

LESBIAN MOTHERS: QUEER FAMILIES

The Experience of Planned Pregnancy

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ABSTRACT

Lesbian-identified women are choosing to become parents in increasing numbers. This 'lesbian baby boom' has implications for midwives and their practice. The purpose of this study was to gain insight and understanding of planned pregnancy from a lesbian perspective, in order to facilitate the provision of appropriate care for lesbian mothers and their families.

The methodology used for the study was radical hermeneutics informed by lesbian feminism and queer poststructuralism. Purposive sampling identified ten lesbian-identified mothers and conversational interviews with the participants yielded rich data about the phenomenon of inquiry. Thematic analysis of the data was foregrounded by a discussion of the socio-political context.

A number of findings emerged from the study. Careful pre-conceptual planning reflected a highly responsible approach to parenting. The women's partners felt uncertain about their parenting role and experienced a lack of acknowledgement by the wider community. Despite legal access to assisted fertility, the participants usually sought an involved father for their child. Lesbian mothers expressed a preference for a lesbian midwife and all experienced homophobic attitudes from healthcare professionals. Queer families included mothers and their partners, fathers and their partners, children, families-of-origin, and close friends.

Recommendations from the study include the provision of safe and supportive workplaces for lesbian-identified midwives, the use of inclusive language such as partner and parent, acknowledgement of the woman's partner as a co-parent, midwifery resources featuring same-sex parents and midwifery education covering diverse family forms.

KEY TO TRANSCRIPTIONS

The following abbreviations and conventions have been used:

Italics Identifies the interview data provided by the participants.

Names The voices of the participants are identified through the use of pseudonyms.

[] Indicates alterations made by the researcher to enhance clarity.

... Denotes material omitted from the original text.

Pseudonyms have been used to identify the participants, their family members and the health professionals involved in their care.

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CHAPTER ONE: CONTEXT AND OVERVIEW

Personal Context

The year was 1963, and two black and white photos taken with my Box Brownie camera record my life at age twelve. One shows three girls standing on the dais at the Interschool Swimming Sports. I have just won the backstroke 100 yards race against stiff competition. I look tired and proud. I am grinning at my best friend Jan, who is taking the photo. In the second, I am wearing a gingham apron with my name shakily embroidered on the front. I hold a certificate printed with the words, 'Little Mother of the Year'. The first photo shows me as I was; the second shows who I was expected to become. I had no role models in my provincial Aotearoa New Zealand town and no way of knowing if it would be possible to reconcile the two.

Almost four decades later, my partner and our children welcome me home from the Sixth Gay Games in Sydney. I show them my medals, including the silver for the 100 metres backstroke. I am fifty years old: a lesbian, a sportswoman and a mother. I feel very fortunate!

I chose planned lesbian parenting as the subject of my Masters research, because when I 'came out' as a lesbian, I thought I would never be able to have a family. Along with most members of society at the time, I believed that 'lesbian' and 'mother' were mutually exclusive categories. I was mistaken. There have always been lesbian mothers, it is their visibility that is new. In the past women had conceived children within marriages that they subsequently left, used heterosexual liaisons to become pregnant, or cared for children from their extended family, in the role of maiden aunt. However, the phenomenon of lesbian-identified women choosing conception by alternative fertilisation represents a significant social shift, occurring in Aotearoa New Zealand from around 1986.

My journey to becoming a lesbian mother began twenty-five years ago, when I realised that I was falling in love with a woman friend. I left my marriage and later became an enthusiastic co-parent to my partner's four children. Along with several of our friends, we became involved in efforts to convince the justice

system that lesbian mothers could be good parents and deserved to retain custody of their children.

By 1988 my relationship had ended and information about self-fertilisation had reached Aotearoa New Zealand. I talked with friends about my plan to have a child and in this way I met Mark, a nursing colleague who was interested in becoming a father/donor. As the friendship deepened it was clear that we were compatible in our beliefs about parenting. Mark had recently begun a relationship with Tom, who was very supportive.

In preparation for conception, Mark updated his HIV status and I recorded my temperature each morning to confirm ovulation. Six weeks after we commenced trying to conceive my pregnancy test was positive! I felt well throughout pregnancy and our son was born at home following a long labour. Lesbian friends provided support during his birth and Mark and Tom were delighted with their bonny 4.5 kilo boy.

A year later we began to talk about a second child: this time Tom wanted to be the father/donor. It took a little longer to conceive our daughter, probably because of my age (forty years) and her brother's extended breastfeeding. She was also born at home, four weeks after I sat my final midwifery exam. When she was six months old, I began working a few hours a week with the local midwifery practice.

I met my present partner three years after the birth of my daughter. She and her husband had come out as lesbian and gay when their daughter was four years old. Now, our queer family consists of my partner and I, our three children aged ten, thirteen and twenty-three, their fathers, our elder daughter's woman partner, and the aunts. We are lucky to live in a time and place where our 'difference' raises few eyebrows.

My midwifery practice includes pre-pregnancy counselling along with antenatal, birthing and postnatal care for lesbian mothers and their families. I initially worked part-time in a homebirth practice and later joined the midwifery practice attached to the university where I had trained. For the last six years I have worked in a tertiary hospital with women experiencing complex pregnancy. I have chosen to be 'out' as a lesbian mother in my workplace.

When my friends and I had our children, privately arranged donor/fathers were the only option. In 1994 the Human Rights Commission ruled that fertility clinics could no longer deny access to women on the basis of sexuality or marital status. My research question came about because I was interested in finding out how this legislative change had affected lesbian mothers. In this introductory chapter I will discuss the *Professional context* and *Research context* of the phenomenon of inquiry, the *Purpose of the research*, *Definition of terms* and conclude with an *Overview of the chapters*.

Professional Context

The professional context of midwifery in Aotearoa New Zealand today is closely associated with the second wave of feminism and the women's health movement. During the 1980s a group of determined women worked to raise public awareness of the issues and lobbied the then Minister of Health, Helen Clarke, to bring about political change and restore midwifery autonomy (Hendry, 2001). Their success in 1990 brought the midwifery profession back to its origins of women-centred care and foregrounded the midwifery partnership model of care (Pairman, 1999).

At the beginning of the twentieth century midwives cared for women in their own homes, also providing support and reassurance during the 'lying in' period. The Midwives Registration Act was passed in 1904 and midwifery training began at the new St Helen's maternity hospitals in Wellington, Auckland, Christchurch and Dunedin (Kedgley, 1996). In the 1920s concern over high rates of maternal mortality from puerperal sepsis following instrumental delivery led to a Health Department campaign to keep childbirth safely in the hands of skilled midwives, with doctors only attending emergencies (Donley, 1986).

The medical profession retaliated by emphasising the "risks inherent in childbirth" and introducing aseptic birth regulations, thereby transforming birth from a natural process into a kind of surgical procedure that was "done to women" (Kedgley, 1996).

Upon admission [to hospital] a woman was stripped, bathed, given an enema, had her pubic area shaven and was wheeled into a delivery room... In this alien and intimidating atmosphere, she was wrapped in sterile sheets, placed on a

table, usually with her legs strapped high in the air in stirrups, surrounded by medical equipment and attended by doctors and nurses wearing sterilised gowns, masks and gloves (p.79).

The New Zealand Obstetrical Society was founded in 1927 with the aim of encouraging medically assisted hospital childbirth (Kedgley, 1996). Its founder, Dr Doris Gordon, introduced twilight sleep to encourage “a better class of women to have more children. She goes right to sleep with either ether or chloroform, wakes up seemingly a minute later and heigh ho, there is a rosy baby in the cot” (p.85). As hospitalisation and anaesthesia became increasingly common, the midwife’s scope of practice was significantly reduced. In 1938 the Labour government introduced maternity benefits which entitled women to free medical care, including a two week hospital stay and pain relief (Donley, 1986). Within a decade midwives had virtually been made redundant, their skills and compassion replaced by sterility and pharmacology.

The decline of the profession continued until in 1977, the new Nurses Act redefined midwifery as 'obstetric nursing' (Hendry, 2001). The introduction of Comprehensive Nurse training, which included an obstetric component, further contributed to the declining numbers of registered midwives. In 1983 an amendment to the Nurses Act allowed registered nurses who were not qualified midwives, to care for women in childbirth (Hendry, 2001).

This professional crisis for midwives came at a time when many women were married in their early twenties, had an average three children and spent at least ten years parenting at home. Memberships of parent support organisations such as La Leche League, Parents Centre and Playcentre were increasing (Coney, 1993). Following consciousness raising about gender inequity in the early 1970s, women rallied around issues including women's health, equal pay for work of equal value and quality childcare. The power of the women's health consumer movement grew and the politics of childbirth emerged as an increasingly contentious issue (Kedgley, 1996).

The Auckland Homebirth Association was founded in 1978, as a response to growing disillusionment with the impersonal and unnecessarily medicalised nature of hospital birth. The 'Save the Midwife' campaign of 1983 aimed to raise the status of midwives and protect midwifery as a profession (Donley, 1986).

Midwives inaugurated the New Zealand College of Midwives (NZCOM) following a split from the Nurses Association in 1989. The philosophical underpinnings of the College could be identified in the '*Discussion Paper on Care in Pregnancy and Childbirth*' 1989 commissioned by the Department of Health (Hendry, 2001). Headings included recognition of midwifery as a profession, midwifery equality with doctors in maternity care, woman-centred care, continuity of care, and consumer choice of carer and birth setting

"The gradual build-up of midwifery strength, from 1983 onwards, appeared to solidify midwifery as a professional identity, in turn attracting more midwives to stand up and be counted. The timing of this professional growth was fortuitous" (Hendry, 2001, p.12). Midwifery autonomy was finally achieved in 1990, with an amendment to the Nurses Act 1977 that gave midwives the right to provide maternity care in any setting without supervision from medical practitioners. The legislation "had a profound effect on the scope of midwifery practice, payment and status" (p.12). Midwives were once again independent practitioners, able to care for women at home and in hospital.

Women and midwives worked collaboratively to bring about the changes for the midwifery profession and consumers were involved in setting up the NZCOM. The notion of midwifery partnership, 'midwives with women and women with midwives', was articulated in the 1993 NZCOM publications: '*Code of Ethics*' and '*Standards for Practice*' (Pairman, 1999). The midwifery partnership model emphasises continuity of midwifery care and an equal relationship, based on trust, empowerment and informed choice. Stewart (1999) also identifies continuity and choice as significant themes in her study on midwifery care for lesbian women in the UK. Pairman (1999) suggests that the autonomy and reciprocity inherent in midwifery partnership can have emancipatory outcomes for both women and midwives.

Research Context

The lesbian baby boom is a recent phenomenon and, as yet, there are only a small number of published studies. Early research on lesbian-led families was motivated by the need to inform judges and counter prejudicial decisions about the custody of their children (Saphira, 1984). Studies comparing children raised

in lesbian and heterosexual households have found no difference in the development of gender identity, gender-role behaviour, or sexual orientation (Hoeffler, 1981; McCandlish, 1987; Huggins, 1989).

More recent research has shown lesbians to be highly motivated, conscientious parents, who seek antenatal care within the first trimester, attend antenatal classes with their partners and breastfeed their babies for at least six months (Harvey, Carr & Bernheine, 1989; Brewaeys, Devroey, Helmerhorst, van Hall & Ponjaert, 1995; Gartrell, 1999). Lesbian women choose self-fertilisation because they want to experience pregnancy and childbirth (Pies, 1990). Options included privately arranged donors from one's acquaintance group or health care provider assistance. The advantages of using a fertility clinic include legal protection and donor screening; the disadvantages are expense and the possibility that donors might prefer not to be contacted by their children (Churchill, 1990).

Research exploring lesbian women's experiences of the healthcare system found homophobic attitudes to be a significant problem (O'Hanlon, 2000; Stewart, 1999). The quality of care was compromised by inappropriate responses to disclosure of sexual identification, ranging from ignorance and embarrassment through to open hostility and withdrawal of services (Stevens, 1995; Carroll, 1999). Two studies reviewing maternity care services for lesbian women in the United Kingdom showed that even well meaning midwifery practitioners are frequently misinformed and insensitive (Stewart, 1999; Wilton and Kaufmann, 2001).

Purpose of the Research

The research question for this radical hermeneutic study is actually an exploration of a phenomenon: lesbian planned pregnancy. Conversational interviews with a sample group of ten women and interpretation of the data by a researcher with lived experience of the phenomenon, seek to provide a lesbian perspective on the experience of planning pregnancy and parenting. Three questions emerged from a review of the background literature. The first concerned the ways in which the experience of planning pregnancy is different for lesbian women. Secondly, how appropriate was their midwifery care during

the pregnancy, birth and while breastfeeding. Finally, I wondered about the evolution of their family and how closely the reality of parenting matched their plans. Radical hermeneutic methodology refutes any suggestion of finding 'the truth' about a phenomenon. Rather, rich data in the form of the women's own words, is contextualised with a discussion of the historical-political context.

The purpose of this research is to assist midwifery practitioners to provide culturally appropriate, respectful care. A polemic shift within healthcare has resulted in agreement that prejudicial and discriminatory attitudes and behaviour are unethical and undesirable (Wilton, 1999). Stewart (1999) suggests that satisfaction with midwifery care will be greatly increased when women feel safe enough to be out about their sexual identification. Consequently, midwives have a professional obligation to acquire the knowledge needed to form open, supportive relationships with all the women they care for. Midwifery practitioners have a powerful tradition of being 'with women' and could take a personal and professional lead in caring for lesbian women (Wilton, 1999).

Definition of Terms

Radical hermeneutic philosophy theorises that language constitutes meaning and in this way determines social interaction (Thompson, 1990). The following terms need clarifying in relation to this study:

Lesbian: Women who have a primary sexual and affectional orientation to other women and may participate in a lesbian socio-cultural network.

Queer: An inclusive term applied to lesbian, gay, bisexual, transgender, intersex and takatapuhi people, along with others who self-identify as living outside heterosexual hegemony. Trett (2001) makes the point that queer is theoretically avoidant of definition.

LGBTI: A more specifically inclusive acronym for queer people, favoured in international publications.

Self-fertilisation: A less androcentric term than artificial or donor insemination for conception occurring by means other than heterosexual intercourse. As in

“fertilise, to provide an animal or plant with sperm or pollen to bring about fertilisation” (Collins Concise Dictionary Plus, 1990, p.454).

Partner/parent: The partner of a birth mother, who has a commitment to shared parenting. She may also be referred to as a co-parent, or non-biological mother, a description that diminishes her relationship with her child.

Father: A man who has donated sperm to assist with conception and has an ongoing relationship with the child. He is involved in parenting decisions and responsibilities.

Donor: A man who has donated sperm to assist with conception, usually through an assisted fertility clinic. He is less likely to be personally known to the mother(s) and child, but may be traced by the child if she/he wishes.

Lesbian-led families: May include mothers and their partners, fathers and their partners, children conceived together and in previous relationships, extended family-of-origin, and significant non-biologically connected others.

Come out (of the closet): Make one’s homosexual identification known.

Heterosexism: The belief that only heterosexuality is ‘natural and normal’.

Homophobia: An irrational fear or hatred of homosexuals and homosexuality.

Use of the generic ‘she’ when referring to midwives is justified on the basis of the gender ratio of registered midwives in Aotearoa New Zealand; approximately 2000 women: 2 men (Personal communication with G. Stimpson, NZCOM).

Overview of the Chapters

In chapter two I discuss the historical and political context of the research, beginning with the influences of early feminism on mothering and midwifery. During the 1980s lesbian feminists celebrated women's sexuality and asserted their right to be out and proud. A decade later discussion of the Queer Project led to increasing lesbian and gay collaboration. In chapter three a critique of

previous studies looks first at research on lesbian-led families and concludes with studies describing lesbian experiences of midwifery care.

Chapter four is a description of the methodology of the research. I begin by discussing Gadamerian Hermeneutics, including thoughts on the importance of language and tradition. The research question required an explanation of feminist theory, which describes women's lives in relational terms and offers a critique of 'the family'. Owens (1992) theorises a feminist hermeneutics and Weedon (1986) applies a feminist lens to poststructural theory. Queer poststructuralist Foucault (1981) deconstructs sexuality and explains the role of discourse and hegemony. Having decided that Radical Hermeneutics offers the neatest fit with the question of planned pregnancy for lesbian mothers; I eschew Caputo (1987), in favour of Jagose (1996) and Southwick (2001) and their Aotearoa/Pacific sensibilities.

Chapter five describes the method and study design, including a discussion of the ethical considerations. In hermeneutic inquiry, data refers to the text produced from conversations with purposively sampled participants about their experience and understandings of the phenomenon. I outline van Manen's (1990) thematic interpretation of data and conclude with an explanation of the ways in which this study meets the criteria for academic rigour.

The next three chapters present the interpretation of the data. Chapter six is called 'Possibility and Planning' and shows aspects of the phenomenon influenced by the particular context of lesbian feminism. Themes include: encountering possibility, deciding to have a child, negotiating with partners, choosing the father, assisted fertility, deciding on midwife care and considering gender. Chapter seven titled 'Trust and Inequality' describes the experience of midwifery care. Themes include: feeling overwhelmed, experiencing infertility, a pregnant pause, birthing by the clock, losing control, overcoming breastfeeding difficulties, and confronting heterosexism and homophobia.

Chapter eight, 'Queer as Folk' shows the diversity and unique qualities of created queer families in Aotearoa New Zealand. Themes include parenting equally, lesbian dads, involved fathers, extended families, and experiencing satisfaction. Finally, chapter nine concludes with a discussion of the findings,

the recommendations for practice, education and research, and the limits and strengths of the study.

Conclusion

I began the chapter by coming out about my life experience and explaining how it relates to the research question. Southwick (cited in Giddings and Wood, 2001) suggests that when using radical hermeneutic methodology, researchers need to begin by declaring their own position. The professional context in Aotearoa New Zealand is important because of the way midwives and women worked together in partnership, using their feminist political experience to secure the right to autonomous practice for midwives. I have defined the research question, the purpose of the research and some commonly used terms. Discussion of the research context revealed that because of the dynamic nature of the phenomenon and, until recently, the need for lesbian parents to be covert, there is not a lot of published research available.

CHAPTER TWO: HISTORICAL AND POLITICAL CONTEXT

In order to fully understand the phenomenon of lesbian planned pregnancy, I need to describe the historical and political context. The second half of the 20th century was a period of rapid social change, prompted by advances in global communication technology and a growing awareness of disparities around ethnicity, gender and sexuality. I will discuss political developments under the headings: *Feminism and mothering, Lesbian feminism, Queer, and Homophobia and heterosexism*. I then describe historical events in Aotearoa New Zealand: *Kawa Whakaruruhau/Cultural safety, Whanau and whakapapa, Judicial challenges, Planned pregnancy, Assisted fertility, and Demographics*.

THE PERSONAL IS POLITICAL

Feminism and Mothering

"To have borne and reared a child is to have done that thing which patriarchy joins with physiology to render into the definition of femaleness." (Rich, 1976, p.37.)

The experience of mothering young children has changed tremendously within a generation in Aotearoa/New Zealand. When I married in 1972, a small group of family and friends gathered in my parents' garden. At nineteen I was a little younger than the average bride was and unlike most of my friends I did not go on to have my first child within two years. At that time, a family of five could live on one (male) income and women usually spent at least ten years parenting at home before returning to the paid workforce. It was a decade of relative ease and prosperity, yet many women reported feeling bored and isolated. One woman stated, "I had everything I had been brought up to hope for, a nice house, three lovely children and a professional husband. I should have been blissfully happy but I was totally miserable" (Watson cited in Kedgley, 1996, p.232).

The discontent felt by some women found a voice in the Women's Liberation Movement. Media discussion about 'women's issues' led to the formation of suburban 'Consciousness Raising' groups. Weedon (1987) lists the political

issues which the Women's Liberation Movement defined as central to the oppression of women: "sexual division of labour, control of sexuality and the relations of reproduction, access to education, jobs and power over our lives" (p.14). Describing the historical development of feminist theory, she suggests that liberal feminism argued for women's rights to choice and self-determination, equal pay for work of equal value and equal opportunities in the workplace. Socialist Feminist analysis viewed gender as historically produced and prioritised reproductive freedom for women. Radical feminism celebrated "true femaleness" which it linked to lesbian sexuality and to mothering, but warned, "these qualities can only be realised beyond the structures of male control of female sexuality and procreative power" (Weedon, 1987, p.17).

Germaine Greer called on women to revolt against traditional female roles, saying that they were "stifled and imprisoned by the arid effects of motherhood" (Kedgley, 1996, p.233). She viewed parenting as a patriarchal plot from which women must be liberated by the provision of twenty-four hour childcare, enabling them to return to paid employment and self-fulfilment. Rich (1976) rejected this position and celebrated the "joy of mothering", which she described as, "the potential relationship of any woman to her powers of reproduction and her children" (p.13). However, "the institution of motherhood" was responsible for "devaluing the everyday tasks of mothering and the isolation in which most women mother" (p.13). Rich saw the institution of mothering as being inextricably bound to the institution of heterosexuality and she wondered whether other ways of constructing motherhood were possible.

We fell into what I felt to be a delicious and sinful rhythm. It was a spell of unusually hot, clear weather, and we ate nearly all our meals outdoors, hand to mouth; we lived half naked, stayed up to watch bats and stars and fireflies, read and told stories, slept late. I watched their slender, little boy's bodies grow brown, we washed in water warm from the garden hose lying in the sun, we lived like castaways on some island of mothers and children. At night, they fell asleep without a murmur and I stayed up reading and writing as I had when I was a student, til the early morning hours. I remember thinking: this is what living with children could be without school hours, fixed routines, the conflict of being both mother and wife... We were conspirators, outlaws from the institution of motherhood; I felt enormously in control of my life (p.194).

Rich (1976) challenged the pervasive notion that a 'good' mother is self-sacrificing and suggested that when a woman extricates herself from the experience of oppression, both she and her children benefit. Feminist analysis of reproductive freedom culminated in demands for the right for women to decide if and when they would have children and under what conditions (Weedon, 1987). Improved contraception and the hard-won battle for legal, safe abortion meant that women could plan their families to fit in with the other aspects of their lives. With the introduction of the 1973 Domestic Purposes Benefit in Aotearoa New Zealand, women and their children could (just) survive without the economic protection of a man (Coney, 1993).

Bringing up children without being married emerged as a potentially positive decision, not an unwanted and scandalous accident. The idea that women could shape their lives according to their own values and desires, rather than conform to constricting social norms, was attractive and powerful (Benkov, 1996, p.109).

Lesbian Feminism

"The terms 'homosexual', 'gay' or 'lesbian' and 'queer' successively trace historical shifts in the conceptualisation of same-sex sex" (Jagose, 1996, p.73).

When Radclyffe Hall published her autobiographical novel 'The Well of Loneliness' in 1928, she introduced the phenomenon of 'sexual inversion' and made a plea for tolerance of the misunderstood and persecuted minority to which she belonged (Jagose, 1996). The public perception of homosexuality as a disability and/or moral aberration continued for at least another forty years. The clinical term homosexual was used to support the notion of lesbianism as a congenital condition, even by the American homophile organisation 'The Daughters of Bilitis', which provided support for lesbian women during the post-war period.

The 1950s were a particularly conservative period in Aotearoa New Zealand and one newspaper tersely reported, "Gangs of homosexuals who live together for the sake of perversion. You see these warped-brain men, and women too, wandering about the streets or sitting idly in night cafes. Auckland has too many of them!" (Coney, 1993, p.171). Kamp, an acronym for 'known as male

prostitute', was the preferred term for the women and men who met in selected hotels and coffee bars. Paranoia about 'the new breed of rebellious teenagers' combined with homophobia following the Parker-Hulme murder case in 1954 (Coney, 1993), and parents and teachers were advised to separate same-sex friends who were becoming 'too close'. At the age of eight, my best friend and I were suddenly moved into different classes, with no explanation. It seems likely that a play I had written, starring Ann as a flamenco dancer and myself as the handsome toreador was the catalyst!

A frenzy of social and political change followed the beginnings of the civil rights movement in America. The emergence of Gay Liberation in the 1970s and the demand for equality of rights gave lesbian women a sense of community and pride for the first time. Women who came out a few years later in the Feminist Movement preferred to be known as lesbians or dykes. By 1995 the inclusive term queer had become popular with women who positioned themselves outside the heterosexual norm. The words dyke and queer have been reclaimed from derogatory usage, although some lesbian women still find them problematic.

Women's liberation and gay liberation were organised around analyses of gender and sexuality based oppression. The new lesbian feminist movement was seen by some as the logical extension of radical feminism, arguing for "the abolition of the privileging of heterosexuality, freedom to define one's own sexuality and the right of lesbians to raise children" (Weedon, 1987, p.18). Rich (1976) described the institution of compulsory heterosexuality, which "systematically works to the disadvantage of all women. The lesbian experience, like motherhood, is a profoundly female experience, with particular oppressions, meanings, and potentialities" (p.318).

The 'National Organisation for Women' (NOW) took a more conservative position on lesbian feminist issues. Betty Friedan, author of *The Feminine Mystique* (1965) argued that including heterosexism as a category of discrimination would detract from the central, serious message of feminism. A group of lesbian activists within NOW, who came to be known as 'The Lavender Menace', responded that feminist priorities such as safe contraception and abortion, shared responsibility for household tasks and free childcare, were

hardly relevant to their lives. In 1973 the first lesbian feminist group, 'Sisters for Homophile Equality' (SHE), began in Aotearoa New Zealand (Coney, 1993).

Lesbian feminists have written about the tensions surrounding definition by gender or sexual identification and the experience of invisibility in both feminist and gay coalitions. Jagose (1996) suggests that for lesbians "gender, not sexuality, is the primary identificatory category" (p.50). Women who were active in the Gay Liberation movement reported encountering sexism and a lack of concern with women's issues. Weeks (1985) agrees, "Lesbians and gays are not two genders within the one sexual category. They have different histories, which are differentiated precisely along the lines of gender" (p.203).

From euphoric beginnings the growing Lesbian Feminist 'community' became an increasingly complex and contested space. Separatism, while initially important for creating women's space, was difficult to sustain when most lesbians had covert emotionally significant men in their lives, be they fathers, brothers or sons. The slogan 'The personal is political!' encouraged some feminists to temporarily abandon heterosexuality for the excitement of the movement. Gay women tended to view these 'political lesbians' with cynicism. Feminist lesbians, in turn, were appalled by the apolitical writings of sadomasochistic lesbians who defended butch-femme role-playing in erotic relationships. Jagose (1996) noted "challenges to the dominant lesbian feminist assumption that lesbian sex was couple-based, monogamous, woman-identified and political" (p.65). Finally, indigenous women and women-of-colour who experienced racism from within the lesbian feminist movement increasingly prioritised solidarity with their cultural communities (Lorde, 1984).

Mothers, particularly those with sons, had been a rather overlooked minority within the lesbian feminist movement. Pollack and Vaughn (1987) describe how "lesbian mothers had lived in a much greater degree of secrecy and isolation" before the women's and gay Liberation movements, but now "we began to emerge from invisibility, confront the legal system and demand the right to our children and our families" (p.12). Women who were coming out of marriages no longer accepted that the loss of their children was just punishment, and custody rights for lesbian mothers became an important part of the lesbian feminist agenda.

Feminism had enabled women to regain control over their reproductive capacities creating a context of choice. Access to more reliable contraception and safe termination of pregnancy gave heterosexual women the means to plan their families and lesbian women became aware of the potential of developing reproductive technology. Motherhood could be separated from the oppression of compulsory heterosexuality by the relatively simple process of self-fertilisation. Women who had put aside their dreams of having a child when they came out as lesbian now saw a way to achieve pregnancy without compromising their sexual identification. "Increasingly, lesbians are choosing to conceive, bear children, parent and create distinctively lesbian families. There is an entire generation of children growing to adulthood who have been raised by out lesbians" (Pollack and Vaughn, 1987, p.13).

Lesbian feminist politics provided the context for planned pregnancy and lesbian-led families. However feminism's insistence on 'woman' as a unified, stable and coherent category ultimately proved to be untenable and the 1990s saw a further transformation of cultural identity (Jagose, 1996).

Queer

Cultural identities such as lesbian feminist are subject to the continuous 'play' of history, culture and power. Katz (1995) describes how in the late 19th century, medical discourse categorised all non-procreative sexual activity, including heterosexuality, as pathological.

In 1901, Dorland's Medical dictionary, published in Philadelphia, continued to define "heterosexuality" as "abnormal or perverted appetite toward the opposite sex"...The association of heterosexuality with perversion continued well into the twentieth century. But by the end of the 1920s, heterosexuality had triumphed as dominant, sanctified culture. In the first quarter of the 20th century the heterosexual came out, a public self-affirming debut the homosexual would duplicate near the century's end (p.112).

The invention of homosexuality as a category of perversion had occurred a little earlier. Same-sex attraction had been considered a temporary aberration until the publication of Westphal's case study of a pathological homosexual in 1870 (Foucault, 1981).

The psychological, psychiatric, medical category of homosexuality was constituted from the moment it was characterised, less by a type of sexual relations than by a certain quality of sexual sensibility, a certain way of inverting the masculine and feminine in oneself (p.43).

The notion of the tragic homosexual endured for a century. When I came out to my family, my mother wept because her only child would have a miserable life, living in the shadows. She was soon to be reassured. The 1960s became the decade for questioning and challenging prejudice and discrimination. Women and ethnic minority groups demanded equal rights and police raiding a New York gay bar met with resistance for the first time. Talking about the Stonewall riots, Weeks (1985) listed the conditions necessary to politicise sexual identity: geographical concentration, an identifiable opposition, intellectual leadership and readily understood goals.

Saussure (1960) suggested that language constitutes that which it purports to only describe. The role of language in the Gay Liberation movement was to promote positive images, which would counter negative stereotypes. Gay implied a joyful, light-hearted, even enviable lifestyle. The adoption of the Rainbow icon, the growing numbers cheerfully 'outing' themselves in Pride marches and the consumer-friendly badges and bumper stickers confirmed homosexual men and women as a legitimate minority group.

Fundamentalist groups were appalled by the increasing acceptance of sexual freedom and many considered the Human Immunodeficiency Virus (HIV) to be divine retribution. The pandemic decimated the gay male communities, at a time when individuals had finally chosen to stop living as victims. Coping with fear, illness, hostility and bereavement turned 'gay' into a cruel irrelevancy.

The Lesbian/Gay and Women's rights movements have allowed both women and men to think expansively about the ways in which we express ourselves sexually. In many regards, AIDS has stopped these movements in their tracks. The epidemic of stigma surrounding AIDS has given many people license to seek refuge in racist, classist, sexist, homophobic and xenophobic notions of moral superiority (Rieder and Ruppelt, 1988, p.226).

The development of effective retroviral medications towards the end of the 1980s reversed terminal prognoses and gave positive individuals a way to live

with the virus. Anger about political expediency and funding delays attributed to homophobia fuelled the formation of Outrage, an international HIV activism group. The reclamation of the derisory term queer in the slogan, 'We're here, We're queer, Get used to it', summarised the feelings of younger HIV survivors. Where 'homosexual' had politely asked for tolerance, 'queer' demanded acceptance.

Queer also marked a conceptual shift, a growing awareness of the limitations of identity categories and a move away from homogenous lesbian and gay culture. The essentialist view of sexual orientation underpinned the liberation movements and the 'outing' activism of the 1980's. The notion of the closet as a metaphor for the denial of one's 'true identity' as lesbian or gay is central to liberationist politics. This position argues that around ten percent of humans are exclusively homosexual by nature and any variation in that figure is due to an inability or unwillingness to declare one's innate sexuality.

Queer represents a deconstruction of liberationist discourse on power and fixed identity. Foucault theorises 'relations of power', where power may be exercised as oppression or resistance (Halperin, 1995). Rather than grappling power from the grasp of powerful majorities, queer recognises the flux, or "sustained interplay across the boundaries of different competing social/moral perspectives" (Trett, 2001, p.6). Resistance, in the form of repeated acts of transgression, leads to a middle ground of tolerance, complementing the achievements of gay liberation.

Foucault also challenges the notion of a fixed and true sexual identity. In the constructionist view of sexual identification, the binary notion of homosexuality as defined by its relation to heterosexuality, has deferred to a "sense of sexuality as a terrain of diversity, whose ethical principal is above all choice" (Watney, 1992, p. 22). Butler's (1990) controversial theory of performativity articulates complex alignments of class, gender, race and sexuality; to her gender becomes "a free-floating artifice" (p.6). Wilton and Kaufmann (2001) explain; "Sexuality is not a fixed characteristic, but a fluid concept which embraces behaviour, desires, shifting social constructs and self-perception and which may not have a straightforward relationship to identity" (p.204).

The Lesbian feminist response to queer was initially hesitant. Some women were concerned that they would be subsumed within a male-defined queer culture, as had happened in the early days of gay liberation. Reconstructing power did not reduce the prevalence of male-to-female violence. Others, especially those who had worked collaboratively on HIV issues, felt the need to build a more inclusive and resilient community. The evolving queer identity provided a common ground, for lesbian women interested in planning pregnancy to begin discussion with gay men who wished to become fathers.

The Queer project is a response to a crisis of sexual epistemology and the categories of modern sexual identity, which seem increasingly unable to give adequate expression to contemporary sexual beliefs, behaviours and identities. Queer celebrates eclecticism of human experience and a morality formed out of dialogue and choice. It avoids traditional dichotomies such as nurturing mother and predatory lesbian, looking instead at ways of being as a partner and parent. Trett (2001) concludes that queer has become “the most prevalent adjective within our communities in Aotearoa New Zealand for collectively describing evolving affinity, common interests and cause” (p.3).

Heterosexism and Homophobia

By the end of the twentieth century 'being lesbian' had become a matter of self-identification rather than an external categorisation of preferred sexual activities. A woman who identifies as lesbian will usually have woman partners and experience a sense of community through participation in a lesbian socio-cultural network. Coming out as lesbian is a gradual and growing sense of satisfaction with one's own sexual identity. The process of informing significant others involves risk-taking and is a life-long task in a society which expects heterosexuality. Family and friends may then need to come out about their connection to a lesbian or gay person.

Stigmatisation of a person's identity leads to isolation, shame, diminished self-concept, self-destructive behaviours and lower levels of self-care. A stigmatised individual may become hypervigilant about concealing her identity through fear of harassment and discrimination. She will self-censure disclosure and avoid using pronouns that would reveal her partner's gender (O'Hanlon, 2000). In the

recent past lesbian women have been described as deviant, anti-male, anti-family, abnormal, and deranged (Saphira, 1984).

The homophobia that pervades our society exhibits itself in a myriad of myths about lesbian parents: lesbians will sexually molest children, the children will grow up to become homosexuals, lesbians will engage in sexual activity in front of their children, the children will develop psychological problems and be stigmatised by society (Pollack & Vaughn, 1987, p.317).

Homophobia is an irrational fear or hatred of homosexuals and homosexuality. Internalised homophobia represents learned biases incorporated into one's value system and may be expressed as self-hatred and self-harm. External homophobia is the overtly observed and experienced expression of these biases, including verbal abuse, individual and institutionalised discrimination and violent assault. Homophobia is culturally specific and culturally constructed. Wilton (1999) reminds us that "while Oscar Wilde was being vilified and imprisoned in the UK, Nobel Prize winning writer Selma Lagerlof was feted in Sweden" (p.162).

Over the last decade research data has been collected in the USA and UK which reveals homophobic prejudice and discrimination, accompanied by widespread ignorance and misinformation about lesbians and lesbian health, within every sector and at every level of the health and social care professions (Wilton, 1999, p.154).

Using discourse analysis methodology to analyse textual expressions of homophobia in British and North American culture Wilton (1999) identified themes including anxiety about gender ambiguity, fear of female sexuality, sexualisation of lesbianism and characterisation of lesbianism as unnatural. The "notion of naturalness" is used to "reinforce and perpetuate a specific set of beliefs about gender, sexuality, normality and abnormality" (p.160). Many midwives assume that all mothers are heterosexual and therefore, the lesbian mother becomes an oxymoron. She does not make sense. The societal view of mothers and mothering is desexualised, while lesbian sexuality has historically been represented pornographically, from Courbet's painting 'Sleep' to contemporary cinema. Midwifery care involves intimate physical contact and emotional support, and midwives may fear an overtly sexual response.

The relationship between a woman and her midwife is known to be a significant factor in the outcome of labour (Berg et al, 1996). However, lesbian women are often reluctant to seek health interventions, change practitioners frequently and avoid disclosing their sexual orientation for fear of negative consequences (Wilton, 1999). Prejudicial and discriminatory attitudes and behaviour are therefore unethical, unprofessional and counter-productive. Wilton suggests that well-intentioned policy statements, such as the Royal College of Midwives position paper, might not be enough to resolve deeply felt beliefs and attitudes. As recently as 1988 in the United Kingdom, Section 28 of the Local Government Act forbade the teaching of the 'acceptability of homosexuality as a pretended family relationship' (Wilton, 1999).

Midwifery education and academia play a part in perpetuating heterosexism. Eliason (1993) critiques the narrow focus of nursing education on cultural diversity. "Practitioners need to take into account the social and historical context (prevailing attitudes, laws, treatment) of individuals and their identities (age, gender, sexual identity, race, ethnicity, religion, etc.)" (p.114). Australian researchers Horsley and Tremellen (1995) agree that research and funding bodies show a regrettable disinclination to provide information about the health status of lesbian women. The small amount of available data is predominantly American, which raises issues of transferability, and may not be considered valid if the researchers are identified as lesbian.

AOTEAROA NEW ZEALAND

Kawa Whakaruruhau/ Cultural Safety

"Culture can be defined in terms of a philosophical base, a way of living in the world, attitudes, behaviours, the individual's role in society, links and relationships with others" (Ramsden, 1992, p.21).

The Treaty of Waitangi is the founding document of Aotearoa New Zealand. "The signing of the treaty by Maori and representatives of the crown was intended as recognition of an equal partnership and as a foundation for future relationships between the two parties" (Tupara, 2001, p.8). The College of Midwives "*Handbook for practice*" states that "Midwives recognise the status of

Maori as Tangata Whenua of Aotearoa and honour the principles of partnership, protection and participation as an affirmation of the Treaty of Waitangi” (NZCOM, 1993, p.11).

Spence (2001) shows how nursing meanings of culture evolved from ethnicity manifested through physical characteristics such as skin colour, to more anthropological understandings of beliefs and traditions, and then to a socio-political interpretation that acknowledges power relationships. The decision by the Nursing Council of New Zealand in 1992, to include cultural safety in nursing and midwifery education, sparked media debate when a number of students expressed dissatisfaction with the predominantly bicultural focus. There was concern that time spent addressing the Treaty of Waitangi reduced opportunities for clinical experience and it was claimed that the increasing ethnic diversity of Aotearoa New Zealand’s population demanded a more multicultural approach. A committee was appointed to review and evaluate the delivery of cultural safety in nursing education (Murchie and Spoonley, 1995). As a result of the review ‘culture’ was redefined as “the sharing of meaning and understanding” (The Nursing Council, 1996, p.40). “Cultural safety in midwifery education provides a focus for the delivery and quality of care through changes in thinking about power relationships and women’s rights’ (Tupara, 2001, p.7).

Whanau and Whakapapa

The cultural context of lesbian parenting in Aotearoa New Zealand is characterised by the value ascribed to biological connection. In an earlier study (Bree, 1991) it was notable that most lesbian mothers carefully selected a father rather than a donor. The expectation was that while the mother and her partner would provide custodial care, their child would also have frequent contact with her/his father. All three parents, along with other adults (father’s partner, grandparents, aunts and unrelated friends) would provide care and support and be involved in decisions about the child’s welfare. These beliefs about the importance of extended family were significantly different from the ‘procuring sperm’ view, expressed at the time in countries where assisted fertility was already available to lesbian women. I looked to Maori Kaupapa (the correct way of doing things) and Te Reo (the language) for insights.

The Maori word takatapuhi describes an intimate friend of the same sex. Pihama (1998) argues that kaupapa validates takatapuhi taking a parenting role. She explains that whanau is "the basic social unit within Maori society, which may generally be interpreted as an extended family consisting of three or four generations and operated under the guidance of kaumatua (respected elders)" (p.181). Whakapapa is the oral or written record of family and tribal links and provides the foundation for the organisation of whanau, hapu (sub-tribe) and iwi (tribe). A narrow definition of whakapapa, recognising only blood relations and partnerships formalised by marriage, is a consequence of colonisation and the need to conform to pakeha autocracy (Pihama, 1998).

In the pre-European tradition both whakapapa and whanau "assume notions of relationship, responsibilities and obligations that provide opportunities for all adults to take a parenting role in the lives of Maori children" (Pihama, 1998, p.182). Missionary schooling and the denial of Te Reo Maori were instrumental in redefining the role and status of Maori women. The founder of the Royal New Zealand Plunket Society, Dr Truby King, opposed tertiary education for women and promoted 'a cult of domesticity'. Pihama (1998) suggests that for Maori girls and women, "these colonial discourses served to construct particular roles, expectations, values and practices based on ideologies of both racial and sexual inferiority" (p.184).

She argues that contemporary definitions of family, kaupapa whanau, are a "creative response to the impact of colonisation and the movement of Maori to urban centres" (p.182). Maori lesbian women may take a parenting role as whaea and koka, a caregiver, guardian and teacher. Whangai, the tradition of familial adoption, has usually been limited to assisting infertile women and their partners to become parents, but a more expansive definition could include lesbian couples (Pihama, 1998). In the cultural context of same-sex parenting in Aotearoa New Zealand, Maori beliefs about the importance of whanau and whakapapa have contributed to a more expansive view of extended family (Personal communication, Frances Joychild, The Law Commission, November 2003).

Judicial Challenges

The years since the publication of *'Amazon Mothers'* in 1984 have seen a change in focus for lesbian parenting in Aotearoa New Zealand. Saphira's discussion of lesbian culture provides an historical context for the first research to acknowledge the existence of lesbian mothers. Many women were politically active, taking time to be involved with Rape Crisis or the Peace/Nuclear-Free movement. The lesbian soccer and softball teams, Circe and Amazons, were enthusiastically supported. Lesbian literature was difficult to find, although a few liberal bookshops would order early Naiad Press titles. The lesbian publication *'Circle'* and the feminist magazine *'Broadsheet'* debated issues such as lesbian separatism and Maori sovereignty. Women also listened to the Olivia label records, sang along at the Topp Twins' concerts and danced at the Karangahape Girls Social Club. With no queer content on television, the International Film Festival was eagerly anticipated, although the portrayals of lesbian women were often negative or exploitative.

The overriding issue for lesbian mothers in the early 1980s was retaining custody of their children. There had been an attitudinal shift from concealing one's sexuality to challenging the assumption that sexual identification determined quality of parenting. However the courts reflected the prevailing societal myths and stereotypes and even an abusive father was seen as preferable to a lesbian mother. Early researchers were motivated by the need to inform lawyers, social workers and others with influence over judiciary outcomes.

My only concern about the mother's sexual mores can be in relation to any effect on the children. I would hope that she would not be dominated by aggressive lesbians or that despite her good intentions, a lesbian relationship could develop which would act to the detriment of the children. I hasten to add that this Court is not a Court of morals; lesbianism, unlike male homosexuality is not a crime. It's only relevance is the possible effects on the children of either being in a lesbian environment or of witnessing overt displays of lesbianism (Judgement of Barker, J. v B. cited in Saphira, 1984, p.57).

Saphira wondered what signified an 'overt expression of lesbianism'; would a kiss goodbye, a hug or an affectionate touch 'act to the detriment' of the children? She used snowball sampling to distribute a questionnaire, which was

completed by seventy lesbian mothers. Questions included whether the woman was partnered, who lived in her household, the division of household chores, her children's attitudes towards lesbianism, the community reaction to her family, and the nature of her employment and leisure activities. Eighty-five per cent of the participants had previously been married for more than five years and many had been involved in custody disputes. Couples shared parenting responsibilities and most of the children were accepting of their mother's sexual identification. Community reactions to the families had been mixed.

Attitudes towards homosexuality were changing and member-of-parliament, Fran Wilde proposed an amendment to the Human Rights Act, which would decriminalise homosexual acts between consenting adult males (female homosexuality had never been included in the legislation). An alliance of conservative and fundamentalist groups including the Salvation Army organised a petition opposing the amendment, which was presented as a submission. In the homophobic discourse, homosexuality is considered to be unnatural, sinful and evil. Homosexual Law Reform was seen as a threat to the heterosexual nuclear family and dominant gender relations (Pihama, 1998). However the amendment was passed and The Human Rights Act 1993:

Makes it unlawful to discriminate, either directly or indirectly, against a person on the grounds of their sexual orientation. This applies in the areas of employment, access to public places, provision of goods and services, accommodation and educational establishments (p.1).

The first successful application for custody by an 'out' lesbian mother was won on appeal in 1984. With a legal precedent, the social workers acting for the children involved in custody disputes became very influential. Hanna (1986) published her *'Lesbian Households'* study two years later, for the purpose of informing her colleagues.

In New Zealand it continues to be assumed that lesbian families do not exist and there is little published material available which either gives information or acknowledges their presence. Consequently there is limited knowledge and understanding of the incidence of lesbian family groups within the community, of difficulties they experience and the needs and strengths of this particular familial formation (p.2).

Lesbian mothers are one of the least visible minority groups as they are indistinguishable from single heterosexual mothers. While they share some of the problems experienced by other reconstituted or stepfamilies, they also have specific needs related to their status as a non-traditional family. Hanna (1986) hoped to identify issues of concern to lesbian mothers along with successful adaptive strategies used by their families. She was particularly interested in the family's experiences with family-of-origin, the education system, the community, the workplace, the judicial system and custody arrangements. The findings confirmed that lesbian families functioned successfully despite homophobic reactions from individuals and institutions. Early and sensitive disclosure of sexual identification was an adaptive strategy used to assist children cope with the changes in their family.

Planned Pregnancy

By the 1990s the focus of lesbian parenting had shifted to planned pregnancy. Saphira acknowledged in her 1984 study that some women were already using self-fertilisation to become pregnant and briefly described the method. She suggested that using an intermediary provided a greater degree of anonymity and there was no discussion of the child's right to a known donor.

One lesbian couple decided they wanted to have a child, worked out which one wanted to bear the child, calculated when she was ovulating, made a suitable date with a selected chap, went to bed with him and that was the last she saw of him. Now they have a happy healthy child (Saphira, 1984, p.22).

In 1991 I presented feminist narrative research titled '*The Birth Experiences of Lesbian Mothers*' at the Biannual Women's Studies Conference (Inc. N.Z.). As in Hanna's study, birth mothers and their partners shared the responsibility of parenting the children. Father/donors were carefully chosen and spent an average of one day a week caring for their children. Lesbian couples found homebirth midwives to be very supportive and hospital midwives less so. Independent midwives were not yet an option. Interestingly, all the children in the sample (n =12), who were then aged from 3 months to 30 months, were still breastfed (Bree, 1991). The New Zealand studies were part of a growing body of research, which demonstrated that child development, the quality of the

parent-child interaction and family functioning did not differ significantly in families with lesbian or heterosexual parents.

Assisted Fertility

Donor insemination became available to married couples in Aotearoa New Zealand in the 1970s. Historical privileging of biological parents contributed to shame about the absence of a genetic connection and attempts were made to match the physical characteristics of a donor and the non-biological father. In 1987 the Status of Children Amendment Act clarified the legal status of donors as having no legal rights or responsibilities, reducing donor and recipient anxiety and making increased openness possible (NZPA, 2000, June 10). From 1990 donors were asked to agree to be identifiable and fertility clinics encouraged parents to speak openly to their children from an early age (Hamilton, 2001). In 1993 Aotearoa New Zealand ratified the United Nations Convention on the Rights of the Child, which stated that the child's right to information about her/his origins must take precedence over parents' or donors' preference for anonymity (Adair and Rogan, 1998). The Assisted Reproduction Technology Bill 2000 further safeguarded the rights of all children (conceived by medically assisted fertility) to access information about their biological parents.

'Human Reproduction: Navigating our Future', a report released in 1994, stated that all individuals have a fundamental right to choose to have a family and refusal by fertility clinics to provide services to lesbian couples would be a breach of the Human Rights Act 1993 (cited in Pihama, 1998). Assisted fertility providers were advised to alter their practices and policies to ensure that they complied with the guidelines on non-discriminatory service production, with particular reference to marital status, sexual orientation, age, race and disability (Tyler, 1994). In 2000 the Health Funding Authority began to implement national guidelines on fertility services, which entitled infertile lesbian and single women to receive state-funded fertility treatment (NZPA, September 11, 2000).

Demographics

In 1996 the New Zealand Census finally allowed people living together in same-sex couples to identify themselves. Statistics NZ acknowledged that the figure

of 6,518 greatly underestimated the actual number of lesbian and gay people, as the question excluded those living in a different household from their partner (Pihama, 1998). The self-identified couples were living with a total of 1212 children. Member-of-parliament Chris Carter is currently calling for submissions in favour of a question specifically addressing sexual identity to be included in the Census of 2006, as this would more closely match actual demographics (Durkin, 2003).

An indication of the numbers of lesbian women living in Aotearoa/New Zealand was given by an Otago University study of 1000 people born in Dunedin. This revealed that 25 per cent of women and 11 per cent of men have been attracted to a member of the same sex (NZPA, 2003, April 6). The findings surprised researchers, because studies in Britain and the USA have found far lower rates of same-sex attraction in the same age group (21-26 years). It was also noted that while 20 per cent of the women interviewed thought that gay or lesbian sex was immoral, there was a positive correlation between tolerance and level of education (NZPA, 2003, April 6).

In the early 21st century there have been sweeping changes in the legal status of same-sex partnerships. The Netherlands, Belgium, the Swiss canton of Zurich, and the states of Ontario and British Columbia in Canada have legalised lesbian and gay marriage (Young, 2003). Ten European Union nations (including France and the countries in Scandinavia), and some states in the USA and Australia, already have some form of equality for same-sex partnerships and the UK plans similar legislation. In Aotearoa New Zealand the Civil Union Bill (planned for later in 2003) will confer substantive rights and responsibilities to same-sex couples and the proposed Care of Children Bill will protect the parental status of partners of lesbian women who conceive with assisted fertility (Young, 2003).

Lesbian mothers have only been visible in Aotearoa New Zealand for the last twenty years and so far, just one study has looked at the experience of children in queer families. Hauschild and Rosier (1999) interviewed young women and men aged between 15 and 34 years, who had grown up with lesbian and gay parents. All the participants have a positive relationship with their parents and felt that any problems in their childhood related to their parents' initial separation, rather than living with a new same-sex partner. Anecdotally queer

families are known to range from a redefined form of nuclear family with two mothers and their children, through to more complex extended families (Personal communication, Lesbian Mother's Group, 2001).

Conclusion

I have discussed the historical and political context of lesbian planned pregnancy, beginning with the influence of feminism on the institution of motherhood. The evolution of lesbian politics has seen a move from shame and internalised homophobia through liberation and pride to an assertion of equal rights and theoretical mainstream positioning. I have summarised key events in the history of lesbian parenting in Aotearoa New Zealand, looked at the Maori understanding of whanau and whakapapa, and traced the development of cultural safety in midwifery education and legislation related to the status and rights of queer families.

CHAPTER THREE: RESEARCH CONTEXT

LESBIAN MOTHERS

Although the traditional two-parent family was yielding in prevalence to a myriad of other family forms by the 1980s, a lesbian mother seeking continuation of parental rights was disadvantaged by subjective criteria used to determine the best interests of the child (Thompson, 2002). Indeed, McNeill (2000) suggests that her best chance was "to portray herself as being as close to her heterosexual counterpart as possible and preferably asexual" (p.24). Early studies confirmed that the difficulties associated with being a lesbian mother did not appear to be inherent in the role, but rather came from society's attitudes and discriminatory behaviour (Hanscombe and Forster, 1982; Saphira, 1984; Hanna, 1986). Researchers attempted to provide the courts with an alternative to myth and stereotype when determining custody and access.

The very notion of lesbian and mother was a contradiction in terms to the average judge. For him, lesbian mother was semantically, physically and ideologically impossible; he was likely to believe that the lesbian standing before him was the only one he had ever seen (Pollack and Vaughn, 1987, p.44).

Research which judged lesbian mothers on how well they compared to the heterosexual norm reassured the courts, but obscured some positive characteristics of queer families, such as children being exposed to cultural and individual diversity (Lewin, 1993; Chan and Paterson, 1997). In this chapter I review research relating to lesbian mothers and their families, along with studies focussing on the experience of healthcare. The first section, Lesbian mothers, includes the headings: *Partners and parents, Fathers and donors, Importance of family and community and Children in queer families*. The second section Midwifery care for lesbian mothers, discusses findings related to: *Disclosure of sexual identification, Appropriateness and sensitivity of midwifery care and Experience of heterosexism and homophobia*.

Partners and Parents

In the 1990s the focus of research moved from proving the legitimacy of queer parenting to recording a historically unique sociological phenomenon. The 'lesbian baby boom' in the USA, Britain and Europe prompted a number of studies and demographic research was welcomed by lesbian-identified academics as an opportunity to refute homophobic stereotypes. The lesbian mothers participating in these studies were predominantly Caucasian, middle-class, tertiary-educated, working in professional or managerial occupations and living in an urban centre (Martin, 1993; Brewaeys et al, 1995). Paid employment was shared or the co-parent provided the main financial support for the family (Hanna, 1986; Patterson, 1995). While donor insemination had been available to heterosexual couples for many years in the Netherlands and Belgium, Brewaeys et al (1995) recorded a rapid rise in the number of lesbian couples accessing fertility assistance (from 2% of the total in 1985 to 31% by 1994).

An American longitudinal study (Gartrell, 1996, 1999) followed 84 lesbian-led families with children conceived by donor insemination. The first interview was undertaken prospectively when the woman was pregnant, to learn about the families and communities into which the children were to be born. The second report yielded data on the stability of parental relationships, parenting roles and links with families-of-origin. Parental relationships were found to be cohesive and enduring (Brewaeys et al, 1995; Gartrell, 1996) and lesbian mothers shared parental roles and tasks equally, including responsibility for feeding, playing, changing nappies, and waking at night (Patterson, 1995; McNeill, 1998). Children usually called both women by a maternal title such as Mommy/ Mama and half had both women's surnames (Gartrell, 1999). Concern was expressed about insufficient acknowledgement of the partner's parenting role (Gartrell, 1999; Thompson, 2002) and co-mothers admitted to feelings of envy related to the experience of pregnancy (although not usually childbirth!) and the breastfeeding relationship (Pollack and Vaughn, 1987; Lewin, 1993).

Collaborative research titled *'Families, health and reproduction: An exploratory study of lesbian, gay, bisexual and transgender parents in Australia'* (McNair and Dempsey, 2002) used qualitative and quantitative methods to generate data about age, ethnicity, length of relationship (85% over 2 years), number of

children, education (85% tertiary educated), employment and accommodation of participants. Respondents were also asked, how do lesbians (in conjunction with donors/fathers) achieve their families, what role do men play as donors/parents in the lives of children in lesbian-led families and what kinds of social and support networks sustain queer families in a heteronormative culture.

Fathers and Donors

Early studies on lesbian mothers described families consisting of two mothers and children conceived in previous heterosexual relationships. Lewin (1993) was surprised to find that, despite the hostility evidenced in some custody battles, lesbian mothers still believed fathers to be vital influences in their children's lives. The number of lesbian women using anonymous donor insemination increased in the USA through the 1980s (Martin, 1993), leading to discussion about the child's right to an identifiable donor. In Gartrell's (1996) study donor preferences were equally divided between a known and unknown donor. Three years later, a quarter of the children had an actively involved father and some mothers regretted using an unknown donor (Gartrell, 1999). Brewaeys et al (1995) also found that, retrospectively, most lesbian parents who conceived with assisted fertility would have preferred a known donor. In many cases, friends and family had taken on the role of male identification model. McNair and Dempsey (2002) report equal numbers of fathers and donors and lesbian women conceived with the assistance of a friend, a respondent to an advertisement, or through a fertility clinic.

Importance of Family and Community

All the participants were out to their children, family and friends, whereas only a third felt able to talk about their relationship with their colleagues (Brewaeys et al, 1995; Gartrell, 1999). Being open about lesbian identity positively correlates with psychological wellbeing and children are growing up in a social network with positive attitudes to their family (Patterson, 1995). Lesbian parents expressed some concerns about the potential for stigmatisation, but all expected to discuss their lesbian identity and the method of conception openly and in an age-appropriate manner with their children (Gartrell, 1996). Most had

spent time educating health care providers, childcare workers, colleagues, relatives and neighbours about their families (Gartrell, 1999).

Lewin (1993) was surprised by the value placed on family-of-origin as the most reliable source of support for lesbian mothers. The results were consistent with Patterson's (1995) evaluation of the importance of extended family and friendship networks in lesbian-led families. The children in her sample had monthly or more frequent contact with approximately six adults (4 women and 2 men), contradicting the stereotype of lesbian mothers and their children as being isolated from kinship networks or living in single-sex worlds (Patterson, 1995). Children who had regular contact with their extended family had fewer reported behavioural problems. The authors concluded that the study confirmed the value of extended family networks in lesbian-led families. The lesbian parents in Gartrell's (1999) study saw themselves as having strong social supports, close relationships with friends and many were active in lesbian/gay organisations. Children fared best if the mother had a strong lesbian identity, good parenting skills and support from other lesbians (Gartrell, 1999; Patterson, 1995). Acceptance of their mother's sexuality was enhanced by her active participation in the lesbian community

Children in Queer Families

Research carried out with lesbian-led families aimed to disprove a correlation between family form and function. Contrary to stereotype, lesbian mothers described their relationships as stable, had regular contact with their extended families and benefited from good community support. Chan and Patterson's (1997) study compared the psychosocial adjustment of children with heterosexual or lesbian mothers, who were conceived via donor insemination. Children with lesbian parents were assessed as well adjusted, high on social competence and low on behavioural problems, and the children's development appeared to be unrelated to variables of family structure and parental sexual identity.

Braeways et al (1995) concluded that same-sex parenting did not negatively influence the psychosocial, emotional and behavioural development of the children. McNair and Dempsey (2002) identified some strengths of the queer

family structure, including equality within lesbian relationships, the ability to negotiate flexible roles, and an increased commitment to teaching children tolerance. Challenges for lesbian parents included a lack of recognition for co-parents, the difficulty inherent in forging a new path with few role models, and anxiety about children being exposed to homophobia.

There is abundant and convincing evidence that sexual orientation is not a valid consideration in regard to parenting abilities. In addition to the studies previously described, research comparing children growing up in lesbian households with children of heterosexual parents found few or no differences in the development of gender identity, gender-role behaviour (Hoeffler, 1981), sexual identification, emotional development, intelligence (Kirkpatrick, 1981), self-esteem (Huggins, 1989) and independence (Flaks, 1995). Homosexual parents are at least as capable of raising healthy, well-adapted children as heterosexual parents. Some data suggests that there may even be important and beneficial outcomes from being the product of a lesbian family, such as an increased appreciation of diversity and expanded views of gender roles. The American Psychological Association review concludes that,

There is no evidence to suggest that lesbians and gay men are unfit to be parents or that psychosocial development among children of gay men or lesbians is compromised in any respect relative to that among offspring of heterosexual parents. Not a single study has found children of gay or lesbian parents to be disadvantaged in any significant respect relative to children of heterosexual parents. Indeed, the evidence to date suggests that home environments provided by gay and lesbian parents are as likely as those provided by heterosexual parents to support and enable children's psychosocial growth (cited in Hauschild and Rosier, 1999, p.12).

MIDWIFERY CARE FOR LESBIAN MOTHERS

Lesbian women are part of every ethnic group and every socio-economic class. They may be single or partnered, teenagers, mothers or senior citizens. Every healthcare worker, clinic, hospital and community service providing care for women also cares for lesbian women. The invisibility of this marginalised group is a consequence of feeling unable to safely disclose sexual identity (Carroll,

1999). Under-utilisation of healthcare services by lesbians can lead to sub-optimal care and under-funding for specific needs.

Disclosure of Sexual Identification

Coming out refers metaphorically "to stepping out of a closet, an emotional hiding place where one need not disclose one's identity" (Zeidenstein, 1990, p.11). Wilton and Kaufmann (2001) suggest that the complexity of the decision to come out to service providers "is often unappreciated by heterosexuals, who enjoy much greater freedom to be themselves without fear of hostile reaction" (p.204). Although most participants in their research disclosed their sexual identity to their midwife, the women who did not cited fear of prejudice and discrimination or concerns about confidentiality. Non-disclosure complicated interactions with health care providers and precluded a trusting relationship.

Some health professionals used disclosure to express their own views in an inappropriate manner, refused to book the women or even reported them to social services. Others were embarrassed or determined to ignore the information, implying that it was of no significance (Wilton & Kaufmann, 2001). Many midwives asked questions unlikely to yield any benefits for maternity care, such as how the woman got pregnant, what she would tell her child and if she had ever been heterosexual. On the other hand, many did not ask if she had a partner, or how her partner felt about the pregnancy. Most importantly, hardly any midwives asked women their wishes regarding confidentiality (Wilton & Kaufmann, 2001).

Stevens (1995) described the stressful, tautological exercise of having to come out over and over, everywhere, with everybody. "When you go in, the receptionist calls you 'Mrs'. The magazines in the waiting room, the forms you fill out... Nothing matches anything about your life" (p.27). Reactions from health care providers to disclosure of sexual identity included: embarrassment, refusal to treat, voyeuristic curiosity, breaches of confidentiality, and overt hostility (Stevens, 1995). "Demonstrations of surprise and discomfort diminished lesbian clients' sense of safety" (p.28).

Zeidenstein (1990) reported that the participants in her study all came out to lesbian practitioners, only half disclosed to (presumed) heterosexual healthcare workers and a third to male doctors and nurses. Some lesbian women stated that they believed their appearance was self-evident; they expected that their haircut, clothes and wearing of symbolic jewellery would signal their sexual identification. Women came out when they felt very comfortable and safe (seldom) or desperate. A significant number also felt unable to discuss their lesbian family with a healthcare provider. Brogan (1997) agreed that anxiety about a homophobic reaction from healthcare providers causes lesbian women to conceal their sexual identity by "being vigilant about the intimate details of who they are, how they act, how they look, what they say, who they are with and where they go. Such a task is extremely complex and is not paralleled in the experiences of non-lesbian women" (p.6).

Appropriateness and Sensitivity of Midwifery care

McNair and Dempsey (2002) suggest that lesbian prospective parents are highly responsible in preparation for pregnancy, updating pap smears and screening for hepatitis B, HIV, and rubella immunity. Sources of support include midwives, pregnancy books, websites, lesbian mother support groups, other queer parents and fertility specialists. Women choose self-fertilisation because of a desire to involve their partner, beliefs about the child's right to know their father, cost, and feminist opposition to unnecessary medical intervention. They use assisted fertility because of a failure to conceive using self-fertilisation, feelings of urgency related to maternal age or if they can't find a known donor (McNair and Dempsey, 2002).

Despite difficulty with disclosure of sexual identity, lesbian mothers express high levels of satisfaction with midwifery care. The first published research to look at the experience of midwifery care from the perspective of lesbian mothers was an American study by Harvey et al (1989). Most participants felt able to disclose their sexual identification to their midwife but very few felt the same level of safety with an obstetrician. Mothers described their experience of midwifery care as generally positive and reported higher levels of support from and satisfaction with midwifery care. Zeidenstein (1990) listed strategies such as

booking with a home birth practice, attending antenatal classes together and when possible, meeting with the midwife prior to the birth. Couples used their lesbian network to locate lesbian or lesbian-friendly practitioners and left the hospital soon after the birth, as they felt nervous about hospital policy on the postnatal wards.

A decade later, Stewart (1999) attempted to determine how successfully maternity services in the UK were meeting the needs of lesbian parents. She highlights the importance of open, honest, respectful communication, issues of choice, continuity and control, and the value of support as demonstrated by taking time, kindness, warmth and acceptance. Stewart also discussed the negative effects of heterosexist assumptions and stereotyping on the relationship between women and their midwives. Her participants stated that they wanted to be perceived as 'ordinary' and given the same level of information and support as other parents (Stewart, 1999).

Stewart's research became the pilot for a much larger study exploring the maternity care experiences of lesbian women (Wilton and Kaufmann, 2001). The proposed outcome was the publication of a position paper by the Royal College of Midwives. As with the American studies, participants were more likely to be Caucasian, older than most other maternity service users and to live in an urban centre. A quarter of the participants birthed at home, where they felt "less vulnerable to the assumptions and prejudices of others" (p.207). Most midwives acknowledged and included the women's partners as equal parents and the couples appreciated even small gestures of acceptance and support. They did, however, ask to be accepted 'as lesbian women' (Wilton & Kaufmann, 2001).

Experience of Heterosexism and Homophobia

Although many same-sex couples are in committed, long-term, monogamous relationships, there is no category on health history forms that acknowledges them (Harvey and Carr, 1989; Stevens, 1995). Inquiries about partnership status that relate to heterosexual marriage leave lesbians without the opportunity to communicate their own circumstance (Harvey et al, 1989; Wilton and Kaufmann, 2001). McNair and Dempsey (2002) commented that

discriminatory comments, along with a lack of acknowledgement of the lesbian mother's relationship and her partner's role in the family, left many women feeling dissatisfied with healthcare services.

Alleyne (2000) described her experience of homophobic reactions during a hospital admission. "It was always assumed that my partner was a man and I got tired of correcting this assumption" (p.10). The nurse responsible for much of her care became "increasingly cold and rude and the quality of my physical care was compromised. I felt as if I was being punished for my 'deviancy'." Unable to openly acknowledge her lesbian identity, she felt, "isolated, dislocated from my sense of who I am, invisible. It was fine to be a grandmother. It was clearly not fine to be a lesbian" (p.10).

Satisfaction with midwifery care did not extend to antenatal education in the UK study. Wilton and Kaufmann (2001) note that participants felt excluded by the overwhelmingly heterosexual nature and content of classes and suggested that, individual practitioners need to think about the inclusiveness of their knowledge, attitudes, language and behaviours. Recommendations from Wilton and Kaufmann's research (2001) underpin the Royal College of Midwives' position paper on the care of lesbian mothers. They conclude that:

Most of the women who participated in this survey were forced to negotiate a range of obstacles to good care, including ignorance of their needs, assumptions which made them feel excluded or marginalised, moral disapproval or even, albeit rarely, outright hostility and negligence (p.210).

All the researchers reiterated that efforts should be made to redress systemic exclusion, prejudice and discrimination. "Lesbians require a service that accepts their sexual orientation as an integral part of their identity, does not stereotype or make assumptions and is overtly intolerant of homophobia" (Stewart, 1999, p.418).

Conclusion

A review of the relatively small amount of published research on the experiences of lesbian parents reveals some recurring themes. Comparisons of children growing up in queer families with children of heterosexual parents,

confirm that there are no discernible differences in gender identity, sexual identification, intelligence, emotional development and self-esteem. There may even be some advantages for children with lesbian parents, such as an increased tolerance of diversity. While lesbian mothers' experiences of midwifery care were mostly positive, they often encountered insensitivity and heterosexism during interactions with other maternity service providers.

CHAPTER FOUR: METHODOLOGY

METHODOLOGY

In the first part of Chapter Four I discuss the theoretical and philosophical influences on my decision to use radical hermeneutics as the methodology for this study. I began the journey with an understanding that this would be qualitative, interpretive research from a hermeneutic rather than a phenomenological perspective. As the data revealed more of the phenomenon I realised it was important to consider other theoretical positions. Radical hermeneutic philosophy, an emergent methodology defined here as hermeneutic interpretation informed by the theoretical frameworks of lesbian feminism and queer poststructuralism, seemed to fit the research question and the data. The epistemology is qualitative, interpretive and social critical, reflecting the belief that knowledge is socially constructed and contextualised.

The Journey begins with the Researcher

Southwick (cited in Giddings and Wood, 2001) suggests that when using radical hermeneutics, "You have to declare yourself to the whole world. People have a right to know how you came to the decision. Probably more than other positions, it is very revealing of the researcher" (p.11). Revealing the process and providing a map which others may follow, is congruent with Gadamerian notions of horizon and prejudice. For Gadamer, the terms horizon and prejudice refer to the culturally and historically produced preunderstandings that influence interpretation and thereby constitute understanding (Spence, 2001).

Gadamer differentiates research method and research philosophy, the latter being the "embodied understandings of 'being human' and 'doing research' which guide our thinking and our actions" (Smythe, 1998, p.79). I bring my experience of the civil rights movement, the second wave of feminism and gay liberation to the research task. Involvement with organisations such as La Leche League and Playcentre has helped to shape my beliefs about childhood and parenting. As an autonomous practitioner who works in partnership with women and their families, I am a product of my professional education and

midwifery politics. Finally, I hold an ethical position that participants should be empowered by and benefit from research in which they are involved.

Towards a Qualitative Approach

My early experience with nursing and education research involved small, quantitative studies, reflecting the dominant positivist paradigm of the time. As a feminist, I understood the role of research in effecting change, but believed that statistical empiricism was necessary in order to be taken seriously. Experience with questionnaires confirmed that ticks in boxes are an inadequate means of recording participant responses. People either add their thoughts along the side of the paper or elaborate verbally when they return the questionnaire.

My nursing dissertation used feminist narrative methodology to explore "The birth experiences of lesbian mothers in Aotearoa/New Zealand" (Bree, 1991). Structured interviews yielded rich data, but reporting the findings quantitatively diminished the significance of the conclusions. Sarantakos (1993) describes the characteristics of qualitative methodology; "a small number of respondents, aims to understand people not measure them, perceives the researcher and researched as two equally important elements" (p.45).

Interpretive Methodology

Interpretive methodology is congruent with the way human beings experience the world. Weber defined the interpretive quality of "Verstehen" as an "empathetic understanding of human behaviour" (cited in Sarantakos, 1993, p.34). Humans are complex beings who attribute unique meaning to their life situations and with this research I hoped to provide an opportunity for lesbian women to tell the stories that they considered to be important. Van Manen (1990) suggests that interpretive descriptions of a phenomenon should "resonate with our sense of lived life", eliciting the "phenomenological nod" of recognition (p.27).

HERMENEUTICS

Hermeneutic methodology originates from theological interpretation of biblical texts for clarification of the intention of the (divine) author. Later philosophers such as Heidegger and Gadamer focused on the ontology of understanding rather than the epistemology. Heidegger (1962) suggests that hermeneutics is the study of ways of "being-in-the-world" or "Dasein" (p.61). Smythe (1996) makes the connection between the ontology of midwifery and the "kinds of being" which Heidegger calls "Having concern, producing something, attending to something and looking after it, undertaking, accomplishing, considering, discussing, determining..." (p.8). The Dasein of the phenomenon I am exploring might include deciding, planning, negotiating, taking control and then relinquishing it.

In hermeneutic research, text has come to include transcribed conversations with purposively selected research participants. Geanellos (1998) describes hermeneutic interpretation as a dynamic process, which acknowledges textual multiplicity or the layers of meaning within a text. Textual plurality is the different interpretations available to researchers through their particular pre-understandings of the phenomenon of inquiry. For Geanellos then, "Interpretation is an attempt to grasp and recreate meaning in order that more complete or different understandings occur; it seeks to make clear or bring to the light, that which is fragmentary, confused or hidden" (p.155).

Language and Tradition

Heidegger's (1962) notion that we first come to understand "being" in its "temporality and historicity" seems to fit philosophically with the study of an emerging socio-political phenomenon (p.42). Gadamer (1982) supports the view that meaning exists within a "linguistic tradition" or social historical context. "We stand always within tradition, it is always part of us, it is a precondition into which we come, we produce it ourselves, we participate in its evolution and hence further determine it ourselves" (p.261). Allen (1995) describes interpretation as "an interaction between a historically produced text and a historically produced reader" (p.175). While my experience as a lesbian mother

and midwife enhanced my understanding of the experience of the participants in this study, there were also some significant differences.

Gadamer (1982) emphasises the importance of language as "the fundamental mode of operation of our being-in-the-world and the all-embracing form of the constitution of the world" (p.147). Lesbian-identified women have maintained a covert historical consciousness and linguistic tradition despite the threat of exposure leading to loss of family, friends, liberty or even life. In order to understand the experience of planned pregnancy from a lesbian perspective, it is necessary to explore the meanings and marginalisation of language. Thompson's (1990) assertion that understanding is based on "shared meanings and shared experiences within a common linguistic community" (p.240), is supported, for example, by the success of the carefully chosen words 'Gay Liberation' in altering the public perception of homosexuality.

Open Dialogue

Acceptance of difference and sensitivity to others are central to the purpose of my research. Hekman (1986) states that, "Understanding, like conversation, is always a reciprocal relationship" (p.108). Gadamer (1982) uses metaphors of conversation and play to describe the dialectic and dialogic nature of human understanding. He argues that if interpretation is genuinely open, then new and different understandings became possible through an ongoing dialectic or fusion of horizons. Prejudice has been considered a barrier to open dialogue and reciprocity, but Gadamer (1982) insists that our ability to understand can be enhanced by our specific cultural perspective and personal tradition. He rehabilitates prejudice when he suggests that our linguistically mediated pre-understandings have the potential to both enable and limit interpretation.

Fusion of Horizons

The researcher brings her experience and assumptions to the interpretation, leading to a unique and temporal understanding of the phenomenon. Describing the historicity of understanding, Heidegger (1962) speaks of "horizons of future, present and having been" (p.416). For Gadamer (1982) the horizon is "everything that can be seen from a particular vantage point... into which we

move and that moves with us" (p.302). Understanding occurs when the horizon of the interpreter intersects with the horizon of the author of the text. In order for this to happen, Thompson (1990) suggests "one must be able to tolerate the ambiguity of relaxing (not eliminating) one's own pre-conceptions" (p.246).

Gadamer's notion of effective historical consciousness refers to understanding the horizon of the text through the context in which the text was produced and the meanings of language within that context (Allen, 1995). Hekman (1986) identifies three methodological tasks for hermeneutic researchers, firstly to describe the historical and cultural horizons of the participants and secondly to differentiate the horizon of the interpreter. Finally and crucially, "to explicate how and why the interpretations (horizons) of the researcher have informed the choice of the research question, research process and the analysis or research findings" (p.257). I have attempted to meet Hekman's (1986) methodological criteria in the early chapters of this work.

The Hermeneutic Circle

Congruent with the notion of understanding as effected by and effecting history, the metaphor of the hermeneutic circle describes the relationships between the parts of the text and the whole of the phenomenon. According to Gadamer (1982), "Every experience is taken out of the continuity of life and at the same time related to the whole of one's life" (p.62). My earlier research into the birth experiences of lesbian mothers reflected my lived experience as a graduating nurse, a single mother and a recent user of home birth midwifery services. I returned to the phenomenon as an experienced midwife and a partnered parent to three children, having completed postgraduate research papers. The hermeneutic circle affirms both the 'emic' expressions of participants and the 'etic' descriptions of the researcher; one perspective is not privileged over another (Thompson, 1990).

The way to reveal the phenomenon under investigation is to engage with the text within the hermeneutic circle by addressing pre-understandings, reflecting upon their origins, adequacy and legitimacy, and considering their influence upon the research/er (Geanellos, 1998, p.161).

FEMINIST THEORY

Feminist research describes women's lives in relational and contextual terms and has particular relevance for midwifery-related phenomena of inquiry. Feminist theory is central to the development of lesbian-led families, to midwifery partnership with women and therefore, to the research question. "Feminist research is always a struggle, then, at least to reduce, if not to eliminate, the injustices and unfreedom that women experience" (Crotty, 1998, p.182). The ontology of feminist research is participatory with an emancipatory purpose, empowering the participants by making their voices heard. This fits philosophically with the notion of midwifery partnership in Aotearoa New Zealand; the same issues of trust and equality appear in clinical and research settings.

In her discussion of the historical development of feminist theory, Weedon (1987) refers to "women's absence from the active production of most theory within a whole range of discourses over the last 300 years" (p.13). The contributory mechanisms include: gender division of labour, the specific exclusion of women from institutions of learning, and mythological constructs about biological difference, such as a smaller female brain or an association between academic activity and infertility.

Feminist researchers may share methodologies and methods with researchers of other stripes; yet feminist vision, feminist values and feminist spirit transform these common methodologies and methods and set them apart. Far more than ways of gathering and analysing 'data', methodologies and methods become channels and instruments of women's historical mission to free themselves from bondage, from the limiting of human possibility through culturally imposed stereotypes, lifestyles, roles and relationships (Crotty, 1998, p.182).

Feminist critique of the family

Weedon (1987) presents an historical perspective on feminist theoretical critique of 'the family', "In conservative discourse the family is the natural basic unit of social order... primarily responsible for the reproduction and socialisation of children" (p.38). Liberal feminism argued for women's rights to choice and self-determination, but did not question the nuclear structure of the family.

Radical feminism identified the family "as the key instrument in the oppression of women through sexual slavery and forced motherhood" and suggested that "the life-giving qualities" of "true femaleness can only be realised beyond the structures of male control of female sexuality and procreative power" (Weedon, 1987, p.17). In the Socialist feminist analysis, capitalism, patriarchy and racism are "discrete but interrelated forms of oppression" (p.17). Weedon sees socialist-feminist objectives, including reproductive freedom for women, as having:

Profound implications for family life...The right to decide if and when they will have children and under what conditions...The abolition of the privileging of heterosexuality, freedom to define one's own sexuality and the right of lesbians to raise children (p.18).

Feminist theoretical analysis and discussion simultaneously constituted and was an effect of rapid social and political change. Women who encountered the writings of Friedan (1965), Rich (1976), Oakley (1982) and others, formed consciousness raising groups and initiated changes in their own and other women's lives. The revolution began in the family and ultimately the family was revolutionised.

Feminist hermeneutics

Gadamerian hermeneutics informed by feminist theory contextualises individual accounts of experience of the phenomenon with an explanation of gender power relations. Proposing a feminist hermeneutic theoretical approach to nursing research, Owens (1992) refers to "the richness afforded by the acknowledgement of diversity, complexity and multiple perspectives and realities" (p.375). Gadamer reminds us "to expect the unexpected, to be open to new experience" and suggests that "understanding is synonymous with wisdom and different from knowledge" (cited in Owens, 1992, p.378).

Owens argues that traditional, apolitical interpretation offers an inadequate understanding of the social historical context. She agrees with Habermas that we need to be "sceptical of taken-for-granted meanings and critically examine cultural and political practices" (p.378). Midwifery practitioners in Aotearoa New Zealand are almost exclusively female, as are the primary recipients of our

care. The political struggle leading to the reinstatement of autonomous midwifery practice was fought on gender related issues, with male obstetricians and politicians as the most vocal opponents.

Narrowly defined gender roles from recent history, notably the Victorian era, also inform our understandings of sexuality. Pihama (1998) defines gender as "the beliefs, values, expectations and practices that are attached to being either female or male within a particular society" (p.188). The experience of colonisation by Christianity radically altered Maori understandings of gender. Feminism seeks to "eliminate injustices based on the social constructions of language and gender" (Owens, 1992, p.380). Midwifery research informed by feminist theory attends to the principles of "inclusivity, justice, freedom from oppression and open discourse" (p.384).

Four dimensions of understanding constitute Owens' (1992) feminist hermeneutics. Understanding is always located within a historical tradition or cultural context. In the critical dimension, the need to "deconstruct the dominant discourses concerning the phenomenon of study" leads to the "empowerment and emancipation" of the study participants (p.382). The reflexive dimension concerns the kinds of activities familiar to nursing and midwifery practitioners: analysis, synthesis and praxis. Owens describes the interpretative dimension as "the outcome of historical, critical, reflective thinking, the conferring of meaning" (p.383). Feminist hermeneutics, then, is "a critical, reflective stance that draws together historical and contemporary cultural, political and social influences into a complex interpretative cycle" (p.373).

As a nurse researcher, Owens used feminist hermeneutics to focus on the exploration of practice issues. While this could have been useful, it did not seem adequate in terms of the rapidly evolutionary nature of my phenomenon of inquiry. My earlier research into the birth experiences of lesbian mothers revealed radical feminist attitudes; lesbian women were challenging the male-dominated medical establishment by conceiving, birthing and parenting outside the system. A decade later the politics and determination were still there, but the mood had mellowed. Lesbian and gay collaboration in Queer politics facilitated friendship and trusting relationships, which then enabled women and men to create new forms of family together.

The tendency of feminist theory to "universalise and essentialise the experiences of some women to be that which is true for all women" (Southwick, cited in Giddings and Wood, 2001, p.18) means that norm referencing the experience of Pakeha, middle-class, heterosexual women excludes and marginalises lesbian women, women-of-colour and others. Southwick concludes that poststructural theory is more inclusive of the particular experiences of women for whom gender may not be the primary category of oppression.

At the heart of the debate between feminist theory and postmodernism is the tension between the 'Universal' and the 'Particular'. Feminist theory is quintessentially concerned with the oppression of all women, but paradoxically is able to speak for only some women because of its insistence on privileging the oppression of the patriarchy (Southwick, cited in Giddings and Wood, 2001, p.19).

POSTSTRUCTURALISM

Poststructural and hermeneutic philosophies agree on the importance of language as "the place where actual and possible forms of social organisation and their likely social and political consequences are defined and contested" (Weedon, 1987, p.21). Poststructural theory originates in Saussure's (1960) claim that reality and meaning are constituted by language rather than being inherent and fixed. Same-sex relationships have variously been defined and constituted by language; 'homosexuality' as psychiatric pathology, 'gay' promising political emancipation, and 'queer' celebrating the diversity of human experience. For Saussure, "meaning is not intrinsic but relational" (cited in Weedon, 1987, p.21). Signs acquire meaning through their difference from other signs and consist of a Signifier, which may be a word, sound or image and a Signified, the meaning or concept.

Derrida's (1978) critique of the Saussurean sign is an attempt to explain 'plurality of meaning' or changes in meaning over time. Derrida proposes that it is "not only the signified content of the text which determines meaning but also its significance" (cited in Crowe, 1998, p.341). In the 'play of difference' there are no fixed signifieds or concepts, instead signifiers are constantly "deferred, always located in a discursive context and open to challenge and redefinition"

(Weedon, 1987, p.25). Poststructural theorists like Derrida and Foucault share the belief that meaning is culturally determined and regulated. "Internalisation of cultural constructions through the medium of language ensure continued adherence to established social order" (Crowe, 1998, p.341).

Foucault (1981) uses the notion of discursive fields, consisting of competing ways of giving meaning to the world, to explain the relationship between language, social institutions, subjectivity and power. Within the discursive field of 'the family' the heterosexual discourse carries more weight than that of same-sex parenting. Foucault suggests that language operates within historically specific discursive relations and social practices. Knowledge is used to construct discourse, which reproduces and legitimises existing power structures by marginalising competing discourse. Thus, when a lesbian woman fills out a pregnancy booking form that requires her to name her husband, when the antenatal educator speaks only of fathers and the postnatal midwife enquires whether she and her partner are sisters, hegemonic beliefs renders lesbian women invisible.

Subjectivity is used to refer to the conscious and unconscious thoughts and emotions of the individual, her sense of herself and her ways of understanding her relation to the world... Poststructuralism proposes a subjectivity which is precarious, contradictory and in process, constantly being reconstituted in discourse each time we think or speak (Weedon, 1987, p.33).

Sexual identification has replaced sexual orientation as the preferred term for the subjective component of one's sexuality. Orientation implies a truth waiting to be discovered, an innate, genetically determined sexuality; while identification suggests that one may be in a same-sex relationship now but anything is possible. The oft repeated narrative of feelings of 'coming home' when first acknowledging homosexual feelings in oneself, and the controversial 'discovery of a gay male gene', support the notion of orientation. However, sexual identification is more appropriate for the many individuals who move along the sexual continuum during their lifetime.

Owens' (1992) feminist critique of poststructuralism acknowledges the appeal of Foucault's offer to "loosen the chains of metanarratives, stereotypes, categorisations, existing dominations and dogmas" (p.371). But she also

cautions that "feelings of discomfort, insecurity, disorientation and existential bewilderment" may replace initial relief, when discarding all affiliations (p.374). Owens suggests that we have a "fundamental need to know who we are, where we are located and the meaning to be attributed to our activities and location" (p.374), a position which is congruent with the Maori notions of whanau and whakapapa.

Feminist Poststructuralism

Weedon (1987) puts a case for feminist poststructuralism, on the basis that "experience has no inherent essential meaning. It may be given meaning through a range of discursive systems of meaning, which are often contradictory and constitute conflicting versions of social reality" (p.34). Meanings of gender and sexuality are socially produced and dominant discourses are found in social policy, medicine, education, the media and the church. Feminist poststructuralism rejects historical dichotomies such as 'nurturing mother' and 'predatory lesbian', and focuses instead on 'ways of being' as a partner and parent.

Weedon (1987) proposes a "mode of knowledge production which uses poststructural theories of language, subjectivity, social processes and institutions to understand existing power relations and to identify areas and strategies for change" (p.40). A great deal has changed since she commented that "alternative feminist discourses of family life" are still "marginal and powerless" (p.40). Marriage has declined in popularity and in some cultures gender roles have become less rigid. Women are excelling academically and in their careers, however, they continue to earn less than their male counterparts and many still do a disproportionate amount of domestic labour. The 'lesbian baby boom' has established an alternative feminist discourse of family life, but is seen by some as formalising disparate gender contributions to childrearing and socialisation (Kleindienst, 1999).

Queer Poststructuralism

Foucault (1981) and Jagose (1996) foreground a discussion of the political evolution of homosexuality with poststructural philosophical constructs. Jagose

has the advantage of hindsight when she describes how the politics of lesbian and gay identity have been superseded by the politics of difference in Queer theory.

The rhetoric of difference problematises gay liberationist and lesbian feminist understandings of identity and the operations of power. The delegitimation of liberal, liberationist, ethnic, and even separatist notions of identity generated the cultural space necessary for the emergence of the term Queer (p.76).

In Foucault's (1981) analysis, marginalised groups have maintained their position in society as a by-product of the very mechanisms of power, which threaten their existence. Power is not necessarily negative or repressive. It may also be productive and enabling. Oppressive acts like police harassment of gay and transgender people in the 1960s may be the catalyst for pivotal and ultimately empowering acts of resistance, such as the Stonewall riots. Foucault, however, does not endorse liberationist strategies of coming out or outing others. He claims that sexuality is a "discursive production... not an essentially personal attribute but an available cultural category" (cited in Jagose, 1996, p.79).

We must not imagine a world of discourse divided between accepted discourse and excluded discourse, or between the dominant discourse and the dominated one; but as a multiplicity of discursive elements that can come into play in various strategies (Foucault, 1981, p.100).

Queer poststructuralism acknowledges the multiple realities of power imbalance around gender and sexual identification and celebrates human diversity and choice. Jagose (1996) concludes that,

Queer is a response to perceived limitations in the liberationist and identity-conscious politics of the gay and lesbian feminist movements. The rhetoric of both has been structured predominantly around self-recognition, community and shared identity; inevitably, if inadvertently, both movements have also resulted in exclusions, delegitimation, and a false sense of universality (p.130).

Queer families offer a deconstruction of heterosexual hegemony and challenge the sanctity of the traditional heterosexual family as 'natural and necessary' for reproduction and the socialisation of children.

RADICAL HERMENEUTICS

Radical Hermeneutics is a critique of any attempt to determine the truth about a phenomenon or experience. Southwick (cited in Giddings and Wood, 2001) explains that "epistemological claims 'to know' mean that we have prematurely foreclosed on other possibilities" (p.8). Radical hermeneutics, then, is suited to the study of complex and rapidly changing phenomena. There is no single 'way of being' as a lesbian parent or queer family; one mother strongly believes in her child's right to know her biological father, while another feels that gender and biological connection are irrelevant if a child has two loving parents. Radical hermeneutics sets out "to somehow stay in the flux, in the chaos; by constantly challenging and deconstructing each position" (Giddings and Wood, 2001, p.8). Radical hermeneutic philosopher Caputo (1987) claims that all "hermeneutics starts out as radical thinking" (p.3). He credits Heidegger with hermeneutic trouble making and a commitment to keeping the question of 'being open'. The notion of the temporal nature of understanding is expanded in radical hermeneutics. Rather than seeking a fusion of horizons, the researcher looks beyond the horizon, acknowledging that any explanation is partial, incomplete and already superseded. For Gadamer (1982) the "discovery of true meaning is never finished, it is an infinite process" (p.265). Caputo (1987) conceded that Gadamer has made some useful contributions to the radical hermeneutic project.

He takes up Heidegger's notion that we are capable of historical study only in so far as we are historical and belong to the very history that we seek to understand. He demonstrates that the distance, which separates us from the past, is productive, not destructive, allowing us to filter out what is classical and enduring from what is merely idiosyncratic and time-bound. He offers an impressive defence of the authority of the text, over and against that of the author. He offers an illuminating account of the dynamics of dialogue, of the expanding and essentially revisable nature of knowledge (p.109).

However, Caputo critiques Gadamer's use of tradition as benevolent, secure and maintaining the status quo of hegemony. He argues that Gadamer did not question the extent to which "the play of the tradition is a power play" or "its vulnerability to difference, its capacity to oppress... In the manner of all metaphysicians, Gadamer wants to give us comfort in the face of flux, to assure

us that all is well" (p.112). Caputo (1987) looks to Derrida to restore the difficulty of life, praising his deconstructive vigilance. "Radical hermeneutics is what becomes of hermeneutics once it is exposed to Derrida's more radical questioning of the classical, metaphysical presuppositions about meaning and truth, about origin and destiny" (p.18). Derrida renounces truth and tradition, preferring:

A cross-fertilising dialogue among many points of view...What I mean by hermeneutics in its radicalised mode has all along been this willingness to stay in play, to stay with the flux, without bailing out at the last moment. Radical hermeneutics, on my reading is the philosophy of kinesis (Caputo, 1987, p.198).

Derrida, like Foucault, is concerned with the power of discourse to normalise, repress and exclude (Caputo, 1987). Deconstruction is emancipatory in that it proposes a liberation of meaning, an openness to complexity (Giddings and Wood, 2001). Queer theory demonstrates this kind of decentering critique with its challenge to the construction and policing of exclusive categories of sexual identity.

Caputo argues that placing one theoretical position in relation to another can create spaces for reconstructed meaning. Radical hermeneutics offers an analysis of the interplay between the universal and the particular. Southwick explains, "A choice between the universal and the particular is unsatisfactory because while both perspectives are necessary, neither alone is sufficient to deal with the complexity" (Giddings and Wood, 2001, p.26). In her study of the marginalisation of Pacific nurses, Southwick (2001) explores moving between the disparate worlds of tradition and the nursing profession. Her methodological decisions were initially influenced by a suspicion of received wisdom, and informed by the analyses of power offered by Caputo and Foucault. Lesbian women planning pregnancy are also positioned between the heterosexual hegemonic of midwifery and their lesbian feminist/queer reality. The focus of this inquiry derives from my experiences in both these worlds. I have placed Lesbian Feminism (universal) in interplay with Queer Poststructuralism (particular) to create the space from which a reconstructed meaning of planning pregnancy and creating a family can emerge.

Radical feminism critiques traditional gender roles in the nuclear family and exposes the paternalistic attitudes of medical science. During a decade of rapid social change women have taken control of their procreative powers and planned pregnancy by lesbian women has become a viable choice. Poststructural decentering of a lesbian feminist idealisation of family, consisting of two mothers and their female (or de-masculinised) children has created a space for the queer family. The extended queer family consists of a variety of biologically and non-biologically connected adults and the children for whom they provide care and protection. Thus, 'Mum' may be a woman who has never given birth, 'Grandma' may be the mother of a biological father's partner, and 'Auntie' may be an unrelated lesbian friend of the child's parents. Or, as three-year-old Aaron put it, "The people in my family are people who love me!"

Conclusion

Crotty (1998) argues for the philosophical underpinning of a research method, rather than the precise adoption of a theoretical approach. "Without access to the researcher's decision making trail, it is difficult to see the internal validity of the project, which contributes to the impression that qualitative research can be undertaken by applying methodological recipes" (Giddings and Wood, 2001, p.12). I have described my methodological journey, beginning with a preference for qualitative research and culminating in a bespoke version of Caputo's (1987) radical hermeneutics.

I have drawn from hermeneutic research methodology because the interpretive process provides a way for researcher and participants to share their experience of a social phenomenon. Gadamer's (1982) focus on language and tradition seemed particularly significant to the discussion of social historical context. The research question concerns lesbian mothers and midwifery practitioners, a uniquely female interaction lending itself to Owen's (1992) feminist hermeneutics. Foucault's (1981) thoughts on deconstruction and discourse cover the multiple realities of power imbalance. Feminist poststructuralist Weedon (1987) offers an analysis of gender, sexuality and family. Jagose's (1996) lesbian feminist/queer Aotearoa sensibility contextualise the research data. Finally Caputo's (1987) discussions of the

radical hermeneutic project and Southwick's (2001) adoption of it for her study of marginalisation and healthcare provide direction for the method.

As researchers, we have to devise for ourselves a research process that serves our purposes best, one that helps us more than any other to answer our research question... Rather than selecting established paradigms to follow, we are using established paradigms to delineate and illustrate our own (Crotty, 1998,p.216).

CHAPTER FIVE: METHOD AND STUDY DESIGN

The Research Question

The starting point of hermeneutic research is the formulating of the research question, which is not so much a question, but rather a phenomenon of inquiry. In the radical hermeneutic paradigm, the researcher brings her/his personal tradition and prejudices about the phenomenon into the hermeneutic circle. So, in one sense, the research question chooses the researcher, for it will be an aspect of their lived experience, a phenomenon in which she/he is already engaged. Radical hermeneutics also acknowledges the constructed nature of knowledge, multiple realities and the temporal nature of understanding. The question is 'what is this experience really like, for this particular group of people, at this particular time?' There is no answer to the question of planned pregnancy for lesbian women; the only truth is in the women's experience.

Radical hermeneutic methodology is emergent in design, evolving during the research process and in response to the data. In chapter four I provided a methodological 'map' of my journey to the decision that radical hermeneutics is congruent with the research question. Southwick (cited Giddings and Wood, 2001) believes that radical hermeneutics is a philosophical position rather than a recipe for research. 'Keeping the question open' allows for greater flexibility in the study design. Working under the umbrella of hermeneutics, I have incorporated the feminist principles of autonomy and empowerment, van Manen's framework of life worlds for thematic analysis, and a dynamic deconstructive process of writing and rewriting.

Ethical considerations

Humans are complex beings who attribute unique meaning to their life situations. Showing respect for human dignity and the uniqueness of the individual are intrinsic to ethical behaviour. Verstehen, the empathetic listening of the hermeneutic interpreter, demonstrates respect for the research participant (Sarantakos, 1993). Interpretation has been described as "the attentive practice of thoughtfulness" (van Manen, p.38). During the

conversational interviews participants reveal attitudes and beliefs that differ from those of the researcher. It is not the role of the researcher to debate or attempt to influence the opinions of the participant. In the context of this project, I needed to be clear that while engaged as a researcher, I would not offer midwifery information or provide care.

Autonomy, the right to self-determination, is a key concept for feminist research and midwifery partnership. Feminist research has an emancipatory purpose; the ontology is participatory and avoids the 'othering' of participants. Thompson (1990) claims that, "Emancipatory social research calls for empowering approaches to research... the research process enables people to change by encouraging self-reflection and a deeper understanding" (p.266).

Autonomy is demonstrated by gaining specific and informed consent from research participants. There has been debate about the validity of informed consent in healthcare settings, where a consumer is dependent on the truthfulness and objectivity of the information. The participants in this research were given an information sheet detailing the scope and purpose of the research, along with a written consent form (see appendices, a. & b.). They were aware that their consent could be withdrawn at any time. The nature of conversations, as opposed to structured interviews, enables the participants to determine significant experiences and understandings. Transcripts and audiotapes were returned to the participants, who were given the opportunity to request the exclusion of any part of the text.

The principles of 'beneficence' (to do good) and 'nonmaleficence' (to avoid doing harm) guide ethical behaviour. A benefit for the participants of this research was the opportunity to talk about their experience with an empathetic listener. The participants also had the opportunity to give feedback on the research process at the completion of the data collection and contribute to the recommendations. Several expressed their appreciation for the tape and transcript as a record of their experiences, which they planned to share with their children.

The potential for harm exists when people talk about sensitive issues in a non-supportive atmosphere. I faced an ethical dilemma when a participant became

distressed while describing her feelings about her midwifery care. The difficulty was compounded when she identified the practitioner, who was known to me. I stated that I was stopping the interview, turned off the tape-recorder and moved to offer support. When she felt able to continue with the interview, I moved back into my 'researcher chair' and resumed taping. Strategies to minimise harm when the research interview evokes an emotional response, include adequate debriefing and arranging appropriate referrals. In this case, I made a follow-up phone call and was able to recommend a lesbian-identified general practitioner. The participant stated that she found the opportunity to talk about her experience to be "*very therapeutic*".

The ethical principle of 'justice' is achieved through the purpose of the research, which is to enable midwifery practitioners to provide sensitive, appropriate care for lesbian mothers. In making the conclusions and recommendations widely available to midwives, I hope to effect change, both in individual practice and within organisations. The literature confirms that heterosexism and homophobia occur frequently and cause significant distress (Stevens, 1995; Stewart, 1999; O'Hanlon, 2000). The 1993 Human Rights Act specifies that discrimination on the grounds of sexual identification, in the areas of employment, access to public places, provision of goods and services, accommodation and educational establishments, is unlawful (Human Rights Commission, 1998).

The right to 'confidentiality' is central to ethical principles. The Privacy Act states that if a person chooses to disclose information relating to sexual identification and health status, this must be treated with the strictest confidentiality. In many qualitative studies, including this one, pseudonyms are offered for the protection of identity (Lofland and Lofland, 1995). I occasionally used two different pseudonyms for one participant in order to avoid building up an identifiable profile. The assurance of confidentiality has particular implications for specific small communities, where the rich data presented in interpretive analysis may serve to clearly identify participants. This study concerned the interaction between two small communities, lesbian mothers and midwives. Excerpts from the data and discussion have been carefully edited for publication and oral presentation.

Two participants had particular concerns about confidentiality, because of their personal circumstances. One couple was unwilling to compromise their children's acceptance by members of their cultural community, who were unaware of the women's relationship. Another couple had become parents through a unique set of circumstances and felt that any information related to this would identify them and their child. The women offered general comments rather than specific stories. The other participants were not at all concerned with anonymity, as they had made the decision to be 'out' when they began planning pregnancy. This did not alter my ethical responsibility to protect their identity.

A further aspect of confidentiality is the need to protect hard data, audiotapes and access to electronic media. The ethical requirement is for tapes and printed copies of data to be kept in a locked cabinet, in a private office, for six years following the research. The transportation of identifying data, or data sent via information technology, needed to be carried out with careful consideration of confidentiality. In summary the steps to ensure ethical integrity in the research included seeking and gaining ethical approval, the provision of information and use of a consent form, voluntary participation throughout the process and a trusting, empowering relationship with the participants.

Purposive Sampling

Qualitative interpretive research requires purposive sampling, the selection of participants whose lives and stories reflect the phenomenon of interest. Lofland and Lofland (1995) discuss the ethics of insider research (doing research within your own community) as opposed to outsider observation. Morse (1989) suggests that a participant researcher will be knowledgeable about the topic and the community. A participant researcher is particularly important in researching marginalised groups, where a known member of the community engenders greater trust among potential participants.

The tasks of purposive sampling include making your intentions known, gaining an indication of likely co-operation, selecting the participants and seeking formal consent. Participants need to be articulate and able "to reflect and provide detailed experiential information about the phenomenon" (Morse, 1989, p.121). They also need to be willing and able to share the experience with the

interviewer. I used a mix of purposive and nominated sampling to access the participants in this research. Nominated samples are obtained by eliciting the support and assistance of those already selected to access further participants (Morse, 1989). In this way, the researcher can "build upon pre-existing relations of trust" (Lofland and Lofland, 1995, p.38).

The participants in this study were lesbian mothers who had conceived by alternative methods of fertilisation. Their children were aged less than four years at the time of the research. The sample was accessed through discussion with lesbian midwives and a Lesbian Mothers' Playgroup. At an informal meeting to discuss the research proposal I received an enthusiastic response from all the interested parties. Radical hermeneutics methodology supports meeting with community interest groups before and after the one-to-one interviews.

I used purposive and nominated sampling of ten participants to yield no less than eight useful conversations. As previously mentioned, two participants were willing to contribute as long as they were not quoted. Sandelowski (1995) suggests that an adequate sample size in qualitative research is one that is, not too large for deep analysis and not too small to result in a "new and richly textured understanding of experience" (p.183). For her radical hermeneutic research, Southwick (cited in Giddings and Wood, 2001) used fewer participants and three separate conversations with each participant. My research question also fell into three sections: the planning of pregnancy, the experience of midwifery care and the evolution of the family, but the smaller scope of this study allowed the participants to share their experiences in the course of one conversation.

While quantitative research seeks to eliminate bias through randomised controlled sampling, the qualitative researcher influences the composition of the sample in order to meet the requirements of appropriateness and adequacy. "Appropriateness refers to the degree to which the choice of participants and method of selection fits the purpose of the study as determined by the research question" (Morse, 1989, p.122). Adequacy refers to the sufficiency and quality of the data, which leads to the question of data collection.

Conversational Interviews

In hermeneutic research, data refers to texts produced from conversations with purposively sampled participants about their experience and understanding of a phenomenon. The data was contextualised by a description of the wider historical and political background of the authors. The unstructured nature of a conversational interview, as opposed to a structured or semi-structured interview, resulted in flexible, rich data. Hermeneutic methodology has been described as an attempt "to gain insightful descriptions of the way we experience the world" (van Manen, 1984, p.38).

The personal preparation of the researcher includes an in-depth understanding of the methodology and the context of the phenomenon. I needed to assemble my equipment, including a tape recorder and audiotapes, ascertain access to power points and bring spare batteries. I experienced a problem with equipment during my first interview and double-taped subsequent conversations. Consideration should be given to the use of a cue card with open-ended questions relating to aspects of the phenomenon. While this was not usually needed, it sometimes served the purpose of returning the participant to the research question. A presuppositions interview was carried out between my research supervisor and myself, prior to commencing the participant interviews.

For radical hermeneutic research, data collection involves purposeful one-to-one conversations that include story telling. A useful sequence for the conversational interview is the introduction and warm-up, the main part of interview, slow-down and closure. During the introductory meeting I met with selected participants and explained the purpose and scope of the research. They had already received the information sheet and consent form and some women had questions to be answered. I requested permission to tape the interviews and outlined the amount of time involved and the means of maintaining confidentiality. When they had signed the consent form, we planned the time and place of the interview to suit them and their family. Most participants chose to meet in the privacy of their own homes, while their partner or another family member cared for their child. Childcare support was offered to limit interruptions, but two mothers with younger babies needed to take time out during the interview to breastfeed.

I used the same opening question for all the interviews, "How did you decide to have a child?" Gadamer (1982) proposes that genuine questions are non-directive, maintain a focus on the experience and lead to several possible answers. As the conversation continued I used prompts such as, "What happened then?" "How did that feel?" and "What do you understand about...?". Attentive listening by the researcher and encouragement for the participant to go where the story takes them, help to elicit experiential narrative. Smythe (1998) maintains "When the participant begins to tell a story, it is important to let the story unfold with all the details deemed relevant by the person telling it" (p.83).

Thompson (1990) discusses reciprocity in research; "Interviews are conducted in an interactive, dialogic manner, that requires self-disclosure on the part of the researcher" (p267). However, Southwick (cited in Giddings & Wood, 2001) reminds us of the need to maintain a balance between self-disclosure and the voices of the participants. The researcher should only offer her experience if it is helpful for empathy or to prompt further stories. "Patience or silence is a more tactful way of prompting the other to gather recollections and proceed with a story. But if there seems to be a block, then it is often enough to repeat the last sentence or thought in a questioning sort of tone" (van Manen, 1984, p.56).

Foucault (cited in Crowe, 1998) critiques the research interview as a confessional, since it is the researcher who determines the phenomenon of inquiry, the research question, the participants, the method of data collection and the significance of the data. Crowe argues that narratives of experience and memory processes are mediated by the socio-political context.

Techniques seek to uncover, interpret and illuminate the meanings of what is happening, being done, being understood or being interpreted by participants in particular social activities. This assumes an intentional subject and fails to recognise the constitutive relationship between the activities and the social structures within which they are performed (p.341).

I was fortunate in that my sample selection yielded participants who were very articulate and committed to the purpose of the research. The conversational interview offers the participant a unique opportunity to talk freely without interruption and women often continued after the tape had stopped. As the

interview came to a conclusion I gave a reminder of time, referred to the cue card or any notes taken during interview and asked if there were any other issues she wished to discuss. I signalled the end of the interview by switching off the tape and putting down my pen.

I personally transcribed the interviews and found this to be an essential part of immersing myself in the data. Efforts were made to complete the transcription of each conversation before the next occurred, but inevitably there was some overlap. My immediate assessment of the success of an interview proved to be unreliable. The three interviews that proved most challenging ultimately yielded the richest data. All tapes and transcripts were returned to the participants for verification prior to analysis.

Thematic Analysis

Hermeneutic research is described by van Manen (1984) as:

A dynamic interplay among six procedural activities: turning to a phenomenon which seriously interests us and commits us to the world; investigating experience as we live it rather than as we conceptualise it; reflecting on the essential themes which characterise the phenomenon; describing the phenomenon through the art of writing and re-writing; maintaining a strong and oriented pedagogical relation to the phenomenon; and balancing the research context by considering parts and whole (p.39).

Interpretation of textual data in hermeneutic research involves a fusion of the horizons of the interpreter, the participants and their social, historical and political contexts. Geanellos (1998) explains, "Bringing pre-understandings to consciousness is an attempt to maximise their facilitative aspect, as it allows the interpreter to examine their origin, adequacy and legitimacy in relation to the phenomenon under investigation and textual interpretation" (p.243). Included among my professional and personal prejudices are the beliefs that children have a right to knowledge about their biological parents, that many women can birth safely in their own homes and that children are not disadvantaged by their parent's sexual identification.

Thompson (1990) refers to "relaxing (not eliminating) one's own precepts... the researcher documents personal reactions, noticing that his or her own horizon is operating in the way the interpretations are made" (p.245). A reflexive journal was used to detail my methodological decisions. This took the form of responses to theoretical articles, mind mapping the connections between the literature and previous research, and commenting on everyday events which challenged my thinking. Considering the queer position on sexual identity as a fluid construct (Butler, 1990; Trett, 2001), I wrote about celebrating our elder daughter's birthday. Her four 'parents', her mother and I and her father and his male partner, identify as lesbian or gay rather than queer, but we have all been married in the past.

Interpretation is "a process of insightful invention, discovery or disclosure" (van Manen, 1990, p.79). Thematic analysis is a tool for ordering the data and giving shape to the discussion. Taped conversations with lesbian mothers yielded a vivid telling of their experience. I began by listening to the entire tape twice, then transcribed the conversation. I read each text to further understand the whole, then reread highlighting essential and significant phrases in different colours. Emerging significant or recurring themes were noted on a large sheet of paper. I printed the transcripts and cut out colour-coded significant stories, placing them in labelled clear plastic envelopes. Techniques for immersing myself in the data included grouping and regrouping, then rewriting to show the meaning rather than tell the story. van Manen (1990) proposes a framework for thematic analysis consisting of:

Four existential 'life worlds', which pervade the experience of all human beings: lived space (our physical environment), lived time (our situatedness in, and sense of, passing time), lived body (our corporeal and mental experiences), and lived relation (our interaction with others) (p.215).

Southwick (cited in Giddings and Wood, 2001) described her radical hermeneutic approach to the data as a "cycle of interpretation and reflection (which) seeks to uncover the meaning of the experience for individuals (frequently those who are socially marginalised) as they construct stories about their lives" (p.14). The interpretive process is not looking for 'the' truth about the phenomenon, but multiple realities of experience. Gadamer (1982) calls this "the opening up and keeping open of possibilities" (p.266). I needed to show the

connections and tensions between the parts and the whole of the hermeneutic circle and the dynamic, complex, interconnected nature of the phenomenon.

Rigour

The use of determinants of legitimation and representation of data and findings for research carried out with small numbers of purposively sampled participants has been extensively debated in the literature. Koch and Harrington (1998) critique the use of positivist criteria such as reliability and validity for qualitative research, and argue for an expanded reconceptualising of rigour. They seek a "liberation from the stranglehold of objectivism", proposing instead that researchers "insert their social selves" into their inquiry (p.886). This notion has coherence with Gadamer's (1982) exoneration of prejudice and the place of the interpreter within the hermeneutic circle. Thompson (1990) agrees that "the researcher and researched move between a background of shared meaning and a more finite, focused experience within it" (p.243).

Considering criteria of truthfulness for this radical hermeneutic research, I looked first at the feminist contribution to the debate, specifically Bhavani's thoughts on accountability and positioning, and Hall and Steven's use of dependability and adequacy (cited in Koch and Harrington, 1998). In order to meet these criteria my study needed to acknowledge the constructed nature of knowledge, identify historical influences (as in the feminist critique of the family), create a space for multiple realities to emerge (inductive research) and contribute to women's lives. Providing an audit trail by recording theoretical, philosophical and methodological decisions is central to Guba and Lincoln's (1985) theorising of rigour. They propose the application of criteria of credibility, transferability and dependability to determine the confirmability of qualitative research.

Credibility is demonstrated when the participants and the wider community may judge the truth of the findings and interpretation (La Biondo-Wood and Haber, 1994). At a preliminary discussion with a group of lesbian mothers there had been a positive response to the fact that I had 'lived experience' of both planning pregnancy as a lesbian identified woman and midwifery care of lesbian parents. Midwifery colleagues also indicated that they would welcome the

proposed research. The data for the inquiry included transcribed conversations contextualised by relevant articles and texts. Koch (1996) questions the 'rule' of returning the data to the participants, claiming that this may not always be feasible. My decision to return the tapes and transcripts was guided by the feminist notions of accountability and autonomy. I did not, however, return the interpretation, as this represents a temporal fusion of my horizon with those of the authors of the texts (Spence, 1999). I intend to present my research and publish an article summarising the conclusions and recommendations. Such actions will further 'test' the credibility of the research findings.

Transferability is satisfied when the research is faithful to the everyday reality of the participants and described in sufficient depth and detail for others to evaluate its significance for their lives and practice (La Biondo-Wood and Haber, 1994). Adequate description of the method of data collection is significant in determining transferability. The intimate quality of the conversational interview allows the participant's voice to be heard in the interpretation. Koch (1996) suggests "understanding like conversation is always a reciprocal relationship" (p.176). Transferability is dependent on accurate interview transcription and the themes must capture the meaning of the participants' narratives (Polit and Hungler, 1997). The inclusion of women's stories and thick, rich, vivid description of the phenomenon and context assists decisions regarding transferability. Excerpts of transcripts, together with their interpretation in the data chapters, will provide the reader with evidence on which to judge transferability.

Dependability can be seen when information regarding the researcher's pre-understandings and decisions around the methodology and method provides an audit trail, from the research question through the data collection to the interpretation of the findings (La Biondo-Wood and Haber, 1994). The research question specifies a phenomenon of inquiry rather than a question to be answered or a hypothesis to be proven. Gadamer's notion of dialogue (1982) refers to the open-ended nature of inductive research. "Meaning emerges as the text and the interpreter engage in a dialogue, in a hermeneutic conversation. The goal of hermeneutic inquiry is understanding, reconstruction, advocacy and activism" (Koch, 1996, p.1189).

In order to meet the criteria of dependability, the philosophical perspective of the researcher must be made explicit. In previous chapters I have detailed both my lived experience of the phenomenon and my professional pre-understandings. I used a reflexive journal, as suggested by Koch (1996), to record my decisions around theoretical paradigm, philosophical framework and methodology. This is particularly important in radical hermeneutics, where 'keeping the question open' might be interpreted as failing to reach useful conclusions. Purposive selection procedures identified a small sample of articulate participants with recent lived experience of the phenomenon.

Approaching the study as a participant/researcher and stating a commitment to transparency of process contributed to high levels of trust from the wider participant community. The procedures of data collection and interpretation show that I engage with the personal presuppositions I bring to the interpretation. The data has been contextualised with links to existing theory (hermeneutic, feminist and poststructuralist) and literature (previous studies and popular texts). The cited references include primary sources and are current and relevant to the phenomenon of inquiry.

Koch and Harrington (1998) contend that researchers need to decide on a suitable means of determining rigour for their own inquiry. "We suggest that evaluation criteria can be generated within the research product itself through detailed and contextual writing and a reflexive account of the actual research process" (p.886). For this study I have chosen to apply Guba and Lincoln's (1985) paradigm for establishing trustworthiness. In showing that this radical hermeneutic research demonstrates attention to credibility, transferability and dependability, I have endeavoured to ensure that it meets the criteria for confirmability.

Conclusion

The research method describes the attention paid to ethical considerations, the decisions about purposive sampling, the form of conversational interviews, and the framework for thematic analysis. Careful consideration of the study design and clear documentation of the research method assist this qualitative study to meet the criteria for academic rigour.

CHAPTER SIX: POSSIBILITY AND PLANNING

Lesbian Mothers

"Lesbian mothers transcend or challenge the ordinary organisation of gender in American culture, which conflates 'woman' and 'mother' and defines lesbians as neither" (Lewin, 1993, p.15).

'Lesbian' and 'mother' were considered to be mutually exclusive categories until near the end of the 20th century. While there have always been covertly lesbian-identified mothers, their children were usually conceived in heterosexual relationships and very few women were able to live together as a family (Pollock and Vaughn, 1987). When I was eleven years old, our neighbour left her husband and teenaged children to 'run away' with another woman. So from childhood, I understood that if a woman declared her homosexuality, then she forfeited her right to be a mother. It was simply not possible to be both.

The act of consciously planning pregnancy outside the 'protection' of marriage shows a dramatic shift in attitudes over a relatively short time. Two friends who supported me during my son's birth, had been coerced into giving babies up for adoption rather than shaming their families with their 'unmarried mother' status. Feminist involvement in women's health and reproductive politics led to challenges to the dominant discourse around marriage and mothering. Organisations such as The Council for the Single Mother and her Child, offered support for women who chose to keep their babies and receive the new Domestic Purposes Benefit (Coney, 1993). Martin (1993) reflects that, "Women who wanted children were becoming parents by choice. Though it wasn't common, it wasn't a rarity either. The ancient spectre of illegitimacy had become a dowdy old notion. There were possibilities" (p.3).

The lesbian baby boom has created a culture of its own, evolving new definitions of family relationships. Planning to have a child as a lesbian-identified woman is inevitably a political as well as a personal decision. The participants in this study were articulate and assertive in negotiation with their partners, prospective fathers, assisted fertility providers and midwifery and medical practitioners. They described themselves as "*very out and proud*" from

the beginning. Accessing the necessary information to achieve pregnancy and overcoming obstacles required determination and courage. Martin (1993) suggests,

We have learned to make our differences our strength. The creativity of our community, which has allowed us to redefine healthy sexuality, loving relationships and the bonds of friendship, is now evolving new ways of having, loving and relating to children (p.6).

The emerging themes from the stories of planning pregnancy are *Encountering possibility, Negotiating with partners, Choosing the father, Planning conception, Assisted fertility, Deciding on midwifery care and Considering gender*.

Encountering Possibility

The understanding that conception by self-fertilisation is possible is profoundly significant for lesbian women. The realisation of possibility came about only after feminism had dismissed the notion of marriage and mothering as inextricably linked. The participants in this study were fortunate to have come out with the knowledge that their sexual identification would not exclude pregnancy. Just a decade earlier lesbian women like myself believed that childlessness was the price we paid for our sexual disobedience (Bree, 1991). A well-thumbed pamphlet, brought back from London in 1986 by a lesbian friend, was my first indication that this was not necessarily so. Martin (1993) described her search for information about a way to become a parent that did not involve heterosexual intercourse:

A tiny pink pamphlet entitled 'Woman Controlled Conception' by Sarah and Mary Anonymous, published in 1979 by Woman-share Books, gave us all the go-ahead we needed. In twenty-three pages of text and drawings it described how two lesbians had used artificial insemination to become pregnant. It discussed ovulation and showed how to chart a menstrual cycle. It talked about finding donors and there was a drawing of a woman inseminating herself. It was thrilling to discover it could be done so easily (p.40)!

The sharing of information through interpersonal networks, the queer media, and the visibility of high profile lesbian mothers have all contributed to the 'queer baby boom'. Thompson (2002) comments on the information sharing

function of lesbian and feminist publications as a crucial resource for lesbian parents. Having individually encountered possibility, women set about spreading the good news with an evangelical zeal. The same neighbourhood networks that had disseminated feminist analysis now buzzed with news of lesbian baby making. Workshops and support groups teaching women's self-defence and car maintenance included planning pregnancy in their curricula. The women in this study described talking with other mothers, using Internet resources and ordering how-to books from a specialist feminist bookshop. Kara began to plan her pregnancy after talking with friends:

Meeting [lesbian couple with a son] made it a reality; showed us that it was possible. My partner is a nurse, so we had access to materials and we talked to other lesbians who had done self-insemination at home. We read a lot and I found a couple of sites on the Internet. Even hearing Melissa Etheridge [musician] talk about her children was encouraging.

Deciding to have a Child

Every one of the participants began their conversational interview with the words *"I have always wanted to have children"*. Their decision-making was about finding the right time rather than whether children would be a part of their lives. They completed the other antipodean rites of adulthood; study, overseas travel, a significant relationship and buying a home; and were ready to begin a family. Jenny became aware that her biological clock was ticking:

I have always wanted to have children, to have a family. I didn't really think I would get married, I've only ever had women partners. In my twenties I got on with other things, work and lots of travelling. Then when I turned thirty I thought, I ought to get cracking on that!

Realisation of her own mortality was the cue for Helen:

I always wanted to have a child and when I met Jo, I knew she was the one I wanted to spend my life with. We were working overseas when a friend of ours died suddenly. It got us thinking and we felt that the thing we would most regret [in that situation] was not having had children.

The participants also considered how children would affect their relationships and careers. Reproductive choice has enabled their generation to plan the course of their lives fairly precisely, however for lesbian women, planning pregnancy is a particularly conscious and conscientious choice. Women reported changing diet and exercise regimes, considering occupational and environmental hazards, stopping smoking and refraining from drinking alcohol. Martin (1993) agreed:

The children of lesbians and gay men are the most considered and planned-for children on earth. We go to support groups and workshops on considering parenthood. We talk to our friends and lovers and family. We read books. Many years go into the planning process. We do an impressively careful job of weighing our needs, our resources and our expectations (p.15).

The age of the participants was a factor because they were aware that pregnancy could not be postponed indefinitely. The decision had already been delayed by the different life-tasks of lesbian women, coming out to oneself and important others, along with a second adolescence if the first had been obscured by confusion and self-doubt. When information about self-fertilisation became available, I had also wondered if I was too old to have a child. Would the method work for me and could I manage as a single parent? Like Tam, I was reassured by the knowledge that my own mother had been in her forties when I was born:

After thinking about it for years, it happened really quickly. I thought being an older mother was an advantage because my mother had me when she was nearly forty-one. But there was a sense of urgency. I had read about how it was harder to get pregnant and that you could have more problems with the baby.

Most of the research participants described the decision to have their first child. One couple who were already successfully co-parenting two children from previous relationships spent a long time considering how a baby conceived together would affect their family. Lisa described the first year they lived together as challenging. They were combining very different lifestyles; Lisa parented at home and was involved with La Leche League and Playcentre, while Meg worked long hours in her career. As their relationship developed they became “*very much a family unit with two mums and two boys*”.

Lisa had always wanted to have more children but Meg felt concerned that a new baby would change the successful dynamic of their family. Their concerns are common to many parents (lesbian or heterosexual) who wonder about adding to their family. They were very careful about the balance of relationships, taking everyone's needs into account, including those of their planned child(ren):

When Meg and I got together the boys were two and a half and seven. I had them from two previous relationships. The first year we were living together was certainly full of ups and downs but we made the decision to stay together and we bought a house. We had become very much a family unit with two mums and two boys. I always wanted to have more children but Meg wasn't so sure and we spent three years talking about it. If we did, it was going to be me that did the pregnancy, birth, breastfeeding and home parenting, so that part of the decision was quite easy...

There were several things the decision impacted on and one was the family as a financially viable unit. I think children should be in twos or fours; even numbers are good numbers for kids. That means you need more bedrooms in the house and you need a bigger car, the kind of financial explosion that goes with it. But if you wait for the perfect time to have a child, when there's enough money and enough resources and enough everything, you're never going to have them.

Negotiating with Partners

All the participants in this study were partnered when they began discussing having children. Most couples had been together for more than three years. Martin (1993) suggests that while a powerful longing for children overwhelms some women, others may cautiously feel that parenthood is something they are willing to consider. In each case it was the birth mother who initiated discussion about having a child together. Becky's partner acknowledged her feelings of biological imperative:

Even when I came out as a lesbian, I didn't think for a moment that I wouldn't have a baby. It was a matter of when, not if. I'm surprised I didn't get pregnant when I was fifteen and having sex with boys! But when I met Kate she didn't want to have children. About two years into our relationship, after we bought our

house, I said I need to do this and it isn't negotiable. We came to the decision that she would see how she felt when I did get pregnant. If she was really not into it, then we would probably break up. As it turned out, it took so long to get pregnant that she had totally changed and desperately wanted to have a baby as well.

A recurring theme was the decision to prioritise mothering over the relationship. Like Becky and Kate, most couples were uncertain how the pregnancy would affect their relationship, but hoped that they could overcome any difficulties. The partners accepted that it was unlikely that you could be in a relationship with a woman with children and not play some kind of parenting role. However, each of the mothers was prepared to be a single parent if the situation became untenable for their partner. Couples resolved these issues with open communication and an acceptance of different priorities. Jenny's story, in common with others, reveals the thoughtfulness, the voicing of uncertainty, and the mutual consideration shown by the participants and their partners:

She wasn't sure about having a baby. She wasn't madly keen, but she wanted me to be happy. We didn't know whether we'd stay together or if it would be really difficult for her. We would just see how it went. I feel like we know each other very, very well. We're not the sort of people who dream and talk together; we're very pragmatic. I think we just felt more and more excited. We're different people so we are going to do things differently. We're old enough and wise enough now to not try and change each other or impose our will.

The women also discussed issues they perceived to be potentially problematic, such as differential income and the lifestyle change involved in becoming parents. Their feminist politics had given them a theoretical understanding of the challenges of parenting young children at home. Helen and Jo were able to be flexible in their parenting roles and find a solution that suited them both:

I wanted to go through pregnancy and childbirth and as a [health professional] I thought it was a good experience to have. But I absolutely knew I was not an 'at-home mum' type; I would go 'round the bend'. I wanted to have the children but I didn't want to bring them up. Jo was exactly the opposite. She had no interest in being pregnant but she really wanted to look after our children.

Choosing the Father

Despite legal access to fertility assistance, most of the participants chose an involved father for their child rather than a donor. Martin (1993) defines an involved father as a man who donates sperm to assist with the conception and has an ongoing relationship with the child, which involves care and decision-making. His partner may also take a parental role in the child's life. The seemingly anachronistic legal understanding is that heterosexual intercourse (or the possibility that it occurred) determines fatherhood (Adair and Rogan, 1998). The law has been framed to privilege both the medical profession and infertile men whose partners are the recipients of donor insemination. Therefore a donor legally relinquishes any right to participate in a child's upbringing and has no financial obligation to contribute (Adair and Rogan, 1998). However, if the child was not conceived under medical supervision, then a named donor may be considered legally and financially liable. Tam felt strongly about having an involved father for her daughter:

I've argued for years about the donor thing. I can remember going out to dinner parties and there would be five other lesbians saying why would you want a known father? I wanted a known father because there has been a child adopted out of our family and a child adopted into our family, struggles around adoption. I'm a genealogist and I thought it was crazy not ever being able to meet your father or know your history. I think having a good relationship with a father is very healthy for a girl. It's healthy for a boy as well.

Becky and her partner needed to negotiate the question of a father or donor:

We came from quite different perspectives. I didn't know my birth father until I was about sixteen, so it was really important to me to have an involved father. But Sara comes from a family with an abusive father who used to beat her mother. We talked about it a lot and decided that together we could choose someone who would be a really good father.

Prospective fathers were sought through conversations with acquaintances and advertisements placed in the queer media. The experience of choosing someone who would be 'a good father' more closely resembled conducting a significant job interview than 'falling in love'. The magazine 'Express' includes a Donor Wanted column in its classified section, featuring advertisements such

as 'Lesbian couple, 30's, stable long-term relationship, seek gay man to father a child. It is hoped you will take an active role in the child's upbringing. Professional, non-smoker preferred.' Benkov (1996) reflects that, starting the process at an older age, she and her partner were very clear about what they did and did not want. They hoped to create a family, but also knew enough not to expect everything on their list:

We had never met before. We sat down with this stranger to ask questions like, Could you make a life-long commitment to a very intimate relationship? His integrity and level of commitment to parenting immediately impressed us. It was very awkward, like going through a series of courting behaviours, checking each other out, putting your best foot forward (p.137).

As lesbian women 'searching for the right man' our position is paradoxical. We hold the balance of power in making the decision, but at the same time, we are vulnerable because our desire for a child may be greater than that of the prospective father. Hera's problem was solved by an offer from a friend:

When I came back to New Zealand, I thought it's the right time and I can't find a man, typical! A friend thought that we would make wonderful parents, so she talked to her boyfriend. He said he'd never really wanted to have children, but he thought this was a nice thing to do. He is younger than we are and at the moment he is overseas, gone off to see the world. It's important for Alex to know his biological father and my feeling is that he will continue to be involved. I think he's an exceptional young man for helping us and his whole attitude towards it has been delightful.

Martin (1993) comments that, while for many women separatism offered a space to emerge from the domination of a sexist culture, parenthood raises issues that require us to transcend our gender differences. At the time that I began talking with my gay friends about having a child, very few men were interested in becoming fathers. Before the Queer movement, the lesbian and gay communities were culturally and politically divided by gender. Men were wary of being used to provide sperm and then excluded from their child's life, while women were fearful of HIV infection and legal battles over custody. As levels of trust and communication increased, more queer people parented successfully together. Most of the participants in this study did not have difficulty finding gay men who wanted to be fathers. Some couples met with several

(unsuitable) prospective donors before making their decision. However pragmatic the process of choosing a father, the language used to describe the moment of decision was intuitive and celebratory. Kara talked about meeting the man who would become their child's father:

I wanted a gay guy but he had to be a certain kind of gay guy, because I'm going to know him for the rest of my life. He had to be a friend, he had to want involvement and show real commitment to the child. We met David at a café and just knew straight away! We had so much in common. In some ways he is quite conservative and I like that. He is very easy going and laid back and has similar values. We spent a long time getting to know each other.

Having met and decided on a father, the women embarked on a form of 'accelerated' friendship. They considered getting to know each other to be very important but felt conflict in relation to the delay in commencing the actual fertilisation process. Spending lots of time together and discussing parenting issues began while the man (and sometimes the woman) confirmed their HIV status. Benkov (1996) reflects on the unique relationship between a lesbian woman and the gay man who will become the father of her child. "It is one of the most intimate relationships you can have, not sexual, but as close as you can be. We were starting to cross all the traditional lines between gay men and lesbians" (p.136). Becky described the process of negotiating parenting philosophies and strategies with her son's father:

We advertised in 'Express' and had a few answers. When we met Bob we immediately said, 'Yes, he's the one'. We spent a long time talking about what we believed in and how we wanted to parent. Things like discipline, because we don't believe in smacking. In the first year of our son's life there was discussion, discussion, how are we going to work it? Now it just works itself.

Planning Conception

In most cases conception by self-fertilisation was carried out at home with materials provided by the woman's doctor. The participants did not say a great deal about the specifics of becoming pregnant, unless they had experienced infertility. This contrasted with earlier research, when women regarded the method of achieving pregnancy as new and precious knowledge (Bree, 1991).

The participants in this study described beginning the process of conception confidently; feeling relieved that the difficult task of finding the right father had been successfully accomplished. Jenny conceived straight away:

It was incredibly quick and easy. We did it twice over the weekend and I was pregnant! He felt quite awkward but his girlfriend assisted him. (Laughs) We had a glass jar and she came screaming through the house with it, saying, 'Ugh! It's horrible!' That's all we did. It was lovely that his girlfriend was able to help, be excited and shriek. My partner was in the kitchen the first time, putting a cake in the oven. Not quite a 'bun', but she thought it was symbolic. The second time she felt more comfortable, so she stayed and helped me.

When conception was delayed the initial exhilaration turned into anxiety and doubt. Becky became obsessed with taking her basal temperature and checking her vaginal mucous. She also worried that the donor would become frustrated with the length of time it was taking to become pregnant and change his mind:

It was awful because there was no pleasure associated with it. It's not like, 'Oh yeah, let's have sex'. I was so desperate to be pregnant and I thought, what's wrong with me? I had been trying for fifteen months when we went to [assisted fertility provider]. They did a post-insemination test and found that my mucous was killing all the sperm. Lesbian mucous! So I got pregnant the next day!

Assisted Fertility

After a long and thoughtful process, two couples made the decision to access a donor through an assisted fertility provider, as previously mentioned. Martin (1993) defines a donor as a man who helps with the biological creation of a child but has no parental involvement. Although the mother(s) and child may know who he is, it is more likely that he will be anonymous but contactable through the clinic. Lisa believed that with two mums and their combined extended families, her child would have enough family to love and support him:

We had issues about the donor, a known donor or an unknown donor and what that meant for us. We were concerned that having a known donor would take something away from Meg's role as mother, which is a role that she takes really seriously. She is very much the other parent in this family, on the school lists

and everything. We have two fathers already and we had enough uncles and aunts and cousins. So we decided that we wanted an unknown donor.

The dialogue around this decision challenged my prejudice about a child's right to have knowledge of their biological parents. The decision to have involved fathers for my children was informed by the experiences of friends who have been disadvantaged by stigma about pregnancy outside of marriage and closed adoption. Lisa grew up at a time when divorce was more accepted and the introduction of the Domestic Purposes Benefit meant that women could survive as single parents.

Helen's beliefs about inherited characteristics and environment have changed since they chose an unknown donor four years before. If she had known then what she knows now about children, she says she would have been "utterly obsessive" about choosing the father:

The social worker gave us a donor profile and left us alone to look through it. We had decided that it didn't really matter who the donor was, as long as he was a nice person. Originally I wanted someone who belonged to MENSA and represented New Zealand in sport. Then [my partner] said, 'Really, we just want a healthy child'. The social worker was relieved when we said, 'He sounds like a nice bloke, is he available?' because the other nine donors had refused to donate to a lesbian couple. I said, 'Well, we wouldn't want their sperm anyway' and within a month it was all happening.

Deciding on Midwifery Care

The participants chose lesbian midwifery practitioners whenever possible and expressed high levels of satisfaction with their care. They live in large urban centres and were able to use their lesbian social networks to locate a midwife. Kara articulated the reasons why many lesbian women feel most comfortable with health professionals who understand and share their sexual identification and culture:

I was really clear that if it was possible I wanted a lesbian midwife. I suppose I thought I wouldn't have to explain things like my relationship. It would be seen as important. I didn't want someone coming to my house and judging me for

being a lesbian. I get sick of that! I was lucky to have Gill and I got on really well with her.

Becky chose her midwife even before she became pregnant, because she had attended her friend's birth and was impressed by the care she received. She felt particularly fortunate to be able to have a midwife and a general practitioner who were also a lesbian couple:

I have very fixed ideas about birth and pregnancy because I'm a [health professional]. I knew I wanted a home birth and I knew who I wanted to look after me. Sue is a GP but she is also a homeopath. She is very professional and I totally trust her decisions. Ann is her partner, she is a midwife and they have a daughter. I really liked Ann and I liked how she practised. They're fantastic, both of them!

Lisa changed her midwife partway through her pregnancy. Initially she had thought it was important to have a lesbian midwife who would understand her partner's role as parent to the new baby and their older boys. She used her friendship and parenting networks to find a lesbian practitioner but, after experiencing bleeding in the first trimester, the relationship "didn't feel right at all". Around that time she saw a flyer at the Women's Centre for a midwife who only attended home births. Lisa has a personal and political commitment to home birth. The home birth midwife was "fabulous" and her acceptance of Lisa's sexuality allowed a trusting relationship to develop. The partnership was enhanced by Lisa's ability to communicate her concerns clearly.

Chris had recently arrived back from overseas and was uncertain about how to contact any midwife, let alone a lesbian one. She was significantly less happy with the care she received during her pregnancy:

I saw a sign for a midwifery practice and talked with two of the midwives. One woman was highly recommended and very experienced, so I chose her, but the experience wasn't a good one. We didn't really connect that well. I'd go for visits once a month and it seemed very quick, in and out the door. She was very busy. We didn't talk much about the birth and towards the end I said, 'What do I do when I go into labour?' I don't feel that I got the information or support I needed. I didn't feel I had time to build a relationship with her.

Helen was the only woman who had obstetrician rather than midwifery care during her pregnancy. She explained the reasons for her decision:

As soon as I found out I was pregnant I rang Trish's office. They said, 'Oh she's booked out' and I said, 'don't be ridiculous'. There was no hassle; she was delightful. I knew that I wanted an obstetrician even before we found out about the twins. We did think about having a midwife, but I had done the Diploma of Obstetrics. You go into it thinking birth is a wonderful, natural process and come out of it thinking it is the most dangerous thing we do in our lives!

The participants in this study considered themselves fortunate to be able to contact lesbian midwives, because they did not want to have to cope with homophobia or spend time educating healthcare professionals. Two women based their choice on other criteria (homebirth experience and obstetric expertise) and both appreciated the caring and professionalism of their non-lesbian maternity carers.

Considering Gender

The question of gender selection has contributed to some of the most enduring myths about lesbian mothers. In the past, homophobic individuals and organisations have relied on stereotypical descriptions of lesbian feminists as man-haters to negatively influence public opinion (Hauschild and Rosier, 1999). It has been falsely assumed that lesbian women only want daughters and also that alternative fertilisation produces a higher ratio of boys. In Harvey et al (1989) slightly more than half of the participants hoped for a daughter, but only a small number attempted to influence the gender of their child with the timing of insemination or other sex selection techniques. The participants in my study welcomed their pregnancy regardless of gender, although the prevalence of the myth prompted Becky to comment:

Kate desperately, desperately wanted a girl. I knew the minute I was pregnant that I was having a boy and at the twenty-week scan there it was, sticking up. She was so disappointed and it was hard between us, because I felt quite resentful. I was thrilled to be having a boy! I was thrilled to be having a baby! Now she's delighted to have a son and it doesn't matter.

Helen was surprised by her own and others' reactions to the news that she was having twin boys:

At twenty weeks we had another ultrasound and (the doctor) said, 'You've got two healthy, strapping lads there'. For about three days I went into quite a deep depression and I felt really ashamed of myself. I'm not a man hater. It wasn't so much that it was two boys but that I thought I was going to have a boy and a girl. We decided to name the children to help me form a relationship with them. I felt so guilty! Then a friend said, 'It must feel weird having two penises inside you'. What a bizarre thing to say!

Conclusion

Until very recently 'lesbian mother' was considered to be an oxymoron. While I was pregnant with my son I was invited to be on a panel of lesbian and gay people speaking to nursing students. When I arrived there was an audible gasp of surprise in the lecture theatre. Within a decade publicity about high-profile lesbians, some of whom are also mothers, has changed public perception. The experience of planning pregnancy as lesbian-identified women involved the participants in research, networking, negotiating, careful choice and deliberate decision-making.

CHAPTER SEVEN: TRUST AND INEQUALITY

The Experience of Midwifery Care

The stories of planning pregnancy in chapter six describe a very deliberate and controlled course of action, from the decision to have a child through to choosing a midwife. The women negotiated with others and overcame obstacles to achieve their goal of pregnancy. This chapter describes the women's experience of midwifery care, when things did not always go according to plan. The themes are organised chronologically and include: *Feeling overwhelmed, Experiencing infertility, A pregnant pause, Birthing by the clock, Losing control, Overcoming breastfeeding difficulties, Postnatal problems and Confronting heterosexism and homophobia.*

Many of the experiences described in this chapter appear to be independent of sexual identification or family circumstance. The preceding chapter and the following one, *Queer as Folk*, discuss some unique aspects of lesbian parenting. However, feelings of ambivalence when a pregnancy test is positive or the emotional roller coaster of infertility are universal phenomena. These stories of birth and breastfeeding describe experiences shared by many mothers, irrespective of their sexuality, and are more likely to elicit the phenomenological nod from readers (van Manen, 1990). The exception is the final section of the chapter, *Confronting heterosexism and homophobia*. All of the participants experienced insensitivity related to their sexuality at some time during their pregnancy, birth or postnatal care. The purpose of this research is to assist midwives to develop an informed understanding of the needs of lesbian-identified mothers and their families, thereby decreasing the incidence of myth-guided assumptions and hurtful stereotyping.

Feeling Overwhelmed

In order to understand a phenomenon such as 'being pregnant' or 'giving birth', we need to study lived-experience descriptions and discern experiential commonalities (van Manen, 1990). The four existentials of lived body, lived space, lived time, and lived relation to other, form an intricate unity, which van

Manen calls the lifeworld. I have used this theoretical framework in the thematic analysis of the data relating to the experience of midwifery care. The embodied sense of 'being with-child' may cause us to question our suitability as parents-to-be, even when the pregnancy has been eagerly anticipated. Kara expressed apprehension about the implications of pregnancy when her pregnancy was confirmed:

As soon as my period was a day late I thought, I'm pregnant! We went to Family Planning and I had the test. It was an overwhelming feeling, things had completely changed but everything was the same. I was shocked, because after all the time I had spent thinking and planning, I thought it would take months. It felt quite unreal to have this incredible change happening within me!

Lisa shared these feelings of ambivalence, but as she had been pregnant before she was able to look ahead to planning for the birth of her baby:

I actually knew that I was pregnant two days before my period was due. It was fabulous; it was absolutely wonderful! Then I came down and went, 'Oh my God, what have I done? It's real now, there's no going back.' But I think there's that phase in every pregnancy, no matter how well planned it is. It's that there's no little bit pregnant, you either are or you aren't! So it was nice to switch from the very clinical focus of conception into now I get a midwife and have a home birth.

Experiencing Infertility

While most of the participants became pregnant quickly and easily, a few women experienced difficulty conceiving. Helen described the stressful nature of infertility and receiving fertility treatment. When she finally did conceive the emotional ups and downs continued. Having planned and negotiated to get to the point of pregnancy, her body became the subject of prolonged scrutiny to the point where it no longer felt like part of her:

My ovulation was uncertain, so we went to the clinic every day for blood tests. Jo was allowed to put the semen in and they had no problem with us holding hands during the procedure. It took a long time [to get pregnant] and like anyone going through fertility stuff, we went a bit wacky. I had my little goddess

and we lit candles. Your whole life goes on hold. You get a phone call to say 'Insemination' and you race over in the rush hour and then race back to work...

I didn't tell people, because heterosexual couples don't tell everyone they're going home to have sex and make a baby. Still, everyone gave us stupid advice. You think what a load of rubbish, but you actually do it because you are so desperate. [Dr] wanted to do a laparoscopy and I wasn't keen. I had a recurrent nightmare where I woke up from the anaesthetic and he said, 'You've wasted our time. You're not a woman at all!'...

We took a month off and went on holiday. Then we came back for one last try and it worked. Amazing! They said, 'You're pregnant! But your HCG is very high and we think you might have triplets'. We were walking around bravely saying, 'My three sons'. My dad called them Huey, Dewey and Louey. Then we had a scan at about six weeks and it showed two babies. I was over the moon! It felt just right. We were delighted!

Helen's experience of infertility reminded me of the year I spent waiting to conceive my second child. I had been aware that at the age of forty it might take a little longer but the feelings of hope and then despair each month were very difficult. Everything else in my life receded in importance as I focused on becoming pregnant. The subjective nature of our lived experience of time (van Manen, 1990) means that while a pleasant evening with friends is over all too soon, time spent waiting for a longed-for event can appear interminable.

A Pregnant Pause

Pregnancy was pleasant and uneventful for most of the participants. They were well informed and knew what to expect. Having carefully chosen their midwife, they felt able to discuss any concerns with her at the antenatal visits. Despite being an 'elderly primigravida' in obstetric terms, Fiona was delighted with her pregnant body:

I had a dream pregnancy! I felt really well and I was never sick. I loved being pregnant and I would love to be pregnant again. I felt it was such a privilege because I thought about all the women who couldn't have children. I wandered around feeling like I was in heaven, really blooming!

The couples attended antenatal education classes and found them to be helpful and informative. A particular antenatal educator was noted for her sensitivity to the lesbian couples attending her hospital-run classes. In contrast, Stewart (1999) and Wilton and Kaufmann (2001) noted that women felt alienated by the overwhelmingly heterosexual orientation of antenatal education.

Becky experienced increased anxiety about pregnancy because of her professional knowledge. Attending the birth of a baby with undiagnosed severe disabilities, while she was pregnant, had been a profoundly distressing experience. My second pregnancy coincided with my midwifery studies and I could appreciate her difficulty at *"knowing too much"*:

I was really scared that I would lose the baby. I had just started my job and I was exposed to abnormal birth. Then Josh was a really big baby and my midwife thought she could feel extra fluid. Well, polyhydramnios, hydrops, kidneys, all that stuff went through my mind. So it wasn't as pleasurable as it could have been, because I just knew too much. I knew what could go wrong!

Lisa's baby was engaged six weeks before her due date, *"head down, bum up, anterior"*, and her midwife was concerned that he might be born too early. Her older children had been slightly pre-term, but six weeks early meant a premature baby and no home birth. The midwife was about to go on holiday and Lisa's partner Meg was attending a conference in another city. Lisa also worried that the birth might coincide with other family birthdays or their anniversary. She didn't want to share these already special days. Finally, she was waiting for her mother to return from Europe. *"She's been at the other two and I couldn't imagine having a baby without her"*.

Lived time took over her life. Lisa's story is filled with quantitative references to time and the tensions of juggling *"busy worlds and other people's time frames"* with the spontaneity of birth. As she talked I imagined her navigating a giant game board, the countdown to her due date, the tasks to be accomplished and the pitfalls to be avoided. When she did go into labour, she progressed rapidly to the second stage and Meg waited nervously, hoping the baby wouldn't be the first to arrive! She described how, as time raced, the midwives and support people were wending their way unhurriedly to her home.

Birthing by the Clock

By the time the women went into labour, they had maximised their chances of natural birth. They were well informed about labour and had taken steps to optimise their health. They had supportive partners and the confidence to articulate their needs. Most had developed a trusting relationship with their midwife and expected that birth would be a challenging but ultimately exhilarating experience. Supportive care has been shown to not only improve women's experiences of pregnancy and birth, but also benefit the long-term health of women and children (Oakley, 1982). Tam described the powerful experience of giving birth to her daughter:

I had a fantastic birth! My partner is a nurse and very capable. I felt that she was totally my advocate. I didn't do any breathing classes. I thought, I'm going to give birth. I'm a woman and that's what my body is made to do. I felt in control and it was an amazing experience. I was pushing before long and it was incredible, overpowering! You can't stop it. I felt, Yeah! Here comes my baby! I think my midwife was just the right person for me, she took charge without taking over. She felt so competent and I had so much confidence in her. It was five hours of labour essentially and I wasn't exhausted because it wasn't a long time. Afterwards I was ecstatic!

Women told their birth stories in very precise terms of time. *"I went into labour on Monday morning. By then it had been eighteen hours"*. Markers of time and measures of progress become tremendously important, especially when women are feeling overwhelmed by labour. I have noticed the same precision when people talk about the death of someone close to them. Louise appreciated the warm supportive care she received from a hospital midwife:

I got to hospital at five thirty and the contractions were two to three minutes apart. I was in the maternity assessment unit and there was this lovely midwife; she was a Chinese woman and she called me 'Darling'. She was perfect for me. She put her arm around me and said, 'Breathe like this'. As soon as she looked in my eyes I was mesmerised and she breathed with me. I was starting to feel a bit out of control with the pain so she had a look and I was already four centimetres dilated!

Several women in the sample group planned to birth at home, confirming the support for natural birth evidenced in earlier research (Bree, 1991). Wilton and

Kaufmann (2001) wondered if the relatively high numbers of home births among lesbian women reflected a desire to give birth where they felt “less vulnerable to the assumptions and prejudices of others” (p.207). The participants also demonstrated an awareness of women’s health movement and midwifery politics. They hoped to circumvent medical science hegemony and avoid unnecessary interventions by either birthing at home or in hospital with a midwife who shared their philosophy. Lisa’s birth story shows her confidence in her ability to birth safely at home and also provides insight into the notion of lived time and lived space, as she prepares her “*little nest*”:

I woke up at midnight and I'd had a show. That was the first sign. I went back to bed, snuggled down and was just drifting off when I was hit by a whopping contraction! In fifteen minutes I had three contractions. I came downstairs to the room we'd planned to have the birth in, which is the kid's playroom. We had the birth pool set up in the corner, but being the middle of winter there was lots of washing draped everywhere. So for the next forty-five minutes I tidied the playroom. I moved some toys out to the lounge for the boys and folded the washing and made my little nest...

At one o'clock I thought I'd better tell Meg. I put on my labour pyjamas and said, 'Its Wednesday the 16th of August, how's that for having a baby?' She sprang out of bed and said, 'We have to phone the midwife'. But when the midwife asked, 'Do I need to come now?' I said, 'No, it's fine'. So she pottered around at home and got herself organised. When she did arrive I was in the bath on my knees, past transition and trying very hard not to push. The second midwife was a lesbian too and she was pregnant with her first baby. They got here at ten-to-two and he was born at twenty-past, so from that first contraction it was a two-hour labour!

Losing Control

Birthing experiences did not always go according to plan. Feeling 'in control' and 'losing it' were significant in Becky’s birth story. She had carefully planned her home birth and defended her choices to friends and family. “*My colleagues thought that home birth was a dumb idea!*” She negotiated with her midwife and others to gain support over and above that available through the system. Her doctor and midwife provided shared care when this was no longer a state-

funded option and a paediatric consultant agreed to attend her home birth if necessary:

Anne [midwife] arrived that evening, just as I was about to lose it. She was lovely; she took control and put me in the bath. We had the fire going because it was winter and I really cherish that time at home. I needed everyone. Demanding personality! I wanted this. I wanted that. [Lesbian student midwife] came in the middle of the night and she was very supportive too. I felt in control, even though it was a lot of pain. It was just fantastic...

I was six centimetres dilated when Anne examined me and I felt I was progressing really well. Then I went through transition; contraction, contraction, contraction and I started to feel quite out of control with the pain. She examined me again and the head was still really high, so she said that I probably needed to go to hospital. I felt devastated, but I trusted her opinion. We got in the car with me contracting and saying, 'Drive faster, drive faster'. Everyone followed us and we went down a dead end street! [Laughs]...

The first thing I did at the hospital was take all my clothes off. I remember [paediatrician] walking in and it was like, fanny! He looked a bit embarrassed but I couldn't have cared less. I said, 'OK, I'm here. You can give me an epidural'. My feeling of being in control had gone. Eventually I fully dilated, but I had an anterior lip and it kept getting more oedematous. I was so exhausted, I said, 'Just get the baby out'. I had the caesarean and Josh was huge! I know some people grieve [about the loss of a natural birth] but I thought, I've got a healthy live baby, that's OK!

Birth stories tell of an embodied experience and highlight the emotional significance of physiological changes. Becky used language that was a mix of colloquial expression, “fanny” and midwifery terminology, “anterior lip” and “oedematous”. Lived space also features in birth stories as women describe how their surroundings affected them. Becky felt “in control” labouring at home, with the fire going and a warm bath to help with the pain. Although she felt she had surrendered her power in agreeing to transfer into hospital, she eventually succeeded in having almost all of her support team in theatre for her caesarean section. Careful planning for all contingencies served her well and she felt resolved about the outcome. Jenny and her partner had decided against a home birth, but she “felt purposeful” beginning her labour at home. On her

arrival at the hospital, she was “wired up” to the fetal monitor with only a cursory explanation:

It seems like such a huge thing to talk about; I don't want to go on and on. I went into labour in the middle of the night. I couldn't sleep. You're supposed to try and relax, so I hopped in the bath and spent most of the night there. We rang the midwife when the contractions were five minutes apart. I was walking around the house and leaning against walls. Jac was doing a fantastic job massaging my back. The sun then came up and it was a beautiful morning. I felt purposeful, things were happening...

I wanted to go to the hospital, because that's where we planned to have our baby. A hospital midwife showed us into our room and I felt she didn't treat me with any respect. It was really painful and the contractions had been five minutes apart for ages. It went on and on and onnn! After eighteen hours I had only dilated four centimetres. I couldn't understand why things weren't progressing when I'd done everything right...

I had an epidural and the drip and from then on it all became very medical. It was a relief because I'd tried my best! Then the baby's heartbeat slowed right down during a contraction and [the midwife] said, 'I'll just get a doctor to check'. I never imagined that I would have a caesarean. But Thom was great! He had a little cone on his head where he'd been pushing harder than I had! They checked him and said, 'We can't fault him', which was a lovely thing to hear!

The losing control in Helen's birth story happened when she developed symptoms of pre-eclampsia during the latter part of her pregnancy. Her twins were born following an emergency caesarean section and transferred to the neonatal intensive care unit. Despite the drama of their birth, she valued the presence of other lesbian women in theatre. Her relationships with caring health professionals formed the lived other in her birth story:

At thirty-five weeks I put on four kilos, my face was puffy and I was seeing sparkling lights. I was so confused! I said, 'I didn't have to go to the toilet at all yesterday'. My obstetrician said, 'I'd like you to go to the hospital now!' [Hospital midwife] saw our name on the board and swapped so she could be with us. We had five lesbians in theatre! There was us, a friend who videotaped the birth, the midwife and the paediatrician. Trish pulled out George and said, 'I'll get his brother'. Then out came a little girl! It was amazing...

They really didn't look too crisp. George went straight to NICU and I was left by myself with Hannah. Suddenly she went blue! I grabbed an oxygen mask and yelled. I was thinking, if I have to do CPR I just use one finger. Trish came back, took one look and ran with her to NICU. It was very scary! Then [the paediatrician] came to see me. She held my hand and showed me their photos. Now when I worked in [another hospital], we only took photos of babies when we were pretty sure they were going to die. She said, 'They're going to be OK', but I didn't believe her. She left and I went push, push on the morphine pump. I thought, if my babies are going to die, I just want to go to sleep and not wake up!

Overcoming Breastfeeding Difficulties

The participants all planned to breastfeed, but as women having their first baby, some found the experience more difficult than they had anticipated. They expressed a commitment to breastfeeding based on an understanding of health benefits for the baby and the mother. A surprising finding of earlier research had been that the children were still breastfed at the time of the interviews, when their ages ranged from 3 to 30 months (Bree, 1991). Louise did not receive the help with initiating breastfeeding that she had expected:

I think I came across as quite confident, but I was breastfeeding and that's a tricky business. Someone would spend 10 minutes and push your nipple in the baby's mouth and then they'd be off. It's like they were in a rush all the time, so I wasn't impressed with the (hospital) postnatal care.

Jenny was continuing to breastfeed her son at the time of the interview, but the first few weeks had been very difficult. While in hospital she received conflicting advice and her baby was given formula without her consent. The hospital in question has since addressed some of these problems and is working towards becoming accredited as part of the Baby Friendly Hospital Initiative:

I felt so emotional for the first couple of weeks; I was tearful all the time. It was a wonderful feeling looking at Thom, but I felt very vulnerable. I had trouble with breastfeeding and different midwives had different approaches. Some of them were quite brutal and they'd ram him on because he wasn't latching very well. Poor wee chap, he was trying desperately hard. It was incredibly painful! His mouth felt like sandpaper on my nipples and I got quite engorged. I had one

midwife kneading my breasts and talking over me. The other midwife was wonderful; she had a very gentle approach...

I started expressing and I could see them thinking, she's wasting her time. One midwife gave him a bottle of formula, he threw up and it wasn't my breast milk. Some of them were very old school. Probably close to retirement, what can you do when you get someone who has been in the job for years? I was anxious and wanting to do the right thing, so I was racing up and down the corridor expressing madly and cup feeding him. I was in a lot of pain and I was hobbling, hunched over and wiped out...

Luckily my midwife contacted La Leche League and they were incredible! As soon as [breastfeeding counsellor] walked in the door, Thom started breastfeeding properly. She stayed with me for an hour and she took the time. She was lovely and relaxed and listened to what I was saying. The listening and the time, that was the main thing!

Tam reluctantly weaned her daughter after persevering for “six nightmare weeks”. However, she felt positive about the help that she received from her midwife and the hospital lactation consultant:

The first six weeks were really hard. I wanted to breastfeed and then I got mastitis. I had a lot of help but I just couldn't get the hang of it. I had this wonderful woman at the hospital and even she said it was really difficult. Morag wanted to stay on the breast all day and she never seemed to get enough milk. I felt exhausted! Breastfeeding was a nightmare; it was six weeks of nightmare! I would have loved to breastfeed her, but it didn't work for me.

Postnatal Problems

Women who had birthed at home reported no postnatal problems and all breastfed successfully. The stories of postnatal problems appeared to be a consequence of loss of control during labour. The cascade of interventions resulted in a longer stay in hospital and problems were most likely to occur in the postnatal wards. Helen was recovering from pre-eclampsia after the birth of her twins and felt that the postnatal care was suboptimal:

Nobody checked my blood pressure after the birth and I had to get Jo to do it. The first day after the caesarean she took me for a shower. I was sitting on one

of those plastic chairs and I said, 'I don't feel very secure'. Halfway through the shower the chair collapsed and I was down on the floor with my legs in the air! Jo used a facecloth and threw it in the corner because there was no linen bin. When we left on the fifth day it was still there...

People [ward staff] made assumptions that because we were two women we would inherently know all about babies. I was completely ignorant! I said, 'I don't know how to bath a baby and I have no idea how to change a nappy,' and they would just laugh. Hannah wasn't feeding well so I would express and then find someone had given her formula. I woke up one night and George was crying and crying in the nursery. He was soaking wet and shivering...

I thought it was unsafe and it was a horrible experience! We actually left the hospital early, discharged ourselves. I rang Jo and said, 'Bring the car seats, we're coming home'. The paediatrician was horrified because Hannah was still below her birth weight, but I knew we would be better off at home.

One woman felt very unhappy about her postnatal midwifery care. During her pregnancy she had felt as though her midwife was *always rushing off to see someone else*. According to Berg, Lundgren, Hermansson & Wahlberg (1996) good communication between a woman and her midwife is essential to build a trusting relationship:

My midwife and I had a big problem. [Baby] was born on Thursday night and she came to see me on Friday for about five minutes. She raced in and out and said, 'I'll see you on the weekend' but she didn't show up again until Tuesday. I thought, I wouldn't say anything because she's here now. She stayed twenty minutes and said, 'I'll come and see you tomorrow' and then didn't show up again. I got more and more upset so I gathered myself together and rang her. She was very defensive and said, 'Oh I had the weekend off.' I was angry but I was crying too. My trust had gone...

I think it was very unprofessional. She seemed so pressured, racing off to other people. I started feeling quite angry about how things had gone, the pain, recovery from the caesarean, breastfeeding and not getting the support that I needed. I had begun to doubt myself; to feel pathetic and that I should pull myself together. I had never felt like that before! I expected the midwife to understand, to know. It was incredibly difficult!

Confronting Heterosexism and Homophobia

The participants all reported experiencing cultural insensitivity related to their sexual identification. Wilton (1999) suggests that prejudicial and discriminatory attitudes and behaviour towards lesbian women are unethical, unprofessional and counter-productive. Negative reaction to the news of pregnancy by family-of-origin had been a significant feature of my earlier research (Bree, 1991). Ten years on, most family members were surprised but supportive. Media coverage of high-profile lesbian mothers like musician Melissa Etheridge and portrayals of queer families in movies and on television had prepared them for the possibility. However Louise was disappointed by her family's reaction to the news of her pregnancy:

Mum and Dad felt very ambivalent. That was hurtful, because when my brother's partner was pregnant they rang everyone. It was doubly shameful; my daughter is not only a lesbian but she's pregnant. All these secrets! I rang my sister and there was a silence, then she said, 'Does Fiona know?' I said, 'Of course, we've been trying for ages'. Mum and Dad hadn't even mentioned it. Then we were on television and they were really anxious about that. Fortunately, after the show lots of their friends rang and said, 'You must be so proud. It's wonderful!' All the anxiety fell away and suddenly they were telling everyone too.

Despite legislative change barring discrimination on the basis of sexual identification the women encountered homophobic gatekeepers at assisted fertility clinics. Harvey et al (1989) found that most providers were supportive of requests by lesbian women. It had taken three years of careful planning for Lisa and her partner to get to the point of contacting a fertility clinic and the reaction was very disappointing. They needed to travel several hundred kilometres to access services in another city:

We approached a fertility clinic and I was very 'out there' about us being a lesbian couple. I spoke to the donor co-ordinator and asked a few questions and she was great, but when we fronted up to see the doctor, he was awful! It was \$120 for an appointment and he was late, so we were only with him for twenty minutes. He didn't tell us anything that we didn't know already, which I think is what we found the hardest. I don't know if it was personal, but he wasn't happy! He told us that our best bet was to recruit our own donor. No discussion

about why we had chosen to have an unknown donor. We felt bloody awful! It was devastating!

Helen was similarly outraged at the attitudes expressed by a medical practitioner at another fertility clinic. She persevered and finally found a doctor who was willing to assist them:

Friends were talking about getting pregnant and they said, 'Of course the fertility clinic wouldn't take us because we're lesbians'. It was like waving a red rag to a bull. I said, 'Won't they just?' I thought how dare they! I phoned the clinic and talked to the woman [doctor] because I thought she would be more sensitive. It was absolutely the wrong choice! She was very uncomfortable with the situation and said, 'I just don't think that lesbians can make competent parents'. I harangued her for about an hour. I said, 'You've never met me, how can you possibly say I wouldn't be a good mother?' Eventually she said, 'Well sometimes [another doctor] can be talked into this kind of thing'. And he was fine, no problem at all.

Wherever possible the women in the study chose a lesbian midwife. As most lived in a large city with well-developed lesbian networks, it was not difficult to access a lesbian-identified practitioner. Kenney and Tash (1993) reported that lesbian-identified women preferred either a lesbian midwife or a midwife who could demonstrate that she was knowledgeable about and felt comfortable with lesbian issues. Chris was disappointed that her midwife didn't offer to introduce her to a lesbian midwife working in the same practice. It seems likely that if her 'cultural difference' been related to ethnicity, then such an offer would have been made:

She assumed I had a male partner and when I said, 'Her name is Jan', she said, 'I'm usually much more politically correct than that'. Jan came along to some of the visits with me and after the initial embarrassment, all that was fine. But she didn't mention that there was a lesbian midwife in the practice and I didn't realise that until now.

Wilton (2001) concluded that satisfaction with midwifery care was dependent on a woman feeling able to safely 'come out' to her midwife and the midwife being informed about and accepting of lesbian women. Non-disclosure of sexual identification complicates interactions with health care providers and contributes

to inappropriate treatment, such as discussion of contraception. Continuity of care by lesbian midwives served to protect the women and their families from homophobic attitudes. Problems usually arose outside of the midwifery relationship and insensitivity was commonly experienced during postnatal care in hospital. Earlier research had shown that home birth midwives were very supportive of lesbian mothers while hospital midwives often expressed surprise, dismay and disapproval (Bree, 1991). Several participants in this study identified particular healthcare workers and postnatal wards. Nicky commented:

The fathers paid for us to go to a (postnatal unit) but I wouldn't go back there. I hardly saw anyone on the first day; I was alone for almost six hours! I had my baby and I had stitches and I felt completely abandoned. My partner came back and no one had checked my blood pressure and no one had checked Sophie. I felt that there was quite a lot of judgement! My partner was there all the time and the only men around were the two gay guys, who came every day.

The women frequently expressed gratitude for small courtesies, warmth and friendliness. Wilton and Kaufmann (2001) were pleased to note that more than half of their respondents felt accepted as a lesbian by their midwife, an improvement over Stewart's (1999) findings. They agreed that lesbian mothers were appreciative of minimal acts of kindness and caring, while being willing to overlook unintentional insensitivity and hurtful comments. However, women were unhappy when their partner was "not included fully in decision making, not taken seriously or given proper acknowledgement and respect" (p.207). Julie:

The midwives changing shifts all the time at the hospital made it hard. Most of them didn't know that Caro was my partner. They all assumed I was married, which I thought was strange because there must be a lot of single women having babies. One fantastic midwife did connect with me and cracked jokes. She said, 'When am I going to meet your husband?' and I said, 'You've already met her', because I knew that would be OK. When I left she said, 'You're going to be a wonderful mother. Your baby is a lucky boy!'

The Royal College of Midwives position paper (2000) suggests that "The old custom of addressing all clients as Mrs, regardless of their marital status, used to be considered good manners but is now widely perceived as presumptuous or even offensive" (p.1).

Conclusion

Lesbian mothers were very satisfied with their care when healthcare professionals demonstrated acceptance of their partner and their relationship, provided information about methods of conception and practical help, such as providing syringes (McNair and Dempsey, 2002). Comments from respondents indicated that some practitioners were getting it right. "The hospital birthing centre were very helpful and completely accepting of us as a couple, inviting me to cut the chord and putting both our names on the door so it was clear we were partners" (p.50). Actions described as unhelpful included a lack of acknowledgement of the relationship and the partner's role in the family and discriminatory comments.

While lesbian mothers share many of the experiences of heterosexual women during pregnancy and birth, they also have particular needs for acceptance and acknowledgement as a couple. Wilton (1999) concluded that, "Midwifery, with its time-honoured and deep-rooted tradition of being 'with' women and its powerful associations with the fundamental human matters of birth and (sometimes) death, is perhaps the best place to begin treating lesbians with recognition and respect" (p.162).

CHAPTER EIGHT: QUEER AS FOLK

Queer Families

As the number of nuclear families declines (Maharey, 2003) lesbian mothers are redefining what constitutes a functional family. Queer families challenge the discourse which maintains that the heterosexual family is 'natural' and necessary for reproduction and the socialisation of children. Benkov (1996) suggests that there is growing recognition of the diversity and strength of the multiple constructions of family that exist outside the conservative tradition of the western, nuclear, heterosexual family norm.

The lesbian mothers who participated in this research were invited to talk about how their family had changed since the birth of their child. At the time of the interviews the children ranged in age from four months to almost four years and I wondered how closely the reality of parenting matched their pre-conceptual planning. In this last data chapter I look at the composition of queer families and discuss the complexity and satisfactions of the relationships between the mothers, their partners, donor/fathers and the children. The significant themes emerging from the conversations about family include: *Parenting equally, Lesbian dads, Involved fathers, Extended families and Experiencing satisfaction.*

Parenting Equally

The findings from this study supported earlier findings that lesbian couples share parental roles and tasks equally, including responsibility for feeding, playing, changing nappies and waking at night (Hanna, 1986; Bree, 1991; Braeways, 1995; Gartrell, 1999). The participants described their partners as extremely supportive and committed parents. While the breastfeeding mother usually took the role of the primary parent, staying home to care for their baby, her partner continued in paid employment to support the family. Later the couple shared paid work and parenting equally, often working complementary hours in order to reduce the need for childcare. Becky explains:

As far as our roles went, I always knew that Kate would be a mother like me and that while I would have a biological advantage, we would parent equally. And we have. She has just been amazing, totally there, taking her turn, doing all she could. I don't know how women do it without a supportive partner. She found it hard because people didn't acknowledge her as being his mother and she played such an equal parenting role. It was difficult for ages, almost two years. Their [Kate and the baby's] relationship wasn't as obvious because when you are the breastfeeding mother, the baby just wants you. Now he treats us all [two mothers and father] very equally.

The mothers' partners struggled with the nature of their parenting role during the first year. Their position was paradoxical. They had spent a long time anticipating the birth of their baby, but they were unable to breastfeed, showed no physical signs of being a mother (apart from tiredness) and outwardly their lives continued as though nothing had changed. While close friends, family and colleagues knew about the baby, they received little of the recognition given to new fathers. They were not legally entitled to parental leave, although one woman had it written into her employment contract. The inequality between biological and social parenting was exaggerated in the early months and birth mothers described it as a difficult time for their partners. Personal doubts about the significance of their parenting role, coupled with a lack of acknowledgement by the wider community, contributed to feelings of uncertainty and exclusion. White (2000) agrees:

I'm like a mother because I'm a major caregiver, but Gina was the one who breastfed. I'm also the one who goes out to work, so in that way it's like the traditional father role. But I'm neither. It was weird at first. I had no name and no identity, so it was hard. However our daughter relates to us equally so it's not a problem at home (p.46).

Lesbian Dads

The proposed legislation relating to same-sex relationships and the care of children will address the power imbalance which exists when one parent has legal rights and responsibilities and the other has no socially recognised role. The American Academy of Paediatrics recently reviewed published social science and medical research on same-sex parenting and recommended co-

parent custody, access and visitation rights in the event of parental separation or death (Young, 2003). The Care of Children Bill will make it possible for queer parents in Aotearoa New Zealand to name their partner as their child's legal guardian and provides rights and responsibilities for lesbian partners of biological mothers who have used assisted reproductive technologies.

Discussion of this legislation in parliament caused a furore when it was revealed that the term 'father' was intended to cover lesbian partners (NZPA, June 10, 2003). Interestingly, the objections focused on the suggestion that lesbian parents might co-opt the term 'Dad', rather than the indication of increasing numbers of women who are parenting children born to their lesbian partners. Lesbian parents do not want to be called 'Dad', but have yet to agree on an alternative term. Women commonly use Mummy (Mommy) and Mama, or Mum and both first names interchangeably (Gartrell, 1999; Bree, 1991).

Language is established in relation to culturally accepted precedents and queer families do not fit readily into the terminology used to describe heterosexual, biology-based family models (Brill, 2001). Helen planned to return to work soon after giving birth while Jo was to be the primary parent to their children:

It's interesting how it's turned out, because Jo is like the 'real Mum' and I'm more a 'Dad' figure in a heterosexual kind of model. I go out to work and the kids get terribly excited when I come home. I spoil them and she's the one who draws the line.

Plans made together during the pregnancy did not always feel appropriate when the child was born. However, the women recognised the importance of good communication in resolving any problems. Most families had successfully negotiated some changes, but Sue and her partner struggled with their differing expectations of family life:

We have been together for just over two years and we are going through quite a rocky patch. She was incredibly supportive through the pregnancy, but when we talked about being co-parents I was very clear that there was only going to be one Mummy. There is Daddy James and Uncle Harry [his partner] and Grandma and the aunts. She feels unclear about her role, when everyone else's role is clearly defined. My family love James so she feels a bit threatened by that, and Rosa [baby] has become very besotted with me lately. I understand

how she feels, but I think a child is such a joy! It is a real gift to have a child in your life...

I've also discovered that we have slightly different parenting styles. She sees Rosa as being naughty when she won't go to sleep at night whereas I just talk calmly to her and she does go to sleep. I parent as I was parented. Her childhood was very different from mine, quite neglectful and abusive. My mother says 'Oh, Rosa has a little pain' or 'She needs a nappy change', so it's never her fault. You develop the feeling in your child that they are wonderful and loved. I suppose you don't know that these things are going to crop up until you start parenting with someone. It has been a very difficult time for our relationship. We're taking it day by day at the moment.

The difficulties experienced by this couple are both specific to lesbian parenting, in the ambiguous nature of the partner's role, and universal, as in different approaches to parenting.

Involved Fathers

In earlier conversations with lesbian mothers I found that they had chosen to involve the donor/father in their child's life (Bree, 1991). In the USA and Britain, where women were able to access assisted fertility, lesbian-led families usually consisted of two women and their children, essentially a differently gendered nuclear family (Pollack and Vaughn, 1987). The expanded notion of family evident in Aotearoa New Zealand appeared to be underpinned by a widely held belief in the importance of biological connection. It seems likely that Maori notions of whanau and whakapapa have influenced our thinking (Pihama, 1998). Feminist involvement in the move towards open adoption has also encouraged discussion about a child's right to knowledge of their birth family (Kedgley, 1996).

I had wondered if legislative change giving access to assisted fertility would alter the composition of lesbian-led families. In this study most women chose to have a known father/donor. Women who conceived through assisted fertility clinics had decided that they wanted their partner to be their child's only other parent. Decisions about the presence and involvement of father/donors in the children's lives followed careful consideration of the child's needs. The fathers have become increasingly involved with the family following the birth of the

child. While the children all lived with their mothers, they spent an average two days a week in their father's care and the custodial ratio was changing, as the children grew older and more independent of their mothers. Tam talked about the personal qualities and practical contributions of Will, her daughter's father:

I felt that my childhood was a really positive one. My parents were calm and gentle and that's how I would like to be with my child. I never got smacked! My father was quite eccentric and extroverted but always loving. Will [baby's father] is very gentle and loving and also really reliable. I never expected him to contribute financially because I don't know any other fathers who do. I'm a teacher so I won't ever be wealthy, but if I got into financial difficulty my family would make sure that we were okay. He rang one day and said this is what I am doing [offering financial assistance]. It has made a big difference in terms of what she can have. I feel I made the right decision because he has made such an enormous commitment to her. I think she has a great Dad!

During the last decade, the queer movement has increased social and political contact between lesbian women and gay men. Collaboration on projects such as the Hero Festival has facilitated a closer relationship between the two communities. However, the stereotype of 'man-hating lesbians' raising their children in a separatist environment is a particularly enduring myth. Becky is often asked whether her son has any male role models, even when people learn that his father is very involved in his life:

Josh spends a lot of time with his Dad. He goes to his house every weekend for a day and a night and he often goes there during the week as well. But there is still an assumption that we will enforce our feminist ideals and 'gay ways' on him, and that his maleness will not be respected or celebrated.

Father's partners are also involved in parenting and many children have *two mummies and two daddies*. Some men have chosen a lesser role, *more like an Uncle figure*. All of the fathers' partners expected to provide protection and support when the child was staying in their home. Issues of trust and beliefs around parenting styles were discussed and agreed on prior to conception. Benkov (1996) described her family as being like "concentric circles with four overlapping adult relationships. The complexities of the four-way relationship can take a lot of energy to navigate" (p.140). Sue:

James started a new relationship the weekend she was conceived. When we met Harry we felt really pleased because he was so excited about having a child. He's like another Dad, although he's going to be Uncle Harry. We had already spent months discussing everything, like I really want her to be raised as a vegetarian, and he hadn't been around for those discussions. But we all have similar values in terms of safety and limits and boundaries. He is very generous; he has a place at the beach and he's just bought a boat, the kind of things I wouldn't be able to provide for her. I really trust James and Harry and I feel so excited about the life that she will have with them around.

Extended Families

The lesbian-led families described in this study included mothers and their partners, fathers and their partners, children conceived in these and other relationships, families-of-origin and close friends. Benkov (1996) suggests that queer families "exist in defiance of the parenting roles defined by gender, heterosexual procreation and legal sanction that constitute the traditional family." (p.145). There appears to be a move away from the two-mother nuclear families of the 1980's to more extended family networks (Patterson, 1995; Hauschild & Rosier, 1999).

A surprising finding of this research was the degree to which lesbian mothers value and depend on their families-of-origin. Coming out to one's family has historically been fraught for lesbian and gay individuals and earlier studies showed lesbian mothers' relationships with family to be problematic (Pollack and Vaughn, 1986; Bree, 1991). It is likely that the change in attitudes largely results from political activism leading to more positive portrayals of lesbian and gay lives in the media. Television sit-coms now regularly feature 'harmless homosexuals' as exemplified by the roles played by lesbian actor Ellen Degeneres. While characterisations such as this perpetuate equally one-dimensional stereotypes, they have been effective in countering homophobic attitudes. The participants often received encouragement and support from their siblings, parents, partners' families and fathers' families. Tam:

My family call in all the time! My sister is eleven years older than I am and she's my best friend. She is with a woman too and they have been incredibly supportive. I don't see family as just us and the baby. I don't want to be a little

nuclear family. I imagine big family gatherings and birthdays and us all going to parent/teacher interviews.

The queer families described in this study were also notable for the presence of non-biologically connected adults who had made a commitment to the children. When my own children were younger, I did not have a partner and their fathers lived in another city. My mother had died some years before, my father was elderly and I have no siblings. A close friend and housemate was very supportive during my pregnancies and attended both home births. She became an 'honorary aunt' and looked after my son while I was completing my midwifery studies. Her love and commitment to the children has continued and she is very much a member of our family. A friend's son invited his eleven lesbian aunts to be in his family photo, which was taken at school. His teacher was quite surprised, but the photographer just moved the camera back and fitted everyone in.

Helen and Jo decided to invite a close friend to take a fathering role in their children's life. Although the women felt that they could provide all the parenting their children would need, memories of close relationships with their own fathers and watching their son and daughter interact with Ed convinced them that the children would benefit from his continued involvement:

Ed was spending a heck of a lot of time here and one day I said, 'How would you like to be their Daddy?' He said, 'Oh yes, yes!' I said, 'Don't make a decision quickly. It is a lifelong relationship and even if we fall out, you can't walk away from them'. He said, 'I'll be their father!' We've decided that Fiona is their legal guardian and Ed is their testamentary guardian. His mother is definitely their grandmother, she knits and writes and comes on holiday with us...

Now we have Mummy and Mama and Daddy and his partner. In the last few months they have started saying, 'We've got two mummies and two daddies'. They don't really understand, but we read books about where babies come from. We explained that we went to a doctor who helped us and gave us some sperm to make them. A year ago they were going to a friend's birthday party and they said, 'Poor Lily, she's only got one Mummy and one Daddy!

Most of the women in this study described the birth of their first child. The experience had been a positive one and several hoped to have another child with the same father/donor “*before it was too late*”. One partner felt that having observed the special connection of birth and breastfeeding, “*she would like to have her own biological child*”. Tam and her partner were still deciding whether to add to their family:

I would like to have another child and my partner doesn't want me to, so that's a difficulty. I loved being pregnant and I know (the father) would like another child. Also, I don't want Morag to be an only child and yet I suspect she will be. I have found my brother and sister to be a great gift in my life; they are always there for me. I couldn't imagine not having my sister; she's my best mate. When my father died, we were all together at the funeral and that really made me think, gosh, I'm glad I'm not doing this on my own.

The participants' stories of how their families have evolved show a cultural valuing of biological connection, coupled with an appreciation of the adults (partners and others) who are family members through choice and commitment.

Experiencing Satisfaction

The created queer family in Aotearoa New Zealand more closely resembles a Pacific-model extended family (Auckland Lesbian Mothers Group, personal communication, Feb. 2001). Parents in this study believe that the increased emotional and economic support is beneficial for their children and are satisfied with the way their families have evolved. Becky explains:

Josh has such an extended family. He has my family, Kate's family and Bob's family, as well as my best friends and their children. I think that's probably the biggest difference with lesbian and gay parents. We have this great book called, 'Who is in your family?' and it says 'people who love you'. If you ask Josh who is in his family, there are a lot of people and animals! His perception of family is quite different.

All of the participants had decided to be *out and proud* as queer parents, because they felt strongly that they should not role model shame about their sexual identification. They believed that their children would be exposed to heterosexism and homophobia and hoped to counter negative attitudes with

openness and honesty. Brill (2001) suggests children with lesbian and gay parents learn to feel positively about their family when they see women and men openly demonstrating affection, respect and caring. Becky:

We don't believe [in being discrete to protect him]. There's all this homophobia and when I got pregnant, we decided we would have to be out, very out. We never wanted our child to see us being in the closet, because then he would learn to be embarrassed and there is nothing to be embarrassed about.

Gartrell (1999) argues that children do best when their mother has a strong lesbian identity and is actively involved in the lesbian community. Having parents who are open and 'out' positively correlates with self-esteem and sociability (Huggins, 1989; Flaks, 1995). The children of mothers in this study are growing up in a social network with positive attitudes to their family. They live in larger urban areas and participate in queer cultural events such as the Big Gay Out. Several of the pre-schoolers attend a Lesbian Mothers' Playgroup and all have friends with same-sex parents. It is possible that lesbian mothers are trying harder to provide their children with a positive childhood in order to compensate for their awareness that society regards them as unworthy parents. If that is so, then the children are the ones who will benefit. Jude's description of her family sums up the feelings of satisfaction expressed by the participants in this study:

We've created a family with the best of both worlds. Ben has a great life! How anyone could say it's wrong is beyond me. He has a father who adores him and is attentive. He has all our love and he doesn't want for anything materially. He's a very fortunate little boy! It's taken a lot to work out that family situation.

Conclusion

Radical hermeneutics has enabled the interpretation of a complex and rapidly changing phenomenon. The findings that, in Aotearoa New Zealand, lesbian women thoughtfully create a family which includes an involved father for their children does not represent 'the truth' about queer families. Although the conclusions of this small sample are supported by discussion with a wider group of fifty lesbian mothers, the phenomenon of lesbian parenting is one of flux and change (Auckland Lesbian Mothers Group, personal communication, Feb.

2001). As I write this chapter, legal recognition of same-sex relationships is being contested internationally, along with proposals for increased legal protection for lesbian mothers and their families. In the final chapter I will discuss the findings of the research and propose recommendations for practice, education and further research.

CHAPTER NINE:

DISCUSSION AND RECOMMENDATIONS

There has been an exponential increase in the number of lesbian women planning pregnancy in Aotearoa New Zealand. A survey of LGBTI people (McNair and Dempsey, 2002) revealed that 63% of those aged under thirty planned to have children. This figure represents a remarkable shift in public perception, given that only twenty years ago children were being removed from their parents' care solely on the basis of sexuality. Lewin (1993) concludes that "the lesbian baby boom and the increasing visibility of lesbians who become mothers constitute the most dramatic and provocative challenge to traditional notions both of the family and the non-procreative nature of homosexuality" (p.19).

In the final chapter I discuss the implications of the findings of the study under the headings, *Lesbian mothers and queer families*, *Cultural safety and Midwifery partnership*. The *Recommendations for practice, education and research* are presented. I conclude with comments on the *Limitations* and *Strengths of the study*.

Lesbian Mothers and Queer Families

Lesbian-led families may include mothers and their partners, fathers and their partners, their children, families-of-origin and close friends. In Aotearoa New Zealand the term whanau (family) is used in an inclusive sense to describe both biological and non-biological relationships (Pihama, 1998). The queer families described by the participants in this study are whanau kaupapa (contemporary urban families), which both honour and are independent of biological connection. Lesbian mothers believe that the increased emotional and economic support offered by an extended family is beneficial for them and their children. "Within both traditional and contemporary Maori society the whanau is critical...whakapapa and whanau assume notions of relationship, responsibilities and obligations that provide opportunities for all adults to take a

parenting role in the lives of Maori children” (Pihama, 1998, p.182). McNair and Dempsey (2002) list some strengths of queer families: equality within the lesbian relationship, the ability to negotiate flexible roles and an increased commitment to teaching children tolerance. They also identify challenges including a lack of recognition for non-biological parents, the difficulty of forging a new path with few role models and anxiety about children being exposed to homophobia.

The participants in this study described their partners as extremely supportive and committed parents. Couples shared parenting responsibilities equally, although the co-mother was likely to work longer hours in paid employment while the children were pre-schoolers. Partners often felt uncertain about their parenting role, particularly while the baby was still breastfeeding, and this was exacerbated by a lack of acknowledgement from the wider community. O’Hanlon (2000) is of the opinion that legislation providing recognition for same-sex relationships would restore legal, societal and financial equity to this disenfranchised group. Many lesbian parents welcome the proposed Civil Union Bill in Aotearoa New Zealand and moves towards the recognition of same-sex marriage, which together, would effectively give lesbian couples equality with heterosexual couples.

Pihama (1998) claims that, “Dominant definitions of family have been imposed in ways that marginalise lesbian whanau” (p.180), because lesbian-led families present a threat to traditional gender relations. Thompson (2002) explains the mechanisms through which media and the law constitute and regulate lesbian maternal identity. The mainstream media characterises lesbian co-parents as evincing false masculinity and usurping fatherhood (“Lesbian Dads”, NZPA, 2003, June 10) and the judiciary hold the power to deny a woman’s claim for continuation of parental rights. The proposed Care of Children Bill will grant parental rights to lesbian co-mothers in Aotearoa New Zealand. Thompson (2002) argues that the parent-child dyad should become the basis for family law decisions, rather than marriage.

Some courts have recognised lesbian parents as co-parents, affirming their right to craft a legal family identity, which, in turn, affords their children legal rights and protections, such as inheritance rights, social security benefits and the right to be supported by the adoptive parent (p.80).

Despite access to assisted fertility, the women in this study usually sought an involved father, as they believed that this would be the best option for their child. While there was a tension between wanting to “*find the right man*” and the biological imperative of achieving pregnancy “*before it was too late*”, the couples spent around two years finding ‘a good father’ and negotiating beliefs about parenting, such as no physical punishment. Fathers spend more time with their children (an average two days a week for two-year-olds), as the pre-schoolers become increasingly independent of their mothers. In all cases, lesbian mothers are delighted with the relationship between their child and her/his father. Tam concluded, “*I think she has a great dad!*”

When making decisions about their family, the women spent a long time considering everyone’s needs. A donor was chosen by two couples, who felt that having a father involved would compromise the partner’s role as the other primary parent. Both couples have large extended families and one couple have since invited a close male friend to take a fathering role in their family. McNair and Dempsey (2002) recorded dissatisfaction with donor anonymity and parental concern about the implications for children of unknown donors. However, Brewaeys et al (1995) found no evidence for the supposition that father absence would lead to increased emotional problems. I take the position that while gender and biological connection are less important if a child has two caring parents, knowledge of whanau and whakapapa (ancestors and family history) is the right of all New Zealanders. Assisted fertility clinics in Aotearoa New Zealand decided a decade ago that they had an ethical obligation to accept only donors willing to be traced by their child (Adair and Rogan, 1998).

Kawa whakaruruhau/ cultural safety

The New Zealand College of Midwives (1993) defined cultural safety as “The effective midwifery care of women from other cultures by midwives who have

undertaken a process of reflection on their own cultural identity and recognise the impact of the midwives' culture on their own practice" (p.48). Papps and Ramsden (1996) suggest that cultural safety is an examination of one's own position of power as a midwife and the impact of that on the midwifery relationship. Cultural awareness and sensitivity are necessary precursors of culturally safe practice (Nursing Council of N.Z., 1996). The principles of cultural safety "apply in all situations in which there are potential power and status imbalances" between health professionals and users of healthcare services (Spence, 1999, p.57).

Each of the participants experienced heterosexism or homophobia causing significant distress at some time during their pregnancy, birth or postnatal care. The terms heterosexism and homophobia refer to prejudicial and discriminatory attitudes and actions. Heterosexism is the belief that heterosexuality is 'normal' and 'natural' and therefore the only acceptable sexual identification. It can take the form of internalised beliefs held by individual healthcare practitioners (referring to all pregnant women as Mrs) or institutional and organisational structures (only fathers can come into theatre for caesarean sections). Heterosexism may be an unintentional and non-malevolent result of previously learned attitudes, and education can bring about positive change. Homophobia is a fear and hatred of individuals who love and are sexually attracted to those of the same sex (Morrissey, 1996). Homophobic actions are intentional and therefore more resistant to change. Studies have revealed a significant prevalence of homophobic attitudes among health practitioners (Stevens, 1995; Stewart, 1999; O'Hanlon, 2000). Morrissey (1996) encourages healthcare professionals to examine their own feelings about LGBTI people and become aware of homophobic assumptions.

I believe that midwives need to put aside their fascination with or anxiety about the 'difference' of queer families and incorporate an understanding of lesbian lives into their practice. Spence (1999) discusses the notion of encountering difference. "Difference as 'having distinguishing characteristics', in the context of cultural difference, is initially most noticeable in terms of language and physical appearance. It is also interpreted as meaning different values, beliefs

and behaviour... Difference is contextual and relational” (p.113). When meeting a person of another ethnicity, we often move from a first impression of difference towards an appreciation of commonality. When a midwife meets a lesbian woman for antenatal booking, the reverse is true. Invisibility complicates the interaction; while the woman waits for the right moment to come out, the midwife is unaware of her dilemma. Brogan (1997) cited fear of homophobic reaction and hostility from providers as the primary reason for non-disclosure of sexual identification. Should she choose to reveal her sexuality, the woman then has to wait for this (shocking/surprising) revelation to be acknowledged. The most common responses, minimising the significance, voyeuristic curiosity or outright disapproval, are all insensitive and unhelpful (Harvey et al, 1989; Wilton and Kaufmann, 2001).

Encountering a lesbian couple challenges and disrupts the midwife’s ‘way of being’. She has to rethink her customary language and understanding of roles and relationships. Lesbian women have historically been feared as mentally ill and potentially dangerous (Saphira, 1984). In the media they have variously been eroticised and satirised, through to present-day portrayals as relatively asexual and harmless (Wilton, 1999; Kleindienst, 1999). Spence (1999) reminds us that, “For Gadamer, the notion of ‘tradition’ comprises the shared understandings that reside in and through language, history and culture. Important too, is the recognition that multiple traditions coexist and interpenetrate simultaneously” (p.35). Shared understandings of ‘being pregnant’ may lead midwives to think that any difference is unimportant. I suggest that neither position is correct, but rather that there are cultural differences along with the potential for significant disadvantage.

Stewart (1999) agrees that treating lesbians as ‘just like everybody else’ is not the best way to avoid discriminatory practice. Lesbian mothers want to be accepted ‘as lesbian women’. Cultural diversity needs to be acknowledged by recognising and understanding each woman’s individual needs and Pihama (1998) cautions against the assumption that all lesbian mothers have the same needs. While we have some similar issues, “against homophobia and for legislation that safeguards the rights of lesbian and gay people, our differences

are significant” (p.179). The services offered to lesbian women should be equitable to that of any other defined population within the community (Wilton and Kaufmann, 2001).

Culturally safe midwifery practice would include a non-judgemental and respectful attitude, a willingness to ask questions and avoid assumptions, and the use of inclusive language such as partner and parent (Harvey et al, 1989; Kenney and Tash, 1993). Initiatives are also needed for midwifery education at tertiary and in-service levels, consumer publications that include images of women birthing and parenting together, and challenges to institutional homophobia to ensure workplaces are safe for lesbian midwives. Wilton and Kaufmann conclude, “The practicalities of providing a professional and appropriate service to lesbians are very straightforward and have no major resource or cost implications” (p.155).

Midwifery partnership

Pre-conceptual planning by the participants in this study was a thoughtful and highly responsible approach to pregnancy, birth and parenting, which often took around two years. Women were articulate and assertive in negotiation with their partners, prospective fathers, assisted fertility providers and midwifery and medical practitioners. Sources of support included midwives and general practitioners, lesbian mother support groups, pregnancy books and websites. The methods of conception used by the women in this study were self-fertilisation or assisted fertility. In common with these findings McNair and Dempsey (2002) noted that women chose self-fertilisation because of a desire to involve their partner, beliefs about the child’s right to know their father, cost, and feminist opposition to unnecessary medical intervention.

All of the participants expressed a preference for a lesbian midwife, based on the belief that she would understand their relationship. Because they lived in large urban centres, most were able to access lesbian midwives through their community networks. Stewart (1999) reported that lesbian mothers in the UK would have liked a way to contact lesbian and queer friendly healthcare

practitioners. The physically intimate nature of midwifery practice and the prevalence of homophobic beliefs about the sexually predatory nature of lesbians mean that individual practitioners may not feel able to be open about their sexual identification (Wilton, 1999). An atmosphere of safety and support in the workplace would enable lesbian midwives to be visible to lesbian women planning pregnancy. Zeidenstein (1990) reported that, while only half of her research participants 'came out' to heterosexual female health care providers, all felt able to discuss their sexuality with lesbian health care workers. Wilton and Kaufmann (2001) commented,

One clear difference between the experience of these women and that of non-lesbians is the necessary decision on whether or not to 'come out' as lesbians to service providers. The complexity of this is often unappreciated by heterosexuals, who enjoy much greater freedom to be themselves without fear of hostile reaction (p.204).

Lesbian mothers wanted midwives who would understand their social and emotional needs, actually use the word 'lesbian', recognise their relationship and include their partner appropriately (Kenney and Tash, 1993; Stevens, 1995; RCM, 2002). The antenatal booking visit is probably the most important opportunity to signal acceptance and respect. The woman needs to feel "comfortable enough to share information on aspects of her personal life that may affect, or be affected by, pregnancy and birth" (RCM, 2002, p.2). Stewart (1999) identified choice, continuity and control as being particularly important for lesbian mothers. Previous experience of insensitivity can mean it is more difficult for a woman to build a trusting relationship with her midwife.

The midwifery partnership model in Aotearoa New Zealand is underpinned by a woman-centred philosophy (Pairman, 1999). Pairman has described the midwifery relationship as professional friendship, because during the experience of pregnancy, birth and breastfeeding, women and midwives often come to know each other on a personal level, relate woman-to-woman and share common interests. Reciprocity, involving openness, shared meanings and mutual empowerment, is intrinsic to midwifery partnership and differentiates it from other health professional models of care (Pairman, 1999). However, an equal, trusting relationship may be compromised by external factors such as

institutionalised homophobia. Most of the participants in this study were very satisfied with their midwifery care and problems usually occurred outside the midwifery relationship, such as in the hospital postnatal ward. Midwifery partnership with continuity of carer increases the likelihood of culturally appropriate midwifery care for lesbian mothers.

Recommendations for Practice

Recognition that the provision of appropriate midwifery care for lesbian identified women is an issue of cultural safety. Individuals who identify as mostly or exclusively homosexual make up around ten percent of the population (Kleindienst, 1999). Lesbian women prefer to have a midwife who shares their cultural understandings and would appreciate the offer of introduction to a lesbian colleague or practice partner.

Lesbian-identified midwives have the right to work in a safe, supportive and respectful environment (RCM, 2000). The need for staff education should be identified and addressed positively and constructively. Using the analogy of racism, discriminatory language and behaviour, however covert and subtle, must be challenged (RCM, 2000).

The midwifery partnership model and continuity of care avoids the need for stressful and repetitious coming out to healthcare professionals. Disclosure of sexuality should be responded to in an encouraging way, should be kept strictly confidential and not recorded in the woman's notes unless she requests it (RCM, 2000). Honouring the principles of autonomy and empowerment facilitates an equal, trusting relationship between women and midwives (Pairman, 1999).

Midwifery practitioners should have a respectful attitude to all women, and avoid assumptions about sexuality, relationship status and method of conception. Verbal and written assessment methods should inquire without presuming the circumstances of women's relational and sexual lives (Carroll, 1999). Enquiring whether a woman is partnered dispels the common assumption of heterosexuality (O'Hanlon, 2000). "Avoid asking unnecessary and intrusive questions. While midwives need to develop their awareness and understanding

of lesbian parenting, it is unacceptable to expect women to educate them or satisfy their curiosity” (RCM, 2000, p.5).

Midwives should use of inclusive language such as ‘partner’ and ‘parent’. Gender neutral language is a means of signalling acceptance to same-sex couples and has the added advantage of raising awareness among heterosexual couples that significant numbers of lesbian women are becoming parents. Talking about ‘planned’ families, rather than ‘alternative’, highlights the thought and care that is evidenced by lesbian mothers.

Midwives should take care to acknowledge the lesbian couple’s relationship and the mother’s partner as a parent (RCM, 2000). Midwives should understand and use appropriately terms like partner, next-of-kin, father, donor and family (RCM, 2000). The use of kinship language privileges function as well as biological connection (Thompson, 2002). Sensitively ascertain whether the couple wish to be open about their relationship in front of others. Partners will have their own anxieties and needs and should be informed and supported (RCM, 2000). Discussion about the challenges involved in becoming parents and renegotiating roles within the relationship may be helpful. It is unacceptable that lesbian parents have to argue to be given information about or access to their partner or child (RCM, 2000). Other members of the mother’s extended family, including the biological father, may accompany the mother to antenatal classes and visits, attend the birth and be involved in parenting.

Midwifery practitioners need to create an environment that acknowledges diversity and choice (RCM, 2000). Ensure that all staff understand their responsibility to treat lesbian mothers with respect and that judgmental attitudes and behaviours are unacceptable. Sensitive use of documentation will avoid perpetuating assumptions of heterosexuality. Midwifery literature and antenatal resources should depict some same-sex couples and single women in parenting roles. Ensure posters and resources feature images of diverse families, including lesbian mothers. Provide contact numbers and leaflets for lesbian-identified and queer friendly healthcare practitioners, lesbian mother support groups and websites providing information for queer families.

Recommendations for education

Midwifery education should acknowledge lesbian sexual identification in the continuum of human sexuality and diverse family situations. Educators should explicitly address the issue of family diversity, including lesbian parenting, during discussions on sexuality, relationship issues, family dynamics, cultural difference, and social equity (RCM, 2000). Lesbian mothers and midwives may be invited to speak with groups of students, in the same way that representatives of different ethnic groups discuss their culturally specific needs. The session would contextualise more frequent references to lesbian mothers, rather than be a single session designed to 'cover' the topic. Particular care should be taken to ensure the safety of speakers in this situation by addressing problematic attitudes in advance and inviting several speakers together.

Midwives have a responsibility to examine their own attitudes about homosexuality. Mims and Swenson's sexual health model (cited in Morrissey, 1996) describes ascending levels of sexual knowledge, attitudes and clinical practice. At the basic level, interaction of perceptions, attitudes and reflection creates awareness. Communicating effectively, acknowledging the importance of sexuality and providing accurate information demonstrate practice at the intermediate level. An advanced level practitioner could design education programmes and conduct research on sexual issues.

The midwifery graduate should be able to demonstrate an understanding of the broader issues that impact on lesbian mothers, including legal recognition of relationships and parental rights. O'Hanlon (2000) reminds us that the American Medical Association has recognised the alienation of lesbian women and gay men from the healthcare system as an effect of ubiquitous discrimination. She contends that a responsible practitioner needs to convey her non-judgemental attitudes to all women. Wilton and Kaufmann (2001) argue that educating midwives about the politics of diversity would also help lesbian-identified midwives to feel more accepted and able to identify themselves to lesbian clients.

Recommendations for Research

Academia has attempted to legitimise the phenomenon of lesbian planned pregnancy through heteronormative comparisons. Studies that reassure the courts by showing that the children of lesbian mothers are no more likely to identify as queer are complicit in the notion that 'becoming gay' is inherently bad. However, comparative studies have partially achieved their purpose of reducing homophobia in the judicial system and foregrounding changes in the politico-legal status of lesbian partnerships and parenting. The RCM (2000) concludes that, "Widespread concern that the children of (lesbian) mothers will face social and psychological disadvantage have been shown to be groundless by the first wave of long-term studies" (p. 2).

Demographic research is needed, to indicate the numbers of queer parents and their children to policy makers, health professionals and educators. The government body funded to collect such statistics, Census 2006, has so far refused to recognise sexual identity in other than residential terms. Collaborative research in Australia (McNair and Dempsey, 2002) has provided valuable qualitative and quantitative data, covering age, ethnicity, length of relationship, number of children, education, employment, and accommodation. Respondents answered questions relating to how lesbians (in conjunction with donor/fathers) achieve their families, what role men play as parents in the lives of children in lesbian-led families and what kind of social and support networks sustain queer families in a heteronormative culture.

Further multidisciplinary research could investigate some of the following questions:

What are the needs of co-mothers?

How do children affect same-sex relationships?

How do the issues change as children grow from infancy to adolescence?

What are the effects of homophobia in the wider community?

How do the children feel about growing up with lesbian parents?

How can we legally protect our families through recognition of same-sex relationships, wills and guardianship?

What is the experience of lesbian parenting like for Maori women/ Pacific women?

Limits of Study

Perceived limitations of this radical hermeneutic inquiry into the phenomenon of lesbian mothers and queer families may focus on the size of the sample and positivist notions of transferability. I stand by my assertion that this research will meet the criteria for methodological rigour precisely because of the intimacy of the sample. It is not my intention to suggest that all lesbian mothers value the contribution of biological fathers or even that most lesbian-identified women are feminist in their political view. Morse (1989) contends that adequacy refers to the sufficiency and quality of the data. The articulate participants in this study have provided rich experiential insights. I present their words, contextualised with an explanation of their socio-political tradition, in the hope that the conclusions and recommendations will be useful for midwifery practitioners.

Concerns about the sample group might include the fact that they are disproportionately well educated, urban pakeha. This critique has been used to discredit the findings of some published international research. Purposive sampling requires that participants have lived experience of the phenomenon of inquiry and be willing and able to describe their experiences. As lesbian-identified women constitute an invisible minority, selection of potential participants is reliant on volunteerism. Health professionals and educators are two occupational groups who value the contribution of social research, and as such, women from these professions were quick to offer their time to participate in this study. Should funding become available for further research, then I am certain that lesbian women from other ethnic and socio-economic groups would be equally willing to participate.

Finally the study does not articulate the voices of some other important people in queer families, the mother's partner, the father/donor and the children. While I considered including mother/partners as participants and one couple insisted that both their comments be recorded, I decided that the insights of co-parents, along with those of children growing up in queer families, could more usefully be included in subsequent studies.

Strengths of Study

In refuting some perceived shortcomings of this study, I have illustrated some strengths of both the methodology and the method. Radical hermeneutics is particularly suited to a study of the experiences of a marginalised group, which navigate the space between hegemony and previously uncharted territory. The findings of this study do not attempt to describe an absolute truth but instead record a moment in the journey. The recording becomes particularly important when homophobia has rendered much of lesbian herstory/history invisible. Radical hermeneutics then, resists absolutes and supports the notion of flux, a dynamic mix of multiple realities. Queer families, whether by choice or circumstance, reside in the flux; the legal status of same-sex relationships is rapidly changing and social acceptance is increasing while homophobia remains.

Radical hermeneutics requires the researcher to declare herself and her methodological decision-making (Giddings and Wood, 2001). This position is congruent with the notion of coming out as lesbian feminist. A particular strength of this study is the researcher's lived experience of the phenomenon, both as a lesbian-identified mother and as a midwife in partnership with lesbian parents. Working as a participant researcher facilitates trust, purposive sampling and the collection of rich data. Lesbian parents and midwives felt that more information would facilitate the provision of culturally appropriate care.

Families in Flux

As I began planning this study, I talked with representatives from the two groups of women who I hoped would benefit from it. Lesbian mothers were enthusiastic and encouraging; they supported me as being the right person to explore their experience of planning pregnancy for the same reasons they had chosen lesbian identified midwives, "You will understand" (Personal communication, February 2001). Midwives were also positive but there was an undercurrent of reservation, best expressed by the colleague who said doubtfully, "Do you still feel you have to do that?" (Personal communication, March 2001). There is a belief that if midwives work in partnership with women, then trust and equality will automatically follow. Maori midwives (Papps and Ramsden, 1996; Tupara,

2001) have articulated that this is not always so; the recipient must determine the safety and appropriateness of care. Cultural difference and external disparity do not disappear because of the goodwill of individual practitioners. So yes, we do still feel we have to do that, to make the statement, wear the earring, sport the bumper sticker and correct the assumptions that because we have (or plan to have) children our partners must be male.

The personal is inevitably political for lesbian mothers and, as I conclude this research, our lives are about to be debated and legislated once more. As the labour government in Aotearoa New Zealand prepares to pass the Civil Union Bill giving parity of rights to same-sex relationships, and the Care of Children Bill recognising lesbian co-parents (Young, 2003), the contested space of 'the family' is politically charged. This study confirms international findings that lesbian-identified parents value extended family, which they interpret as both biological connection and loving commitment (Pollack and Vaughn, 1987; Patterson, 1995; Pihama, 1998). Two decades of research have failed to find any correlation between family form and function, and the first generation of young adults who have grown up in openly queer families tell us that parental cohesion and thoughtful parenting mitigate homophobic reactions (Hauschild and Rosier, 1999).

Midwives need to create a welcoming space for diversity in their practice, signalling their acceptance with inclusive language. As the boundaries between categories of sexuality blur and 25% of women aged in their twenties recognise feelings of attraction towards other women (NZPA, 2003, April 6), the numbers of queer parents will continue to increase. In Aotearoa New Zealand midwifery practice is underpinned by the philosophical paradigms of the partnership model of care and cultural safety. Incorporating an awareness of the issues facing lesbian-identified parents into these existing frameworks is an ethical imperative.

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APPENDICES

a. INFORMATION SHEET FOR PARTICIPANTS.

LESBIAN MOTHERS: QUEER FAMILIES

The experience of planned pregnancy

Lesbian parenting in Aotearoa has been characterised by two distinct periods. During the 1980's lesbian mothers that sexual orientation did not significantly affect the quality of parenting retaining legal custody of their children. By 1990 it information had become available for women who wished to plan pregnancy and create a family. In 1991 I carried out feminist research into the birth experiences of lesbian mothers. It is my intention to revisit this area of research for my Masters of Health Science (Midwifery).

I hope to hear about your experience of planning pregnancy, your partner's role, the decisions you made about a father or donor, whether your midwifery care met your needs, and how your family has evolved. The purpose of the research is to inform midwifery practitioners about lesbian-identified parents and our families of choice.

The proposed method of data collection is a taped conversation of approximately sixty minutes duration with women who have conceived a child by self-fertilisation. Because I am seeking recent recollections, I would like the child to be aged three years or younger on 1st January 2001. The time will be arranged to suit participants and every effort will be made to ensure confidentiality. A transcript of the conversation will be returned to the participants.

I am a lesbian mother of two children aged ten and seven years who were conceived by alternative fertilisation. Our queer family includes my partner, her daughter and our children's fathers. My midwifery practice includes pre-pregnancy counselling and antenatal, birthing and postnatal care for lesbian parents.

b. CONSENT FORM

..... (Name of participant)

I have been fully informed and had all my questions answered on the proposed research on lesbian mothers and queer families. I understand that I may withdraw my consent at any time during the process and that I will have the opportunity to veto information contained in the transcription of the interview.

I therefore consent to be a participant in the research to be carried out by

.....(Name of researcher)

..... (Signature of participant)

.....(Signature of researcher)

..... (Date)