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; Padavic & 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 relegated 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 (2008) 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; Braeways, Ponjaert, Van Hall, & Golombok, 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, & Braeways, 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 web camera 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 Assistive 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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