothering. Increasing knowledge about lesbian mothering may disrupt phobias and discrimination within and outside of the lesbian community. Increased knowledge and understanding about how lesbian couples go about planning, conceiving and parenting their children will
benefit other lesbian couples (with or without children) and the community as a whole. The challenges and benefits of lesbian mothering may also be elucidated in the findings and this should promote understanding and tolerance. Promoting understanding and tolerance in the community may reduce homophobia, increase equitable access to quality health-care and increase validation of lesbians as mothers and their families.

Will the study involve any discomfort for me?
The possibility of reliving certain events may be emotionally distressing to some participants. A list of counsellors and their contact details will be provided to each participant. A list of interview questions will be provided prior to the interview. Where certain illegal activity is disclosed, the researcher is required to disclose this activity under mandatory reporting legislation.

How is this study being paid for?
The student is being supported by the School of Nursing and Midwifery at the University of Western Sydney. There is no other funding or grant to support this project.

Will anyone else know the results? How will the results be disseminated?
All aspects of the study, including results, will be confidential and only the researchers will have access to information on participants.

Can I withdraw from the study?
Participation is entirely voluntary; you are not obliged to be involved and - if you do participate - you can withdraw at any time without giving any reason and without any consequences. Due to the nature of the study focusing on ‘couples’, if you withdraw, your partner will also be withdrawn.

Can I tell other people about the study?
Yes, you can tell other people about the study by providing them with the chief investigator’s contact details. They can contact the chief investigator to discuss their participation in the research project and obtain an information sheet.

What if I require further information?
When you have read this information, Brenda Hayman will discuss it with you further and answer any questions you may have. If you would like to know more at any stage, please feel free to contact:
Brenda Hayman 0407 845 995
Professor Lesley Wilkes 47 343 181
Professor Debra Jackson 46 203 532

What if I have a complaint?
This study has been approved by the University of Western Sydney Human Research Ethics Committee. The Approval number is [enter approval number]

If you have any complaints or reservations about the ethical conduct of this research, you may contact the Ethics Committee through the Office of Research Services on Tel 02-4736 0883 Fax 02-4736 0013 or email humanethics@uws.edu.au.

Any issues you raise will be treated in confidence and investigated fully, and you will be informed of the outcome.

If you agree to participate in this study, you may be asked to sign the Participant Consent Form.
Appendix v: Participant consent form
Participant Consent Form

This is a project specific consent form. It restricts the use of the data collected to the named project by the named investigators.

**Note:** If not all of the text in the row is visible please 'click your cursor' anywhere on the page to expand the row. To view guidance on what is required in each section 'hover your cursor' over the bold text.

**Project Title:** Choosing parenthood: a collective case study of lesbian mothering.

I, ........................................, consent to participate in the research project titled: Choosing parenthood: a collective case study of lesbian mothering.

I acknowledge that:

I have read the participant information sheet and have been given the opportunity to discuss the information and my involvement in the project with the researcher/s.

The procedures required for the project and the time involved have been explained to me, and any questions I have about the project have been answered to my satisfaction.

I consent to participating in an interview with the researcher that will be audio-taped, completing a brief demographic data form and contributing to an online journal about my mothering experiences.

I understand that my involvement is confidential and that the information gained during the study may be published but no information about me will be used in any way that reveals my identity.

I understand that I can withdraw from the study at any time, without affecting my relationship with the researcher/s now or in the future.

I understand that my partner and I will be interviewed together as a couple and that if I withdraw, my partner will be withdrawn as well.

Signed:

Name:

Date:

Return Address: Ms Brenda Hayman
PO Box 555
Toongabbie NSW 2146
Appendix vi: Demographic data collection sheet
Demographic data collection

Names
Birth mother: Pseudonym Age:
Non-birth mother: Pseudonym Age:

General geographical residential area
Sydney metro □
Western Sydney □
Northern beaches □
South Sydney □
Other: __________________________

Length of time in relationship

Length of time cohabitating

Children residing in your home
From this relationship:
Age(s) and gender(s):

From previous relationship:
Age(s) and gender(s):

Your other children

Your level of education
Birth mother:
Non-birth mother:

Your work
Birth mother:
Non-birth mother:

Your combined annual family income:

Your cultural background/place of birth
Birth mother:
Non-birth mother:

Your religion
Birth mother:
Non-birth mother:

Your home
Renting:
Buying:
Other
Appendix vii: Ethics approval
From: Kay Buckley  
Sent: Friday, October 23, 2009 11:53 AM  
To: Debra Jackson;  
87506105@student.uws.edu.au<https://email.uws.edu.au/owa/UrlBlockedError.aspx>  
Subject: HREC Approval H7472

Notification of Approval

Email on behalf of the UWS Human Research Ethics Committee

Dear Debra and Brenda

I'm writing to advise you that the Human Research Ethics Committee has agreed to approve the project.

TITLE: Choosing parenthood: a collective case study of lesbian mothering

H7472 Student: Brenda Hayman (Supervisor: Debra Jackson)

The Protocol Number for this project is H7472. Please ensure that this number is quoted in all relevant correspondence and on all information sheets, consent forms and other project documentation. Please note the following:

1) The approval will expire on 31 December 2009. If you require an extension of approval beyond this period, please ensure that you notify the Human Ethics Officer (humanethics@uws.edu.au<https://email.uws.edu.au/owa/UrlBlockedError.aspx>) prior to this date.

2) Please ensure that you notify the Human Ethics Officer of any future change to the research methodology, recruitment procedure, set of participants or research team.

3) If anything unexpected should occur while carrying out the research, please submit an Adverse Event Form to the Human Ethics Officer. This can be found at http://www.uws.edu.au/research/ors/ethics/human_ethics<https://email.uws.edu.au/owa/UrlBlockedError.aspx>

4) Once the project has been completed, a report on its ethical aspects must be submitted to the Human Ethics Officer. This can also be found at http://www.uws.edu.au/research/ors/ethics/human_ethics<https://email.uws.edu.au/owa/UrlBlockedError.aspx>

Finally, please contact the Human Ethics Officer, Kay Buckley on (02) 4736 0883 or at k.buckley@uws.edu.au<https://email.uws.edu.au/owa/UrlBlockedError.aspx> if you require any further information.

The Committee wishes you well with your research.

Yours sincerely

Kay Buckley
Executive Officer
On behalf of the Human Research Ethics Committee

Kay Buckley
Human Ethics Officer
University of Western Sydney
Locked Bag 1797, Penrith Sth DC NSW 1797
Tel: 02 47 360 883
Appendix viii: Counselling and support services
Family Counseling Services

Auburn Community Health Centre
9 Northumberland Road, Auburn NSW, 2144
Phone: 9646 2233
Fax: 9749 1749

Blacktown Community Health Centre
Unit 1, Cnr. Marcel Crescent and Blacktown Rd, Blacktown NSW, 2148
Phone: 9881 8700
Fax: 9671 6360

Mt Druitt Community Health Centre
Cnr. Burran Close and Kelly Close, Mt Druitt NSW NSW, 2160
Phone: 9881 1200
Fax: 9881 1401

Hills Community Health Centre
183-187 Excelsior Avenue, Castle Hill, NSW, 2154
Phone: 8853 4500
Fax: 8853 4565

Merrylands Community Health Centre
14 Memorial Avenue, Merrylands, NSW, 2160
Phone: 9682 3133
Fax: 9897 3313

Parramatta Community Health Centre
158 Marsden Street, (Cnr Marsden and George Streets) Parramatta NSW, 2150
Phone: 9843 3222
Fax: 9891 2825

Dundas Community Health Centre
12 Sturt Street, Dundas NSW, 2177
Phone: 9638 6866
Fax: 9684 2058
Gay and lesbian Health Victoria

Please send us an email info@ghv.org.au

or telephone 03 9285 5382
Unifam

2 Warwick Street, Penrith
Parramatta

Phone: 4732 3836
Phone: 9891 1628

Salvation Army

Suite 15, Lethbridge Court
Cnr Castlereagh & Lethbridge Sts, Penrith
27-31 Rudd Rd, Leumesn

Phone: 4731 1554
Phone: 4731 1554

Information and Referrals

Mental Health Info & Referral Service
(12:30pm – 4:30pm)

Phone: 1800 674200

NSW Family Services Inc.

Phone: 8512 9850

Aboriginal Children’s Services

Phone: 9698 2222

Migrant Resource Centers

Blacktown
Hills/Holroyd/Parramatta

Phone: 9621 6633
Phone: 9687 9901

Gay and lesbian support services

Gay and lesbian counseling service of NSW

Tollfree: 1800 18 4527