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Research paper

Perspectives from lesbian women: their experiences with healthcare professionals when transitioning to planned parenthood

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What is known on this subject
- Homophobia and heteronormativity both feature in healthcare provision for lesbian women.
- Planned lesbian-led families are increasing in numbers and therefore deserving of further research.
- The transition to parenthood is a challenging time for heterosexual couples. However, less attention has been paid to lesbian couples' experiences of this time.

What this paper adds
- It furthers our knowledge and insights into the provision of healthcare for lesbian-led families.
- It explores the role of healthcare professionals in providing equitable, inclusive and safe healthcare for lesbian-led families.
- It provides specific information on the impact of the transition to parenthood on lesbian couple relationships.

ABSTRACT

Lesbian women experience challenges within the healthcare arena related to their sexual orientation and its acceptability within society. But what happens when lesbians have children together? How do healthcare professionals respond to this difference? And what is the impact of this on lesbian couple relationships? This study explored the perspectives of lesbian women transitioning to planned parenthood in relation to their experiences with healthcare professionals in a heteronormative healthcare system. Eight women in three New Zealand cities were interviewed as part of a wider study of lesbian women's experiences of planned parenthood and the impact of the transition to parenthood on couple relationships. Qualitative data were analysed using a general inductive approach. Queer theory was used as a theoretical framework to interpret the findings. The participants' experiences of healthcare professionals' responses ranged from positive and affirming to insulting and homophobic. Recommendations are made in relation to educating healthcare professionals about the validity of the lesbian-led family and increasing their awareness when dealing with this unique family structure.

Keywords: healthcare professional, lesbian couple, planned parenthood, queer theory, relationships, transition

Introduction

Historically, lesbian women parented children from their past heterosexual relationships in stepfamily-type formations (Bos *et al*, 2007). More recently, lesbian couples have started to plan their own families using donor insemination, with one member of the couple being the biological parent (Golombok, 2000). Such changes in family structures can be expected to have an impact on the couple relationship.

This paper reports the findings from a wider study (O'Neill *et al*, 2012) about lesbian women's reports of their interactions with healthcare professionals. This study follows previous research, including lesbian women's experiences of maternity care in the UK (Wilton and Kaufmann, 2001), their experiences of childbirth (Buchholz, 2000), and heteronormative communication with lesbian families over the transition to parenthood (Röndahl *et al*, 2009). Although this literature has acknowledged lesbian perspectives on health and maternity care, the current study aimed to add specific knowledge of the impact on their couple relationships.

Transitioning to parenthood

The transition to parenthood commences at conception and continues through the first few months following a baby's birth; it is a major occurrence in the relationship (LeMasters, 1957; Goldberg, 1988). Heterosexual couples struggle with issues related to role polarisation post-birth (Katz-Wise *et al*, 2010). For example, a study of relationship quality by Kurdek (2008) found that heterosexual couples reported a marked decline in their relationship following the birth of their first child, with another decline towards the end of the 10-year period surveyed. A quantitative study by Goldberg and Sayer (2006) of 29 lesbian couples revealed that these couples experienced similar relationship changes and increases in conflict with the transition to parenthood.

Lesbian-led families are seen as deviating from the norm. For this reason they are researched from a perspective which assumes that heterosexual families are superior (Stacey and Biblarz, 2001). According to Golding (2006), because lesbians are raising children in a society where lesbians are perceived as deviant, this complicates the process of becoming a parent. Research has focused on the similarities between heterosexual and lesbian mothers to avoid criticism of the lesbian-led family (Vanfraussen *et al*, 2003). Dempsey (2010, p. 1151) discussed the 'reproductive relationship' whereby parenting responsibilities do not rely on biological links. Lovelock (2010) affirmed that lesbian and gay families reject the notion that biological connections to children are important in the role of parenting.

The theme of *heteronormativity* and homophobia is constant throughout the literature; differences between lesbian-led families and heterosexual families relate to the pressures that the former experience with regard to heterosexual dominance (Bos *et al*, 2007; Ryan and Berkowitz, 2009; Bos and van Balen, 2010). Although the differences in terms of family functioning appear to be minimal, the healthcare needs of lesbian women and their families are unique, as they face stressors and challenges that heterosexual families do not. Lesbian couples undergo changes similar to those reported by heterosexual couples, including lack of sleep, changes in patterns of socialising, changes in sexual relationships, and prioritising the role as a parent over that as a partner (O'Neill *et al*, 2012). Heteronormativity featured over the transition to parenthood and to the detriment of their intimate relationship.

Heteronormativity and healthcare

Heteronormativity refers to embedded social, cultural and institutional norms that affirm homosexuality as abnormal and heterosexuality as natural and normal (Warner, 1993). Assumptions that are made about gender and heteronormativity negatively influence the care of lesbian women (Beagan *et al*, 2012). For instance, gay men and lesbians have higher rates of mental health disorders, self-harm and suicide attempts (King *et al*, 2008), due to the effects of homophobia (Meyer, 2003; Meyer *et al*, 2007; Cochran *et al*, 2003; Cochran and Mays, 2009; Kertzner *et al*, 2009; Lewis *et al*, 2006). According to Weber (2008), gay men and lesbians who experience high levels of homophobia also have significantly higher rates of drug and alcohol abuse.

Despite relevant health-related factors among the gay and lesbian population, Markus *et al* (2010) suggested that health practitioners may be unaware of their patients' non-heterosexual identity. The fact that lesbian women often 'pass' as heterosexual means that their invisibility is perpetuated (Mohr and Daly, 2008, p. 990), and they have to make decisions about whether to make multiple disclosures of their lesbian identity to healthcare professionals at the time of planning and conception, during pregnancy, at childbirth and while parenting (Steele *et al*, 2008). St Pierre (2012) has discussed the ways in which lesbian women disclose their identity to healthcare professionals, and she concluded that a lesbian woman will be explicit in her disclosure of her identity if the attitudes and behaviour of the health professional make her feel that it is safe to do so.

The research aim

The overall study examined lesbians' transition to parenthood. This paper presents findings related to lesbians' perceptions of healthcare professionals.

Method

Ethical considerations

Lesbians are a vulnerable group, so care must be taken to reduce susceptibility to harm during the research process (James and Platzer, 1999). A participant information sheet outlined the risks and benefits of the research. Potential participants were given the opportunity to ask questions about the research before signing the consent form. In order to maintain confidentiality, participants were assigned pseudonyms by the researcher; these were used in all data collection and transcripts. Confidentiality was maintained further by excluding the names of the participants' children, their partners, their age and any other identifying information. Data were stored on a password-protected computer and only viewed by the researcher and her supervisors. The University of Auckland Human Participants Ethics Committee approved the study (Reference number 2010/357).

Recruitment and participant characteristics

In order to contact possible participants, an advertisement was placed on an Internet site for female same-sex parents, and in a local women's centre. The advertisement described the study and invited lesbian women to contact the researcher for further information. Eight women who identified as lesbian and as having been in, or currently being in, a lesbian relationship where they had chosen to have a family together and conceived through artificial insemination, agreed to participate. All of the women identified themselves as being of European descent and had completed university study; six had Diplomas and two had Master's degrees. Their ages ranged from early thirties to late forties, and they lived in or around three of New Zealand's major metropolitan cities. Two of the women were non-biological mothers, five were biological mothers, and one woman was both a biological and a non-biological mother. The age of the participants' children ranged from 9 months to 12 years.

Data collection

The first author conducted the interviews in participants' homes and in one workplace. The interviews were semi-structured and the questions were open-ended (see Box 1). This enabled the researcher to obtain specific information and participants to provide information from their own experiences and views on the subject. Consent was sought for the interviews to be recorded using a digital voice recorder. Interviews were transcribed verbatim. The data reached saturation after three interviews, and continued to be replicated throughout the remaining interviews.

Data analysis

A general inductive approach (Thomas, 2006) was used to analyse the data. This approach allows the research findings to emerge from the data without the restrictions associated with a specific methodology. Each interview transcript was read several times and sections of the text were assigned codes for easy reference. All of the codes were placed into nine broad categories. Data were further refined and finally three main themes emerged, namely *planning a family*, *impact of baby on the relationship* and *responses of others*. The latter category particularly concerned the way in which lesbian women perceived health professionals' responses, and is the focus of this paper.

Queer theory

Queer theory was used as a theoretical framework to interpret the findings. It originated from work by Teresa De Lauretis (1991), and is characterised by a number of different theories, all of which use the description of *queer*. For this reason, queer theory merges with other theoretical viewpoints, such as feminist theory and its many earlier contributors (Jagose, 1996). Queer theory embraces the complexity of identity and rejects the idea that people can fall into categories or be labelled, and it can assist in examining ways in which sexual or gender differences are discussed (Henderson, 2003) and in exploring power dynamics (Watson, 2005). Oppression and identity can therefore be viewed through the queer lens. For

Box 1 Examples of semi-structured interview questions

Can you tell me what your experiences were with nurses and healthcare professionals:

(a) during the time you (or your partner) were planning pregnancy
(b) on becoming pregnant
(c) during pregnancy
(d) after having had a baby?

How did these experiences impact on your relationship?

this reason, queer theory has a place in the agenda of examining family, and the forging of social relationships (Henderson, 2003), and as Minton (1997) has suggested, it focuses on universalising issues within the context of sexual diversity.

Queer theory aims to deconstruct and destabilise the idea of fixed sexual and gender identities, thus prompting examination of identity politics (Lovaas *et al*, 2006). Butler (1990) suggested that women perform in ways they believe they should because of social stereotyping; sex and gender are a production of heteronormativity (Lloyd, 2007). Two women who choose to have children must involve a third party who is then linked, biologically, to the family (Folgero, 2008). Genetic and biological parenthood, as well as female and male roles, are disrupted. Lesbian couples who transition to parenthood fall outside the dominant construction of what is family.

Reflexivity

In terms of integrity, a clear and honest approach towards research is imperative (Watts, 2008). Transparency about holding multiple and shared positions is essential for increasing rapport between the participant and researcher (Almack, 2008). There is ongoing debate about whether it is necessary for researchers to identify their own sexual orientation in studies related to sexuality (Almack, 2008). Given this debate, the first author chose to declare, prior to interviewing, that she was a lesbian, a nurse, and in the process of planning a family. The participants commented that this knowledge reassured them that their lesbian cultural perspective was understood.

Reflexivity relates to the intentional or unintentional influences that are involved in the research process and influence research findings (Jootun *et al*, 2009). Queer theory's role in reflexivity relates to complexities associated with researcher identity (McDonald, 2013). Queer reflexivity requires the researcher to consciously decide whether to disclose or hide their sexual identity. This can change the research process and the relationship between researcher and participant, particularly in relation to power. In developing reflexivity in the current study, the first researcher explicitly identified assumptions relating to the research topic, for instance, that 'lesbian relationships should be, but are not, valued equally to heterosexual relationships.' Such assumptions were used in the reflexive analysis process to challenge interpretation of data. The data analysis process was also overseen by the second and third authors, who played a role in linking queer theory to the participants' experiences.

Findings

The findings are discussed in relation to five interrelated themes, namely couple affirmation, seeking allies, devaluing the couple, power and the full disclosure.

Couple affirmation

Although responses to the lesbian-led family by healthcare professionals were varied, most of the participants reported a positive experience. For example, Alex reported that 'in hospital during the birth and that kind of thing, it was a real acknowledgement that we're both parents.' Leah found it helpful that her relationship was respected in that no one referred to the 'daddy'; she felt protective of her partner being recognised as a parent despite being a non-biological mother. It was important that participants felt an acceptance of their lesbian relationship, without it being examined or judged through the imposition of healthcare professionals' heteronormative assumptions.

Alex emphasised that the recognition of both her and her partner as being the parents made them feel safe and comfortable. She acknowledged that this 'safe' response had been influenced by the steps taken by other lesbians who had previously forged the way, resulting in wider change and acceptance of their identity as parents, not only in the health environment but also in wider society. These women who had started lesbian-led families or raised children within lesbian relationships were felt to be instrumental in making Alex's more recent experience with healthcare professionals acceptable and non-discriminatory: 'And I think it's really changing, the world actually. And I think we need to acknowledge people who have come before us.'

Seeking allies

The participants noted that some healthcare professionals were more lesbian-friendly than others. Some responded naturally, creating a sense of safety:

> We had a very good obstetrician, he was very up front and supportive. ... I felt very comfortable with him. We had a nurse there who was clearly against the idea and quite quickly she made her feelings known. And we stopped having anything to do with her.
>
> (Karen)

Participants reported actively seeking healthcare professionals who were known to be sensitive and friendly towards lesbian couples, or who were out as lesbians themselves. The proactive approach to finding lesbian-

friendly healthcare professionals was aimed at protecting themselves from homophobia:

> A friend of ours was a midwife, so she had mates who she recommended. ... There's actually quite a few of them out there ... we had recommendations from [a family group for gay parents], mums as well, who'd used lesbian midwives.
>
> (Natalie)

Other lesbian-friendly professionals were encountered by chance. Karen and Laura accidentally came into contact with empathic staff, having previously encountered other healthcare professionals who had been involved in unsatisfactory and judgemental care: 'there was one woman there ... she was a lot more friendly with me so we just worked through her' (Karen).

Devaluing the couple

Three participants reported negative experiences of healthcare. Another felt that her healthcare experience had been positive since her relocation to New Zealand, but nevertheless she had had experiences of inappropriate or judgemental care in her country of origin.

The challenges associated with negative encounters were demeaning and harmful:

> And the nurses were awful. There were two in particular, one who was very religious and I don't know what the other one's excuse was. ... And then, by chance we got a different nurse to do the procedure. And she was gorgeous. She was just lovely. She was so the opposite of [nurse who was hostile] and that was when I conceived.
>
> (Laura)

The following quote illustrates a heteronormative experience encountered when Laura and her partner were interviewed by a social worker in New Zealand to decide whether they were suitable candidates for becoming parents:

> She had the most appalling ideas about lesbian relationships ... she said things during the interview like 'It would be better for the child if you found someone in the pub, slept with them and got pregnant, because at least then your child would know who the father was ... least then your child would have a father.
>
> (Laura)

To Laura and her partner, this experience was 'appalling.' The social worker highlighted heteronormativity by emphasising the importance of having a 'father' and encouraging conception through male–female sexual intercourse, which was very offensive to the couple. The emphasis on biology and genetic links was seen to be more important than the parenting relationship. This experience demonstrates how lesbians receive overt or subtle messages that their relationships are substandard, inferior and unnatural.

Natalie gave another example of heteronormativity, again in an interview with a social worker assessing her suitability to adopt her own child. Natalie was not the legal guardian at this time because she was not the birth mother: 'She asked us the most inappropriate questions ... we felt like she was kind of, almost looking for something that wasn't there' (Natalie).

Devaluing of the couple included inappropriate questions and suggestions by the healthcare professionals which participants were then forced to defend and justify. The possible consequences of challenging this heteronormative treatment could affect their chances of beginning fertility treatment, conceiving or adopting a child.

Heteronormativity was also apparent within the hospital setting. Laura, a birth mother, described feeling that she was devalued and not fully accepted as a mother post-birth, at a time when both she and her partner should have been receiving optimum care and support:

> At the hospital people were fine but abrupt. You know, they were kind of like, 'OK, what are you doing with a baby? Oh. OK, all right then.'
>
> (Laura)

For the participants who had reported negative or harmful experiences of contact with healthcare professionals, not acknowledging their partner or lesbian status was found to be very unhelpful. This was a denial of their sexuality and their identity, and ultimately devalued the essence of their coupledom. This was apparent in Lila's recollection of her contact with a doctor:

> I said, [name of] my partner, but she's not here, and there's just a blank, there's just a blank and it's non-existent.
>
> (Lila)

This type of response acted as a stressor for the couple at a time when they were at their most vulnerable and, at times, powerless.

Power

Despite the poor treatment that Lila was subjected to, and a lack of acknowledgement of her partner, she was unable to call this to the healthcare professional's attention. This was because she was struggling with her child being ill and needed to prioritise the 'fight' to focus on her child's health. The power imbalance meant that some participants were unable to voice concerns about their treatment and the power that was held over their reproductive opportunities. Thus they

were effectively silenced. Laura, too, acknowledged this power dynamic:

> But it was just because [nurses] had so much power over our lives that really mattered. You know right down to whether we even conceived or whether we are allowed in the programme.
>
> (Laura)

Laura's difficulties related to the nurses who were 'awful' in their treatment and care of her and her partner; their relationship was not respected. Laura also encountered homophobic attitudes from a social worker who was assessing them for fertility assistance at a clinic that they were hoping to use. Laura stated that, for her, the balance of power led her to acquiesce to poor treatment so as not to upset the process they were trying to navigate:

> And we just had to ride with that because if I'd fought against it, she had too much power in the situation.
>
> (Laura)

The sense that Laura and her partner were not 'doing things properly' according to the heteronormative world view added to a feeling of perpetual marginalisation, placing undue stress on the relationship:

> She [the social worker] was derogatory in ... just this sort of attitude ... that I was a lesbian mum. It was kind of like I wasn't doing things properly ... it was kind of like we were odd, but we were then more odd.
>
> (Lila)

The process that Laura was navigating at the time included invasive procedures, as well as reliance on nurses for clear and honest information, which she was not given. The added pressure for some participants related to the feeling of undergoing constant scrutiny and judgement by the heterosexual community, and particularly by healthcare professionals.

The full disclosure

According to Rose, 'We just have to go with the full disclosure.' For her, healthcare professionals' assumptions of heterosexuality meant having to be 'quite up front.' The emphasis on 'having to' suggests the inevitability of what Rose must do to ensure the care of her family. The assumption of heterosexuality is never more apparent than when a child is involved. The participants had to stipulate and clarify their relationship to their own child, with biology being a specific part of their disclosure process. Most of them adopted an upfront approach as a way of reclaiming their personal power within a disempowering healthcare system:

> When we take our children to the doctor, we're just really up front – this is [name of child] and he's got two mums and [partner] gave birth.
>
> (Alex)

> There's still that thing though, that you always have to come out. It's painful and boring.
>
> (Leah)

A common thread in the findings was the emotional energy required to constantly come out or remain closeted. These experiences consistently undermined couples, their relationship, and their relationship to their child. Alex described how the heteronormative responses desexualised their relationship when healthcare professionals assumed that just one member of the couple was the child's parent when the couple were of the same sex. Lila referred to being 'eunuchified', saying 'people turn you into a eunuch. They desexualise your relationship.' This was reported by other participants, who stated that members of the public and healthcare professionals assumed that the woman's partner was a friend, an aunt, a sister or, in one case, the 'nanny.'

> And I think [doctor] kind of looked at us like 'What are you both doing sitting here, why are you both answering those questions?'
>
> (Alex)

Alex's experience also reflected another aspect of her contact with this doctor, the coming out experience. As she explained, the monotony of coming out frequently led her to feel that this was not necessary, yet without disclosure the relationship with the doctor would be compromised. There was also the potential for tension between the couple with regard to their biological parentage status and one parent being favoured over the other by healthcare professionals.

In summary, lesbians experience institutional heteronormativity and homophobia in their contact with healthcare professionals who devalue their couple relationship. Through attempting to acquire allies, lesbians aimed to protect themselves and their family when they had to constantly fully disclose their family structure. Power was found to be an important factor in lesbians' experiences of healthcare.

Discussion

Participants with babies and children under 6 years old generally reported positive experiences of care during the transition to parenthood. The three participants who experienced overt homophobia had older children, ranging from 6 years to early teens. This suggests that there have been improvements in

healthcare professionals' attitudes in recent years. Lee *et al* (2011) examined the negative experiences in maternity care of eight lesbian women. They noted that changes in societal attitudes in the UK meant that the women in their study had been generally treated in a positive manner. None of the women experienced explicitly homophobic views or inappropriate questioning. In contrast, earlier research described overt homophobia in maternity care (Wilton and Kaufmann, 2001). However, Röndahl *et al* (2009) found that negative experiences in maternity care were more likely to be related to personality clashes than to homophobia.

Our participants reported that, because of the homophobia within healthcare settings, they deliberately sought out healthcare professionals who would be responsive to their needs, either through their personal navigation of the system or on the recommendation of other lesbian couples. This purposeful seeking was an attempt to find and secure the involvement of healthcare professionals who were able to easily put to one side their heteronormative assumptions and focus on being respectful and supportive of the lesbian couple's relationship and sexual orientation. St Pierre (2012) found that lesbians used referrals from others to avoid unsuitable practitioners, and stated that lesbians assessed their safety in the healthcare environment before revealing their sexual orientation to healthcare providers. However, facilitating disclosure is only the first step towards acceptable care for couples in the transition to parenthood (Chapman *et al*, 2012). Although the participants deemed it monotonous to keep coming out, couples who disclosed their relationship to others outside of their family experienced increased satisfaction within their couple relationships (Frost and Meyer, 2009; Knoble and Linville, 2012).

Our findings highlighted the power differentials between the healthcare professional and the couple. The participants pointed out that they were often unable to raise their concerns about poor treatment due to heteronormativity within the healthcare environment. The fear of judgement and subsequent invisibility was a consequence of not explicitly stating their sexual orientation. Goldberg *et al* (2009) recommend that health professionals should orientate themselves to resist the heteronormative world view which they take for granted, and change their practice to create inclusive and queer spaces for lesbian parents.

Two of the three participants who used the services of a fertility clinic to conceive had experienced problems with healthcare professionals. Both of these women felt discriminated against or judged, during their process of becoming parents, by both nurses and social workers. Fertility clinics may not currently validate the importance of lesbians' sexual orientation when accessing their services (Yager *et al*, 2010). The healthcare professional is in a powerful position of authority to approve couples as prospective parents. The compulsory pre-insemination counselling that partners have to undergo in the clinic can be difficult and feel insulting when the interviewing social worker is misinformed or holds negative opinions about the nature of lesbian relationships. Feeling comfortable with healthcare professionals during interactions is extremely important (Harbin *et al*, 2012). Lesbians want to ensure that practitioners recognise their right to be parents and that they will provide them with good care.

The participants reported a focus on the biological aspects of conception, which queer theory challenges. This illustrates an overarching ideology that emphasises the interplay of gender and biology within the heteronormative assumptions about conception. The suggestion by one social worker in the pre-counselling phase that a participant should go to a pub and find 'a father to sleep with' is an example of *biologism,* viewing life from a biological perspective, which resonates with debates about lesbian women having children. These largely revolve around heteronormative assumptions about fatherhood (Short, 2007). Anxiety about the lack of a father is associated with the emphasis on the perceived heterosexual family's superiority and the presence of a male figure in the family structure, thus undermining the lesbian-led family (Goldberg, 2010a).

All of the couples in our study wished to be the primary caregivers for their child(ren). Dempsey (2010) found that partnered lesbian couples prefer to keep their reproductive relationship with the donor separate to their own couple relationship. Our participants described how experiences of healthcare professionals' failure to recognise the non-biological mother as a true parent to the child could lead to feelings of insecurity in their role and the need for reassurance from their partner. Healthcare professionals need to have an awareness of the changing structures of families and of how they may, often unwittingly, perpetuate the social stigma that can have a negative impact on the lesbian couple.

A recent study in the UK found that non-biological mothers felt respected by staff and regarded their treatment positively, despite structures, language and practice environments which were predominantly heteronormative (Cherguit *et al*, 2013). Goldberg (2010b) argued that a non-biological mother's role is not easily defined, nor is it recognised within society. According to Ben-Ari and Livni (2006), non-biological mothers are not necessarily regarded as mothers at all. This failure to recognise the non-biological mother has implications for coping with feelings of displacement and the lack of a clear role. Healthcare professionals are in a position to help

couples by accepting and acknowledging their coupledom.

Queer theory offers an alternative lens to de-emphasise the dominant heteronormative focus on sex and gender (Walters, 2005). For example, the exploration by Abes and Kasch (2007) of the multiple dimensions of identity in lesbian university students, and the study by Eves (2004) of butch/femme identity, have both highlighted the role that queer theory can play in examining queer identity and subsequent challenges to heteronormative environments. In our study, queer theory facilitated insight into the lesbian couple's journey through the health system and the responses of the healthcare professionals whom they encountered.

Strengths and weaknesses of the study

The qualitative research design allowed the generation of rich data. The use of queer theory was relevant in examining issues of power within the healthcare context and in deconstructing the emphasis on biologism in healthcare settings. It allowed the lesbian relationship to be viewed without the constraints of gender, and therefore enabled openness in interpretation. Queer theory also facilitated critical interpretation of the findings and consideration of the impact of heteronormativity on the participants' relationships.

The small number of participants and the homogeneity of their ethnic identity could be regarded as a weakness. All of the participants had received tertiary level education, and at least one partner in each couple was in paid employment. Lesbian women in lower socio-economic groups were not represented. However, the findings show that lesbian women continue to experience marginalisation and invisibility which would not necessarily be expected to differ as a function of demographic characteristics.

Implications of the study

This research has implications for lesbian couples who are considering parenthood and seeking an understanding of some of the barriers they may face within antenatal and healthcare services, including fertility clinics. It also has implications for professionals, including nurses, midwives and physicians, and allied health professionals who work in fields of family-related care and reproductive health. Further research is recommended to explore the tenacity and resilience of lesbian couples during the transition to parenthood in the spectrum of healthcare environments for pregnancy, birthing and postnatal care.

Specific recommendations

Healthcare professionals need to recognise and understand the roles of both women in the lesbian-led family. Lesbian-led families are valid, important and diverse, and are not shaped by biological links to one another. Inherent in achieving this is the need for professional preparation, at both undergraduate and postgraduate levels, to meet the needs of lesbian couples and their children.

Creating a suitable clinical environment for the disclosure of sexual orientation is important. This includes consideration of the impact of language needs, for example, naming of the non-biological mother and the use of gender-neutral terms. An inclusive approach is required in both verbal communication and documentation.

Human rights and anti-discrimination policies need to be emphasised within clinical practice environments.

Conclusion

This paper has reported lesbian women's experiences of dealing with healthcare professionals while transitioning into parenthood. To our knowledge this is the first study to have included an exploration of the effects that healthcare professionals can have on the couple. The focus on healthcare professionals is also timely, given recent changes in family formation, and could be relevant to a range of other health settings, given that lesbian-led families are increasing in numbers.

Healthcare professionals still appear to lack knowledge and awareness of the lesbian-led family as a legitimate family structure. They need to be aware of factors that affect the lesbian-led family in relation to the transition to parenthood. By acknowledging the lesbian couple and paying attention to the dominance of the biological emphasis, power dynamics, the influence of gender and heteronormative assumptions, healthcare professionals can have a positive impact on lesbian couples' relationship and on the lesbian-led family as a whole.

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CONFLICTS OF INTEREST

None.

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