Educational Issues Perceived by Expectant Lesbian Couples

Judith A. MacDonnell, B.Sc.N.

Department of Graduate and Undergraduate Studies in Education

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Faculty of Education, Brock University

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Abstract

Despite the increasing public profile of lesbian childbearing, public health resources for expectant women often bear heterosexist assumptions and create barriers to accessing information relevant to lesbian mothering experiences. This descriptive, exploratory study examined one lesbian couple’s perceived educational needs for effective support, barriers to access, strategies for locating care, and the impact of childbearing on their lives, as well as their reflections on inviting ways to offer supportive practices in a public health context.

A case study approach used feminist ethnographic methodology and purposeful convenience sampling. A prenatal and a postnatal open-ended interview were completed with 1 white, middle-class, able, lesbian childbearing couple, each of whom has birthed as coparent and biological mother in this couple relationship.

Despite this couple’s immense situated privilege, they struggled to locate the support they sought for childbearing in a way that offered optimal emotional and physical care from the preconceptual to postpartum stages and which maintained confidentiality or anonymity as desired. They created meaningful care through personal networks. The findings were framed using invitational and feminist theories: how people, places, programs, processes, policies, and politics contributed to educational support. A three part conceptual framework emerged which identified components of access to support: perceived safety of resources, disclosure status, situated privilege, and public or private availability of information. The consequences of lack of public access to comprehensive childbearing care for lesbian women and their communities are described. Educational possibilities addressed systemic heterosexism through the development of sensitive educators, meaningful curriculum, program planning, explicit policies, community partnerships, and political leadership with respect to both institutional and research venues.
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CHAPTER ONE: THE PROBLEM

Introduction and Background

Prenatal education for expectant parents has been widely accepted by professionals and the general public as a valuable method of obtaining current and practical information regarding pregnancy, labour and delivery, and postpartum issues. Education for expectant families remains a priority component of public health programming.

Formal provision for education targets various at-risk groups, single women, as well as adult couples. What has been left out, as Penny Simkin (1997) noted, is information which is relevant to lesbian mothers. It has been my experience as a childbirth educator in a public health setting that there is often an assumption made by health care providers that expectant women are heterosexual.

Several case discussions in my workplace focused on how prenatal educators have responded to same-sex couples who have disclosed their lesbian status. This indicated that public health nurses teaching adult classes demonstrated discomfort, lack of knowledge, and uncertainty as to whether existing classes should be modified or whether lesbian mothers required special programming. Lesbian couples have responded positively when there was supportive acknowledgement of their needs in a class setting. However, the question remains as to whether the traditional class setting meets the needs of expectant lesbian women.

The literature which addresses lesbian health concerns identifies homophobia and heterosexism as pervasive influences in how lesbian women interact with health care systems. There is evidence that many lesbians choose not to disclose their sexual orientation to family, friends, or health care providers because of the stigma of homophobic reaction.

This is a study of expectant lesbian couples’ perceptions of educational issues that they
identify as relevant from their perspective as a marginalized, often invisible segment of the expectant parent population. It focuses on how they access, interpret, and act on information they deem relevant to their experience.

Rationale

From my perspective as a public health educator, current prenatal education often assumes a heterosexist bias. A search of available resources on expectant couple education related to lesbian health and lesbian parenting experiences indicates that lesbian health and parenting issues have been documented in the literature for over two decades. However, there is limited information which offers childbirth educators strategies specifically geared to meet the needs of expectant lesbian couples. There is evidence that expectant lesbian women have unique educational concerns. Lesbian parents represent diverse situated lives. However, many educators remain unaware of these issues. How are expectant lesbian women meeting their educational needs in the community today?

However, this also begs the question about what knowledge is made available to educators and how this is determined. Public health educators place a priority on evidence-based practice. Public health nursing has consistently focused on parent-child health as a mainstay of its mandate. If childbearing lesbian women have been noted in academic contexts for two decades, what factors have contributed to the exclusion of childbearing lesbian women from public health settings? How have research contexts legitimated some childbearing women over others, and how has this marginalization of lesbian childbearing affected what information is available to educators? This study process will offer some insight into these issues.

Problem Statement

With the very recent amendments to legislation that offers same-sex partners spousal
benefits, lesbian and gay couples have been in the public eye. However, lesbian parents have been recognized by the public in very limited ways. The pervasive heterosexist assumptions that direct societal institutions and homophobic attitudes which control disclosure of same-sex orientation to others continue to keep childbearing lesbian women invisible in society.

For the most part, prenatal educators, as part of the mainstream public health institutions, have had limited awareness that expectant lesbian couples existed and have been unfamiliar with the lesbian perspective as it pertains to prenatal education. Educators question whether expectant lesbian couples have different needs than expectant couples in general.

The available literature offered evidence that issues related to disclosure, biological mother and coparent concerns, choice of health care provider, accessibility of educational, health, social, and legal resources, and support systems are meaningful to lesbian experiences.

With these concepts as a guide I explored eight questions with one childbearing lesbian couple, each of whom has been a biological mother and coparent in this relationship. Through a dialogue of their childbearing experiences, we identified those educational concerns perceived by expectant lesbian women to be meaningful to their lives.

By examining issues related to both educational content and process, I sought participants’ input on implications for education and service delivery. As such, I focused on how they defined supportive interactions and interventions in light of the stigma attached to disclosure of same-sex orientation. The purpose of this study is thus to facilitate expectant lesbian women’s access to education and support.

**Study Questions**

1. What are the day-to-day realities of these childbearing lesbian women?

2. What do these childbearing lesbian women identify as educational needs and effective
support?

3. How do they access education and support that is relevant to their childbearing experiences?

4. What support is readily available?

5. What support is not readily available?

6. What support do they create themselves?

7. What impact does the decision to bear a child have on these lesbian women?

8. What inviting possibilities have they imagined for the future?

**Glossary of Terms**

In keeping with the focus of this study, which addresses issues of power relations, several of the definitions I will use are those constructed by lesbians and gays as they have defined issues related to their sexual orientation. In my experience, there appears to be a growing awareness to respect the need for groups to self-define rather than accept definitions imposed by professionals and others in positions of power.

**Alternative care provider:** health care provider who does not fit the traditional medical provider model which includes physicians and nurses. In the obstetrics field this may include midwives, doulas (trained lay labour support persons), naturopaths, reflexologists, massage therapists, aromatherapists, chiropractors, native healers, and homeopaths.

**Alternative or artificial insemination (AI):** The terms used for this process, originally named artificial insemination by medical providers, vary throughout this study. Alternative or artificial insemination (AI) is also commonly known as donor insemination (DI), or if going through a clinic or fertility center, the term is often TDI or therapeutic donor insemination (J. Luce, personal communication, August 20, 2000). It is one of several methods of assisted
conception or reproductive technologies available to lesbian women for whom partnering with a male for the purposes of childbearing is not an option.

**Antinatalism:** This philosophy resists interpretations of motherhood which are oppressive and limited to discourses which tie it to patriarchy; in contrast, motherhood as it is experienced in diverse ways is potentially empowering (Abbey & O'Reilly, 1998).

**Cooptation:** appropriation of resources for use by others for their own purposes. Within this study context, cooptation is briefly discussed in relation to lesbian health research (Bowen, Powers, & Greenlee, 1997), professionalization of midwives (Shroff, 1997), and community development (Labonte, 1990).

In each case, there is a concern by marginalized groups or those oppressed by diverse social locations of gender, sexuality, etc., about whose interests are served when dominant societal institutions become involved with their concerns. They may question whether actions taken in the name of marginalized groups appropriately represent or respect their interests. In fact, institutional involvement may effectively disempower these groups, and thus is interpreted as a form of social control. Perceived cooptation contributes to resistance which may both empower and disempower groups, as I will argue in this study.

**Coparent:** the partner of the biological mother in an expectant lesbian relationship; also known as “co-mother,” “other mother,” and “partner.” Not all partners of lesbian childbearing women choose to identify in this mothering or parenting role.

**Couple:** partners in a lesbian relationship. Not all partners will choose to identify as a couple. For the purposes of this study, participants will include lesbian women who partner and who identify themselves as a “couple.”

**Disclosure:** acknowledgement of lesbian status to self and/or others; “out.” In this study
such identity claims will also be discussed with respect to claiming other identities of social location including cultural affiliations.

**Expectant:** For the purpose of this study, one of the partners in the couple has had confirmation of pregnancy. Participants may be at any stage of the pregnancy.

**Homophobia:** “the fear of gays and lesbians and the hatred, disgust and prejudice that fear brings. Homophobia refers to individual negative attitudes, and personal prejudice” (Canadian AIDS Society, 1992, p. 66).

**Heterosexism:** “the assumption that the world is and must be heterosexual” (Clunis & Green, 1995, p. 61); “the continual promotion by institutions of the superiority of heterosexuality and the simultaneous subordination of homosexuality” (Canadian AIDS Society, 1992, p. 6).

**Lesbian:** The broad definition I will use emerged from the input of grass roots groups of American lesbian women organized by the National Gay and Lesbian Task Force (NGLFT) prior to 1993. Although this description is shaped to encompass the diversity of American women, it appears to have relevance for women across cultural contexts.

A lesbian is a woman whose erotic desire and affectional preferences are directed at other women. Her sexual behavior ranges from exclusive homosexual behaviour with other women to bisexuality to situational heterosexuality prompted by economic status, cultural factors or sexual desire. “Lesbian” is a social/political construct that not all women who partner with women are comfortable with. The process of choosing to identify with the term is highly individualized and fluid and is also affected by other social constructs, such as age and race. Women who identify themselves as lesbian do so in their teens, in young adulthood, in middle age and some late in life. There are lesbians who never claim the identity.
Lesbians are as diverse as all of America. We share with other subgroups of women systemic barriers to access as women of color, poor women, sex workers, incarcerated women, single mothers, women addicted to drugs and alcohol, working-class women, immigrant women, youth and older women. In addition, all lesbians experience the stigmatization, marginalization, and sometimes overt hostility directed at gay men, bisexuals, and transgendered people in our society. As a family unit, lesbians are denied benefits enjoyed by heterosexual married couples, such as joint health care and parenting rights.

Finally, we are often forced to lie and hide our sexual desire for other women so that we can access the health care or social services we need. We also hide in order to guarantee the commitment and support of our biological families, our jobs, our neighborhoods, our children, our language and our access to valued cultural and religious institutions. Medically, socially and economically, the less room we have to run around, the more problematic our crises become as we balance precariously between the women and community we desire and the help and support we need. For many, the process of “coming out” is often dangerous and isolating. (Plumb, 1997, pp. 365-6)

**Lesbian-positive:** pertaining to those verbal and nonverbal messages perceived by lesbians as supportive of lesbian same-sex orientation.

**Maternal epistemology:** ways of knowing and understanding which stem from embodied experiences of mothering (Abbey & O’Reilly, 1998).

**Patriarchal:** pertaining to power structures which systematically privilege males at the expense of females. It is recognized that various feminist theorists view patriarchy in a context of sexual power as well as gender dominance, and may also acknowledge that it is also a form of
oppression over nondominant males (Mandell, 1998).

**Prenatal education:** formal and informal learning experiences which potentially contribute to the production of knowledge relevant to expectant parents; formal education is traditionally offered in class format by professional educators, often in institutionalized settings.

**Prenatal educator:** Educators may have a variety of professional and nonprofessional backgrounds. Some are midwives, doulas, nurses, and certified childbirth educators who espouse a variety of mothering/motherhood philosophies and who negotiate individual or group sessions on a private, fee-for-service basis. In this study, prenatal educators are public health nurses who offer formal classes for diverse expectant women within public health institutions. The focus will be on classes geared to adult couples. It is recognized that educators and childbearing lesbian women are not mutually exclusive.

**Pronatalism:** a philosophy of motherhood which reflects patriarchal values in which compulsory motherhood within the traditional nuclear family structure is viewed as the ideal goal for women.

**Restitution:** term used to describe the stage of vaginal childbirth just after the delivery of the head and before the delivery of the shoulders: external rotation of the head which occurs after the entire head has emerged. The head turns to one side or another of its own accord as the shoulders rotate internally, and the baby is often born immediately after.

**Support:** that which is perceived to facilitate or encourage. This term will be explored further within this study context as it pertains to childbearing lesbian women.

**Theoretical Framework**

Creating safe environments for learning, where individuals are validated, difference is celebrated, and education is meaningful: this is the goal of invitational theory (Purkey & Novak,
1996). For the many expectant women who partner with another woman, inviting support is remarkably absent from the public institutions which set a priority on facilitating care for childbearing women.

Yet, the invitational model presents a framework through which to systematically assess educational environments with a view to creating supportive communities. It addresses the 5 Ps: people, places, processes, programs, and policies in term of their intentions to send messages which affect individuals’ perceptions of themselves as able, valuable, and responsible human beings. With its roots in caring ethics (Noddings, 1984), democratic theory and education (Dewey, 1938), and perceptual, self-concept theories (Kelly, 1955), it seemed apparent that this model could provide a basis for addressing educational issues relevant to childbearing lesbian women.

However, the crux of facilitating access demanded more than this framework seemed to capture. Reflecting on my own experiences offered insight into this dilemma. When I first encountered issues related to childbearing lesbian women, I reacted like many other colleagues with whom I have spoken: with shock and awkwardness. Why was it that caring and knowledgeable public health nurses, many of them mothers, neither thought we had encountered lesbian mothers in our professional practice or personal lives, nor considered that this was relevant to our lives? Although on an intellectual level I realized that homophobia and heterosexism existed, it was only when I was immersed in critical studies related to the analysis of intersection of gender, sexuality, ability, race, class, and other locations that I began to critically examine my own assumptions and privileges. Identifying the ways in which I was positioned in relation to these issues, as a white, middle-class, heterosexual educator, was an important element in developing this critical awareness.
This research study began from my own situated experiences. Feminist theories which value day-to-day realities underscore the relations of power which influence how we come to know and understand our worlds. This case study, or ethnographic dialogue as I prefer, with one lesbian couple reflects a sharing of their daily realities as they seek support for their childbearing. As mothers of two sons, these women encounter families, friends, professionals, and systems whose perspectives are dominated by heterosexist and homophobic influences. In order to facilitate meaningful educational opportunities for childbearing lesbian women it was important to understand how this couple perceived and interpreted their situated lives and actions they perceived to be available to them.

However, if educators are in a position to determine what educational support is available for childbearing women, addressing issues of access for expectant lesbian women necessitates focusing not just on their daily realities, but the factors which shape educators' decisions. It became apparent that the structuring of power was a common thread for analyzing and interpreting both the participants' experiences and educators' limited awareness of lesbian childbearing issues.

In 1992, Dean Fink offered the addition of a 6th P, politics, to the invitational framework. He addressed how political savvy is useful in facilitating the development of inviting educational environments. I have focused on further extending the concept of politics as it relates to invitational theory by addressing how relations of power are implicated in understanding individual and institutional interactions in educational contexts as they relate to access.

For the purposes of this discussion, power has been conceptualized not just as a negative, repressive quality, but also in terms of its positive aspects as it facilitates the production of knowledge. Invitational theory’s use of perceptual and self-concept theory, democratic and
caring perspectives, in conjunction with a variety of feminist approaches, will explain how dominant discourses shape the way in which individuals perceive and interpret their worlds, as well as how institutions represent childbearing women. The concept of enforced heterosexuality as described by Adrienne Rich (1980) and more recent notions of heteronormative discourses (Martindale, 1998) will provide a basis for understanding the pervasive nature of patriarchal power as it defines discourses on lesbian motherhood. The intersection of other hierarchies of oppression will be addressed as they influence childbearing. The ways in which childbearing lesbian women define their needs for inviting support and barriers to access will be explained in a context of the power relations that inform these processes.

Moreover, I have presented the strategies used by these women as they act to overcome perceived barriers as childbearing lesbian women. The power dynamics inherent in the decisions and actions taken in light of their perceived choices will be discussed. As well, the impact of childbearing on their lives will deal with the consequences of their decisions with respect to issues of identity and connections with others. The implications of heteronormative barriers for the larger community of care will be noted.

According to the invitational perspective, the potential for facilitating more inviting educational opportunities lies in an intentionally hopeful stance: through optimism and reflection. A discussion of future possibilities offers a consideration of educational content and processes perceived to be inviting to this lesbian couple as they reflect on their own childbearing experiences. As this couple and researcher together imagine alternatives to the current situation in a public health context, we take into account issues of power relations in terms of how pervasive homophobia and heterosexism have influenced the historical and political contexts associated with community support for childbearing lesbian women. In this way, invitational
processes may demonstrate respect for how support has been developed in the past and may offer insight into how future resources might evolve from that base.

The societal structuring of power as well as the production of power through action are key elements of facilitating education perceived to be inviting to childbearing lesbian women. Incorporating a 6th P, politics, into the invitational framework enhances the potential of invitational theory to enable supportive communities for the diversity of expectant women who partner with another woman.

**Importance of the Study**

Heterosexist and homophobic attitudes and values are so deeply ingrained in society that public health educators, as part of the dominant culture, seldom associate childbearing with lesbian women. In fact, shock and embarrassment mark the typical response to disclosure by expectant lesbian couples. Inherent in dealing with issues related to the lesbian culture is that of societal stigma which would rarely be associated with studying another cultural group identified by ethnicity instead of sexual orientation.

As professionals, public health nurses, who themselves reflect a variety of lived experiences and social locations, are aware of the complexity inherent in the individual and structural determinants of health and practice. Providing education which is relevant and which respects the diverse situated lives of individuals within their communities is a priority.

Recent changes to family and human rights legislation on both federal and provincial levels has indicated that recognition of same-sex spouses is a reality. Nursing practice guidelines and provincial Mandatory Guidelines specify that access to culturally sensitive care is expected as part of effective public health nursing practice. The *Healthy Babies, Healthy Children Program* (Ontario Ministry of Health, 1997) is in place to facilitate supportive conditions for
childbearing women from the prenatal periods through to school age. Public health organizations historically have played a large role in providing high-quality reproductive health education to women of childbearing age and are funded to deliver service to childbearing women in various circumstances. As well, sexual health guidelines promote holistic and inclusive practice. With their well-developed community partnerships, public health educators may be well positioned to facilitate care for expectant lesbian couples.

However, this study will address how educators themselves may contribute to the continued marginalization of childbearing lesbian women when the legacies of dominant ideologies which shape their practice remain unexamined. Supportive individual interactions by well-meaning and caring educators are a start; however, for education to be inviting, educators must address the larger systemic issues. There are implications for both the content and process of delivery of education.

Although the literature describes the dilemmas that expectant lesbian women face, there appear to be no specific guidelines for childbirth educators offering prenatal education in a traditional adult couple class format. Neither is there any discussion which addresses the role of public health in acknowledging its part in facilitating access to childbirth education for women who partner with another woman.

There is a gap in the literature describing specific educational strategies for facilitating education for expectant lesbian women in a context of the Canadian public health system which represents the interests of a democratic society in which equality of access to resources is considered a basic right.

In this study I will attempt to increase educators’ awareness of the barriers which expectant lesbian couples face in their attempts to find meaningful educational resources and
community supports which respect their unique issues. As well, I will describe the creative strategies that lesbian women have developed to meet their needs in order to foster a more inclusive approach to public health education.

It is evident that childbearing lesbian women remain invisible to many childbirth educators, despite published evidence over two decades which points to the widespread phenomenon that is lesbian childbearing. This case study of this lesbian childbearing couple, who themselves have connections to both traditional and alternative care providers of reproductive health, will address some of the underlying issues which have contributed to this situation. This exploratory study has offered an opportunity for participants and a public health educator to dialogue and reflect on possibilities for action which could facilitate more inviting interactions and development of supportive communities.

This study has relevance for mainstream and alternative providers of care, including childbirth and parenting educators, as well as lesbian communities themselves, as potential advocates for expectant lesbian women. There are thus ethical and professional implications for undertaking a study that focuses on education for childbearing lesbian women. In addition, there is legislation in place which addresses discrimination for disadvantaged groups, of which lesbian women are named. There are legal grounds for addressing both direct and systemic discrimination based on the sexual orientation status of childbearing women.

This study will offer information that can extend the available research and theory base as well as offer opportunities to reconsider current practice. A critical reflection upon values and knowledge may be reflected in a process that encourages sensitive educators, meaningful curriculum, program planning, institutional processes, and community partnerships.
Parameters of the Study

The exploratory nature of this case study is intended to provide a basis for describing issues that may be relevant to childbearing lesbian women. The intent of this study is to offer insight, but in no way to represent, the diversity of lesbian childbearing women who are positioned in multiple social locations defined by class, race, ability, age, or ethnicity. This study was limited to interactions with lesbian women and community contacts within the mostly urban Hamilton-Toronto area of Ontario.

Several elements have influenced the study process and will be discussed here: researcher positionality, feminist research processes, language used, disclosure issues, and issues related to couple interviews.

From my perspective, the way the researcher is situated in the study, her positionality, is a key element of feminist research. As a researcher who identifies as a heterosexual public health nurse, my access to potential participants has been affected by potential participants’ comfort disclosing same-sex orientation to a health-care provider who does not identify as lesbian. My limited personal affiliation to lesbian-positive resources influenced the study process. Recent literature on undertaking research with childbearing lesbian women has underscored the importance of the same-sex orientation of the researcher in order to gain the trust of participants and to locate women who partner with other women (Asten, 1997; Mathieson, 1998; Nelson, 1996). As well, my positionality has influenced potential connections with the diversity of women partnering with another woman who represent a variety of social locations of age, race, ethnicity, ability, class, and sexual orientation, as well as their advocates.

Despite the various theoretical perspectives which discuss identity as shifting and fluid (Kemp & Squires, 1997; Mandell, 1998), the issue of researcher identity within this study has
been a continuing focus in this research process. My social location as a white, middle-class, hearing-impaired, heterosexual woman situated within a community of public health nurses, as a mother, and as a graduate student researcher has influenced ways in which this study process has emerged.

As a white, middle-class woman who not only has heterosexual privilege, but may be perceived to align with the dominant culture in other ways, I have been aware that my social location linking me to a mainstream public health organization may be relevant to the study process. Those who have been marginalized by traditional health organizations may have political reservations about the role of public health in facilitating care to childbearing lesbian women. Historically, lesbian women have been ignored and mistreated by many health care providers, and the literature certainly emphasizes the mistrust many lesbians have of any research that may be used to their detriment. Potential advocates for childbearing women or women themselves may be concerned that health corporations may participate in cooptation of resources that have already been developed as a way of “colonizing the marginalized” (Shroff, 1997).

On the other hand, the literature also stresses that stigma is often associated with those that are involved in researching lesbian health issues and that researchers who undertake this research may take professional and political risks. If a researcher can establish credibility in other ways with those who could facilitate the research process, the privilege of being affiliated with a mainstream health organization may be perceived as an appropriate use of privilege which advocates “for” women. The quality of the study may then be affected by participants’ or their advocates’ perceptions of the researcher as either an ally of lesbian women or an “outsider,” and this may affect available support for the study.
However, throughout the study process the explicit or implicit way in which I focused on feminist research approaches also contributed to my perceived credibility as a researcher and of the study itself. This dimension in which the methodology and purpose of the study would stress social action components, reflexivity, and the power dimensions of researcher-participant interaction, in which the participants were encouraged to be involved in the interpretation of findings, also shaped the study. I found myself aware of how this aspect might influence the scope of the study in terms of how those located in various positions as lesbian-positive advocates might provide support for this study.

The language used to describe women who partner with another woman during this study process and the ways in which women themselves identify same-sex orientation have had relevance for the study. My decision to use the term “lesbian” and to search for participants who self-identify as “lesbian” may have limited access to other childbearing women who prefer “bisexual,” “queer,” or another term. As well, the decision to focus on lesbian women who identify as a couple narrowed the study focus further and eliminated those single, childbearing lesbian or queer women whose female, male, or queer-identified partner(s) may take on a coparent role, but for various reasons may not identify as the coparent.

An important issue which influences the study process is that of homophobia—as it shapes all interactions. Certainly I have foregrounded this point throughout the study, positioning myself as a public health nurse undertaking research in order to examine my own heterosexist assumptions. I have acknowledged how this has influenced my own understandings and actions throughout the study through ongoing self-reflection and discussion with others. One of the major obstacles to researching lesbian issues is that of disclosure. The social forces which hinder self-disclosure of lesbian status and/or “coming out” to others affects which potential participants
may be involved, in addition to those community supports which may advocate for this study.

Health care providers may be affected by homophobic stigma and reluctance to fully disclose their experiences with lesbian women. Potential concerns about the political backlash of being perceived by other practitioners as supportive of lesbian couples may be an underlying concern for health care providers who are seeking acceptance by mainstream institutions and who rely on public funding.

The shape of the narratives shared by the couple within the research interview setting will be influenced by the comfort level and group dynamics of the participants and researcher, with no absolute guarantee of confidentiality. Stigma may affect couple partners as they discuss personal issues with a potential bearing on exacerbating issues of conflict or stress as individuals, couples, or with the researcher. Sensitivity to such environments has been a priority during this process.

**Outline of the Remainder of the Document**

In Chapter Two, I will review the literature which pertains to understanding the implications for researching childbearing lesbian women. This review of the literature situates this study in the larger historical and social framework, and in doing so offers insight into the complexity of power relations implicated in addressing education for lesbian childbearing. This literature has been subdivided into eight sections: Sources Used for the Literature Review, Historical Perspective, Theoretical Base: An Articulation of Perspective, Heterosexism and Homophobia, and Heteronormativity, Research Contexts Which Shape Care for Lesbian Women, Lesbian Health Issues, Lesbian Parenting, and Summary of the Literature Review.

Chapter Three deals with the methodology, epistemology, and research methods which have been considered during the research process. A focus on feminist ethnographic approaches
will be described, as will the reflexive nature of this case study process. This section offers insight into the selection of the research participants and decisions made related to data collection, reporting of the findings, and thematic analysis, in light of the issues which emerged through this process.

The fourth chapter describes the narrative findings of this study. Thematic analysis of two in-depth ethnographic interviews, one prenatally and one postnatally, with one lesbian couple will be presented as the themes relate to the eight research questions under study. A thematic synopsis follows each study question, and a final chapter summary provides links to both thematic and theoretical considerations of this analysis.

In Chapter Five I present an interpretation of the study findings in the form of a conceptual framework for access which emerged from the thematic analysis of the study findings. The invitational framework is extended through a discussion of power relations from feminist perspectives which offer support for the inclusion of the 6th P, politics, in the framework. Four components which influence access to comprehensive childbearing support for lesbian women, the consequences of lack of access, and educational possibilities are discussed in the context of the literature. Throughout this conceptual framework, I will discuss implications for theory development, educational practices, and as well, focus on issues related to research which can further develop educators’ understanding of enabling culturally sensitive care for childbearing lesbian women.
CHAPTER TWO: REVIEW OF RELATED LITERATURE

Organization of the Chapter

It became important for me, as a childbirth educator, to research the literature on the childbearing lesbian population to better understand their prenatal and parenting education needs and implications for service delivery.

I have focused on citing sources which specifically address expectant lesbian parents’ issues around pregnancy and have also included those which highlight societal attitudes regarding lesbian health or same-sex parenting which may also have relevance for educators. This includes a discussion of heterosexism and homophobia, as well as historical and theoretical considerations of feminist thought, democratic liberalism, and invitational theory, with a specific focus on caring for expectant lesbian women.

It became evident through this study process that understanding the complex political aspects of educational environments with respect to all levels of interactions was crucial to facilitating care. Each of the sections which follows offers insight into how relations of power have influenced what information is available in educational and research contexts, as well as the related cultural and social dynamics at play as lesbian women seek the information they require for childbearing.

I have organized the literature into several categories:

1. Sources used for the Review of Literature
2. Historical Perspective
3. Theoretical Base: An Articulation of Perspective
4. Heterosexism, Homophobia, and Heteronormativity
5. Research Contexts Which Shape Care for Lesbian Women
6. Lesbian Health Issues
7. Lesbian Parenting
8. Summary of the Literature Review.

**Sources Used for the Review of Literature**

The recent increase of publications dealing with lesbian health, and specifically lesbian parenting issues, attests to the fact that this is a timely topic. Published information, including books and journals, dissertation abstracts, and on-line scholarly publications were used for this review of the literature. As well, information available from nonacademic sources such as on-line sites for information and lay resources on childbearing were briefly reviewed.

Health-related lesbian issues in journals and books date back to the early 1970s (Boston Women's Health Book Collective, 1973; Stevens, 1992), but are few in number (Stevens, 1992; Trippet & Bain, 1992). A review of the literature of lesbian health care research from 1970 to 1990 (Stevens, 1992) noted that many sources available for review were “either unpublished manuscripts or available only through nonprofit organizations, although others appeared in scholarly journals” (p. 117). Until recently the number of refereed journals with studies on lesbian health was small (Trippet & Bain, 1992). Since 1990, lesbian health concerns have been increasingly noted by medical and nursing professionals (DeMarco & Simkin, 1996; Druzin, Shrier, Yacowar, & Rossignol, 1998; Eliason, Donelan, & Randall, 1992; Gentry, 1992; Jones, 1988; Lucas, 1992; Mathieson, 1998; Moran, 1996; O’Hanlan, 1998; Robertson, 1992; Stevens, 1992; Trippet, & Bain, 1992, 1993; Waitkevicz, 1996). However, there is agreement among all authors that this is a neglected area for research.

By the '80s, the expectant lesbian issue was beginning to be acknowledged in the medical (Johnson, Guenther, Laube, & Keettel, 1981; Reagan, 1981) and lay (Hanscombe & Forster, 1981; Rich, 1986) literature. Midwifery sources were noted to acknowledge the lesbian parent from the mid-80s (Buenting, 1992; Harvey, Carr, & Bernheime, 1989; Kenney & Tash, 1992; Olesker & Walsh, 1984; Zeidenstein, 1990). Nursing and medical professionals have increasingly addressed pregnancy and parenting concerns for lesbians (DeMarco & Simkin,

It is worth noting that the editor of Health Care for Women International, under pressure from the lesbian community, agreed to compile a special issue dealing with lesbians and their health. That issue alone contributed enormously to the articles on lesbian health and parenting issues available (Buenting, 1992; Eliason et al., 1992; Gentry, 1992; Kenney & Tash, 1992; Lucas, 1992; Robertson, 1992; Stevens, 1992; Trippet & Bain, 1992).

Several books on the lesbian parent have been published during the last decade. These discuss the issues specific to the expectant lesbian parent in depth (Asten, 1997; Clunis & Green, 1995; Nelson, 1996; Pepper, 1999). Sources which contributed the most insight into expectant lesbian issues included books and journals which focused on lesbian and gay issues and women’s health. A number of these reflect the feminist perspective of the authors, many of whom acknowledge their involvement in social activist and/or women’s collective groups (Asten, 1997; Auger, 1992; Clunis & Green, 1995; Epstein, 1993; Ford, 1993; Nelson, 1996; Vida, 1996; White & Martinez, 1997). Kellogg (1998) recently focused on feminist strategies for childbearing lesbian women. Aldrich (1994) used feminist ethnography in her study of lesbian stepfamilies.

Asten (1997), in her research, has combined a unique research approach to the lesbian parent issue by combining ethnographic interviews and film. This study is one of the first scholarly efforts using videotape as a way to collect data on lesbian families.

The vast majority of books and journal articles on lesbian parenting reflect an American viewpoint. In fact, in Stevens’s (1992) review of the literature mentioned above, all sources were American.

The Canadian perspective on lesbian health remains limited (DeMarco & Simkin, 1996; Druzin et al., 1998; Mathieson, 1998; Moran, 1996; Ramsay, 1994). DeMarco and Simkin (1996) offer general information on lesbian health and lesbian parenting in a context of women’s
health. Auger (1992) describes lesbians’ experiences with the health care system in Nova Scotia. Several unpublished Canadian sources consider family dynamics and supports in relation to lesbian women (Kaffko, 1993) and lesbian mothers (Neuman, 1998). Lesbian parenting experiences (Epstein, 1993) and midwifery advocacy for childbearing lesbian women (Ford, 1993; Shroff, 1997) have been examined. Abbey and O’Reilly (1998) have included the lesbian parent experience in their book on motherhood. Fiona Nelson (1996) explores lesbian pregnancy and parenting in a Canadian context in a book which focuses on urban experience in Alberta. The Association for Research on Mothering published a specific journal celebrating lesbian motherhood in 1999, with a focus on narratives of diverse expressions of lesbian mothering (Lesbian Mothering, 1999). The legal implications of childbearing as lesbian women with respect to custody (Arnup, 1998) and social policy (Eichler, 1997; Epstein, 1996) have been documented.

Other articles on lesbian health are geared to family physicians (Druzin et al., 1998; Mathieson, 1998; Moran, 1996). Capen (1997) advises physicians on the legal repercussions of denying artificial insemination to lesbian couples. The Canadian AIDS Society (1992) discusses gay/lesbian activism with respect to HIV/AIDS. Schneider (1991) has focused on mental health concerns relevant to adolescent gays and lesbians. Israelstam (1998) and Simpson (1994) studied issues for gays and lesbians relevant to substance abuse workers, the latter specifically regarding youth services. C. O’Brien, Travers, & Bell (1993) offer an analysis of residential services for lesbian, gay, and bisexual (LGB) youth. Disclosure issues for gay or lesbian medical students (Robb, 1996a) and curriculum concerns (Robb, 1996b; Robinson & Cohen, 1996; Sanders, 1997) have also been noted in a Canadian context.

The one report, Systems failure: A report on the experiences of sexual minorities in Ontario’s health-care and social services systems (1997), that addressed access issues in a provincial public health context, was completed by the Coalition for Lesbian and Gay Rights in
Ontario/Project Affirmation (CLGRO) in 1997. It offers insight into a range of discriminatory practices within institutions that have implications for childbearing lesbian women and offers systematic approaches to effecting change.

The Internet has been noted to offer a wealth of information and a forum for discussion and networking for this often isolated and hidden population. Because it offers a vehicle for confidential support, it can be seen as a potentially positive resource for information. However, it was difficult to access scholarly sources of information on lesbian women. The American Psychological Association (APA), a well-respected professional body, published a summary of research findings and annotated bibliography on-line in order to address the growing need for information on gay and lesbian parenting (Patterson, 1997). O’Hanlan (1998), has recently made a complete book available on-line which offers medical guidance on lesbian health, pregnancy, and homophobia.

There are, however, many supportive resources for both lesbians and lesbian parents, including prospective parents, on the Internet, which offer support for Canadians as well as those around the world. Lesbian-positive organizations are numerous with chat rooms and links to relevant support people (519 Church Street Community Centre, 2000; Alternative Family Project, 2000; Babydancing: A Page for Mama-Wannabes, 1999; Family Pride Coalition, 1998; Lesbian Moms Web Page, 2000; Lesbian Mothers Support Society, 1999; Love Makes a Family Exhibit, 1999; Momazons, 1999; Prospective Queer Parents, 1999). At times, however, I was unable to access several sites which had previously been available: such is the nature of on-line information.

This is in direct contrast to the few references to lesbian parenting in lay birthing resources geared to pregnancy, breastfeeding, and parenting issues. Several articles in the now defunct Canadian Healthsharing magazine address lesbian childbearing concerns (Epstein, 1993; Ford, 1993). Generally, women’s health books and those specifically focusing on lesbian health
not only acknowledge the existence of lesbian parents, but offer matter-of-fact input on decision-making around pregnancy and parenting issues (Boston Women's Health Book Collective, 1992; Clunis & Green, 1995; Pepper, 1999; Vida, 1996; White & Martinez, 1997).

Information on current prenatal education programming specifically for the lesbian population was not described, except as it could be individually negotiated between lesbian-positive providers of care and lesbian mothers themselves, although childbirth or prenatal classes were noted in a number of articles. This will be discussed under lesbian parenting later in the chapter.

It has been noted that there are limitations to undertaking research with the lesbian women because of issues related to societal attitudes of heterosexism and homophobia. This will be discussed in the third section of this chapter.

Feminist, sociopolitical, and philosophical readings were used to clarify various historical and theoretical perspectives and concepts relevant to the study for the purpose of analysis.

A review of published literature indicates that lesbian health and lesbian parenting issues have been noted for two decades; however, references are limited in number. The paucity of Canadian research on this subject will be discussed with respect to the complex societal influences which have defined lesbian health issues.

Historical Perspective

Although lesbianism has been documented in literature since Greek and Roman times, there have been few references to lesbian parenting in the literature until the last two decades.

In order to understand the diversity of lesbian parent experiences it is essential to understand the historical factors which have affected the development of current societal institutions and the influence of feminist thought on established norms of thinking. The parallels between women's issues in general and lesbian women' experiences within society will be noted, especially with regard to issues of power within the childbearing sector. The development of gay
and lesbian activism in the United States and Canada will be reviewed, as it has contributed to
the lesbian movement. The focus of this discussion will be on patriarchy and hegemonic socio-
political structures as they affect the heterosexual and lesbian perspectives, with lesbian
parenthood in mind.

Homosexuality and Lesbianism

Zeidenstein (1990) notes that “negative attitudes toward homosexuals throughout
Western civilization are intricately related to religious, legal, political, economic, medical, and
psychological institutions of social control” (p. 10). From the early 1900s when lesbianism was
defined as a disease, research on the lesbian population focused on “etiology, diagnosis, and
cure” (Stevens, 1992, p. 92). Exploitive medical treatments which ranged from aversive therapy
to behavioural counselling were frequent methods to confine or reverse the “unnatural”
homosexual condition (Gentry, 1992; Stevens, 1992). With the endorsement of societal
institutions, lesbian women were branded as outcasts (Gentry, 1992; Krahulik, 1996; Stevens,

Researchers who studied lesbians either assumed gay and lesbian issues were the same or attempted to examine the psychopathology of lesbians (Eliason et al., 1992; Krahulik, 1996). This reinforced the negative stereotyping which continues today, and contributed to the invisibility of lesbians within society.

Lesbianism itself as a positive concept was largely invisible in history until the mid-
1970s when the feminist movement and a corresponding lesbian movement had made gains within society. Just as feminists have deemed it important to reconstruct history from a woman’s perspective, lesbian historians have recognized the necessity of “recovering the past” (Vida, 1996). This has resulted in a growing acknowledgement, not only of a history which reflects negative experiences, including death, exclusion, stereotyping, and labelling women as witches and psychopaths (Canadian AIDS Society, 1992; Gentry, 1992; Zeidenstein, 1990), but also of
the celebration of a culture of diversity of women-loving-women who found ways to connect despite societal sanctions on lesbians (Boston Women's Health Book Collective, 1992; Krahulik, 1996; White & Martinez, 1997).

Deyton and Lear, as quoted in Denenberg (1997), describe the gay and lesbian health movement in the United States. "[It] arose from a number of socio-political forces, including the civil rights movement of the 1950-60s, the [second wave] of feminism, and the newly visible gay and lesbian movement of the 1960-70s following the Stonewall riots in 1969" (p. 6). Krahulik (1996) notes that Stonewall was one part of an evolving gay protest which originated in working-class sectors after the Second World War (p. 265).

**Lesbian Health Issues**

As women connected in order to discuss issues relevant to their experiences, lesbian health issues surfaced in a context of a patriarchal medical system which controlled women's health. The lesbian health movement was attached to the more visible women’s health movement (White & Martinez, 1997) which was considered a threat to the established order, but still considerably less so than same-sex orientation. Thus reproductive health and employment issues were supported by female activists, many of whom have been noted to be lesbian. Lesbian women, as a group who understood marginalization, were enmeshed in the broader movement of all women’s and minority’s issues (Boston Women’s Health Book Collective, 1992).

As other major social changes were occurring, the longstanding, intense homophobia of practitioners within mainstream health services prompted two responses. "The hostility bred in the gay and lesbian individuals prompted a necessary secrecy and segregation of any sexual or personal issues when dealing with the mainstream health care system" (Deyton & Lear, as cited by Denenberg, 1997, p. 7). Social organizing resulted as lesbian communities became social activists for gay and lesbian rights.

A landmark event as a result of this social activism was a recategorization of
homosexuality in 1973 by the American Psychiatric Association, no longer designating it as a mental illness unless there was confusion around sexual orientation (Gentry, 1992). The inclusion of homosexuality as a disorder was recognized to have been "reflective of societal prejudice rather than of underlying psychopathology" (O'Hanlan, 1998, p. 4). Within the United States, conferences, specific health services, and professional organizations for gays and lesbians developed. Networks of gay-positive health providers formed (Boston Women’s Health Book Collective, 1992; White & Martinez, 1997).

**Reproductive Health**

In North America, until the late 1800s, midwives oversaw women’s medical needs and childbirth (Van Wagner, 1988). The basis for many of the modern attitudes around birthing have been influenced by events during the 19th century (Boston Women’s Health Book Collective, 1992; Van Wagner, 1988). At this time, men, for the most part, had access to education and scientific endeavours. With scientific progress, developments which contributed to a decreased mortality rate for childbearing women had mixed implications for women’s health (Boston Women’s Health Book Collective, 1992; Oakley, 1986).

The use of new technologies—the vaginal speculum, forceps, and anaesthesia—was determined by males. Midwives were not only denied medical education, but prohibited from using these options. In addition, midwives, as women, were reluctant to use the "forceps and hooks used by barber surgeons, also known as ‘man-midwives,’ when called as a last resort to assist in difficult childbirth" (Boston Women’s Health Book Collective, 1992, p. 438). Control of reproductive processes passed from women to men.

As education and science were highly regarded, upper- and middle-class women changed their allegiance from midwives to scientifically trained men of their own class. Lower class women continued to be cared for by midwives. "Male doctors gradually gained control of childbirth among the upper and middle classes, a control that represented political and economic
triumph rather than scientific necessity” (Boston Women’s Health Book Collective, 1992, p. 437).

According to Ehrenreich and English (1979), as quoted by the Boston Women’s Health Book Collective (1992), “Physicians continued to regard midwives as threats to the masculine medical order they were establishing” (p. 437). Several sources cited by the Boston Women’s Health Book Collective support their intent to “create doubt in midwifery skills by deliberately lying about midwifery outcomes” (p. 437) and instilling fear in women regarding their ability to birth without the technical skills of an obstetrician (Neilans, 1992; Simkin, 1997). By 1930, midwives had virtually disappeared and the move soon after from home birthing to the hospital, symbolized the total dependence on a man-made system—a monopoly on care (Boston Women’s Health Book Collective, 1992, Oakley, 1986; Simkin, 1997; Van Wagner, 1988).

With World War II, birthing became institutionalized, and as such, isolated, infantilized, immobilized, and depersonalized women. By removing control about how to birth and choice of birth supports and settings, women internalized the medical model—losing belief in their own abilities to birth (Boston Women’s Health Book Collective, 1992; Simkin, 1997).

The gains in decreased mortality rates for childbearing women and infants as technology increased predictability in childbirth have had mixed results for women (Neilans, 1992), who now equate birthing with institutional care—and often perceive no alternatives (Simkin, 1997). Women’s health advocates have attempted to promote choice for women.

Mitchell and Oakley (1986) offer an explanation of how feminism affected professional interests in reproductive health,

The first wave of feminism [in the 19th and early 20th century] was involved with redressing the wrongs of women. The second wave focused on the more positive emblems of womanhood, e.g., childbearing, rearing and capacities for emotional intimacy that once felt like oppression . . . . The impact of feminism on traditional medical practice
resulted in a clash of interests of feminism and those of a profession which was threatened by the implication that feminism was relevant to how and why expert knowledge is constructed. It also enabled women to take charge of their own health and health care. (p. 5)

Feminist agendas for choice: reproductive rights, abortion, birth control, and childbirth practices had widespread impact on access to, and provision of, women’s health services today.

**Childbirth Education**

Formal prenatal education has resulted from historical forces related to the emancipation of women and the response of consumers to what was perceived as overmedicalized obstetrics. Enkin, Keirse, and Chalmers (1991) note that “natural childbirth and psychoprophylaxis’ classes promoted psychological or physical, non-pharmacologic modalities for the prevention of pain in childbirth” and were developed as an alternative to the operative delivery and liberal use of analgesic medications which were considered the norm (p. 24). Simkin (1997) indicates that prenatal care began in the United States after WWII. Public health nurses in Canada offered prenatal and parenting health education in conjunction with medical providers from this time (Arnup, 1994). The ’50s saw a beginning interest in natural childbirth and childbirth education as a reaction to cruelty in the maternity wards.

Family-centered care developed in the ’60s with an acceptance of husbands in the delivery room, formation of La Leche League for breastfeeding support, and the International Childbirth Education Association. The ’70s involved a return of the midwife, homebirth, a holistic health movement, and alternatives to conventional medicine and practices which were offering increased technology and caesarean birth (Boston Women’s Health Book Collective, 1992; Simkin, 1997). At this time, childbirth education was perceived by medical providers and women alike as essential to natural childbirth. By the ’80s midwives were offering water birth, while hospitals were dealing with nursing shortages and “defensive obstetrics” related to lawsuits
for childbirth damages (Simkin, 1997).

According to Simkin (1997), the '90s were characterized by the institutionalization of childbirth education and the advent of doulas in North American childbirth within a conservative political environment which included a backlash against the women's movement.

The effect of political and patriarchal influences on childbearing issues is significant for lesbian couples who parent today. According to Oakley (1986), the medicalization of motherhood has been influenced by another factor which is external to the consumer movement and feminism, that of professionalization. She notes that "in the 20th [century], industrial society has been increasingly characterized by the growth of monopolistic power among professions: medicine [is] only one example" (p. 138). In addition to the previous explanations of the role of science and that of gender relations on childbearing women, this professionalism, which "claims a monopoly over the definition of deviance" (p. 138), has influenced the schism between traditional obstetrical providers and alternative care providers.

**Alternative Care Providers in Reproductive Health**

Midwives, although they are now part of the professional establishment in some centers, have until recently been considered alternative providers in Canada and the United States. This has been as result of their efforts to become political and visible themselves in their attempts to be recognized by mainstream medical providers (Neilans, 1992; Van Wagner, 1988). Until 1991, when Ontario passed legislation which established midwifery as a recognized profession (Neilans, 1992), "Canada [was] the only western industrialized nation with no legal provisions for midwifery care" (Van Wagner, 1988, p. 115). According to Vicki Van Wagner (1988), who represented the Midwives Collective of Toronto, "the revival of the midwifery profession in the 1970s arose out of women's increasing dissatisfaction with the medicalization of pregnancy and birth, and from health activists' critiques of male-dominated obstetrics . . . midwifery began to redefine childbirth in women's terms" (p. 115).
However, the process in which midwifery licensing occurred indicated the very real threat that it presented to the traditional professions of nursing and medicine. Neilans (1992) stressed that, “midwifery is a turf battle” (p. 8). Nursing organizations advocated for a nurse-midwifery model (Van Wagner, 1988) rather than an independent midwifery profession.

“Whereas an overwhelming majority of consumer and women’s groups supported the proposals of the Ontario association of midwives, all medical and nursing groups took a position against home birth” (Van Wagner, 1988, p. 117). The final recommendations continued to subtly undermine confidence in midwives’ abilities to practise (Neilans, 1992), with continued focus on safety and place of birth as political symbols of power (Van Wagner, 1988).

With an understanding of the political and patriarchal forces in place, midwives have sought to include marginalized groups within their practice, those often without a voice (Van Wagner, 1988) and considered of less value in society (Ford, 1993). By acknowledging that those involved on policy-making committees represent culturally, socially, and educationally advantaged women (Ford, 1993), midwives have advocated for, and thus enabled, less visible groups to access reproductive rights.

**Effect of HIV/AIDS Movement on Lesbianism**

As the AIDS movement grew and males became visible in their dealings with HIV issues, many lesbians again dealt with invisibility and sexism, even as they supported the gays within AIDS activism. “Feminists and other lesbians often criticized lesbian AIDS activists for abandoning ‘women’s issues’” (Denenberg, 1997, p. 10). However, the issues of “a sense of body ownership and knowledge, demystification of medicine, informed consent and professional-client partnership” (Denenberg, 1997, p.10) were contributions that could be traced to earlier feminist gains.

**Canadian Perspective**

In Canada, a document produced by the Canadian AIDS Society (1992) documents the
struggle for recognition of gay and lesbian rights from the 1950s. The “feminist movement, which challenged sex and gender roles within the patriarchal order” (p. 13), was seen as a catalyst for change. It spearheaded organizing and visibility of gay rights by the end of the 1970s, especially within the large urban cities of Vancouver, Montreal, and Toronto which were similar to those in the United States (p. 13). This document, which reflects the work of a coalition of over 70 community-based AIDS organizations, emphasizes the contribution that lesbian women have made in supporting AIDS issues, despite the laws which, until 1988, defined sexual activity between men as a criminal offence and which totally ignored lesbian sexuality (p. 12).

The Canadian AIDS Society (1992) explains how lesbian women’s support for AIDS issues has had implications for their image within the larger society:

The association of AIDS with homosexuality impacts upon lesbians in two ways. On the one hand, within the AIDS=gay equation, all gay people are linked to “disease” and lesbian experience is likewise defined as “unnatural,” “deviant,” and “other.” On the other hand, all too easily lesbians have been completely ignored in the context of AIDS because they aren’t catching it anyway. (p. 12)

**Lesbian Parenting**

Because of the association of lesbians with gay issues or feminism, many in society are unaware of the many women who are part of a lesbian parenting experience. Clunis and Green (1995), who have authored a book on lesbian parenting, relate that lesbian families have been invisible until recently. They note that:

Starting in the late 1970s and early 80s there has been a baby boom among visible lesbians, particularly in some of the larger, lesbian-friendly urban areas in the United States. A Newsweek magazine article estimated that by 1990, five to ten thousand lesbians had children after coming out. (p.11)
Until the last two decades, most lesbian pregnancies involved a heterosexual coupling, with either a supportive partner or occasionally an unsuspecting male (Harvey et al., 1989; Kenney & Tash, 1992; Nelson, 1996; Olesker & Walsh, 1984). The ethical and legal issues inherent in such arrangements as well as the potential tensions incurred within the lesbian relationship have been factors in the increased use of self-insemination options (Kenney & Tash, 1992).

Donor insemination (DI) for lesbian couples was infrequent until the mid-80s, when the increased invisibility of the lesbian population facilitated access to supportive health care providers. Clunis and Green (1995) emphasize that it was logical that the “baby boom” came after the Gay Movement, from which lesbians benefited by their association with a larger group. “This is not to suggest that lesbian women never had babies via donor insemination prior to the last ten or twenty years, simply that it was not happening in the significant numbers that it is now” (Nelson, 1996, p. 4).

Societal acceptance of reproductive choice, which usually refers to contraception and abortion options, as well as technological advances in new reproductive technologies, increased the availability of the donor insemination as an option to infertile couples (Nelson, 1996). As nontraditional couplings in a traditional medical system, lesbian couples were often forced to access infertility clinics geared to conventional heterosexual relationships in order to conceive (DeMarco & Simkin, 1996; Kenney & Tash, 1992; Nelson, 1996; White & Martinez, 1997).

Access to supportive traditional providers in Canada was possible by the early 1990s (Nelson, 1996), although this access varied by provider (DeMarco & Simkin, 1996). Denial of artificial insemination to lesbian couples by a physician has recently been ruled a violation of human rights in British Columbia (Capen, 1997). Another barrier, the cost of obtaining donor sperm which has been screened for HIV, is prohibitive, as provincial health plans often consider this an elective medical expense and this has been available only to medical providers, not
couples (Kenney & Tash, 1992; Nelson, 1996). Self-insemination is considered to have fewer barriers than using medical providers; however there are considerations regarding locating a male donor, discussing medical history, and legal considerations should a pregnancy result (Kenney & Tash, 1992). DeMarco and Simkin (1996) indicate that the local lesbian association in large Canadian cities is a link to the AI (Alternative Insemination) underground network.

In addition to those who experience pregnancy as a lesbian, there are many lesbians who have been in traditional heterosexual relationships and have children (Asten, 1997; Boston Women’s Health Book Collective, 1992; Clunis & Green, 1995; Nelson, 1996). These women continue to parent, closeted, or become part of a new relationship after the male partnering dissolves (Clunis & Green, 1995). Adoption and step-parenting relationships also add to the diversity of lesbian parent possibilities (Asten, 1997; Clunis & Green, 1995; DeMarco & Simkin, 1996). Knowledge of the actual prevalence of lesbian parents is limited by the social stigma issues which preclude full disclosure to others (Abbey & O’Reilly, 1998; Clunis & Green, 1995). Internalized homophobia contributes to the reluctance to self-identify as a lesbian, as do potential custody concerns (Abbey & O’Reilly, 1998; Kenney & Tash, 1992; Zeidenstein, 1990).

Along with concerns related to safety and negative attitudes which inhibit disclosure of same-sex coupling to others is the heterosexism which extends to legal rights of couples. Although human rights legislation is in place in four provinces, including Ontario, legislation related to insurance, pensions, and spousal benefits, for the most part, may exclude gay/lesbian partners. Ontario public service workers introduced benefits for same-sex couples in Ontario in 1990, but these moves have been considered the exception. This contributes to the invisibility of same-sex couples and continues to confer a higher status on same-sex couples who may have children (Canadian AIDS Society, 1992, p. 35). Yet, the recent federal and provincial moves to offer spousal benefits to same-sex couples in Ontario in October 1999 and federally in February 2000 were made within a context of conservative opposition to such legitimation of sexual
orientation, in addition to reluctance by those lesbian and gays who perceived this step as approaching the nuclear family model which has historically had exclusionary overtones.

Historical developments which have influenced the current political society in which lesbians become pregnant include tensions between traditional providers of care, who often reflect mainstream patriarchal attitudes, and alternative providers, who may, as they have struggled for legitimation in various ways themselves, offer an alternative for marginalized groups seeking reproductive care. However, the practice of alternative health care will also have been influenced by philosophies which reflect historical, political, and cultural factors which may or may not facilitate provision of care perceived to be supportive of lesbian parents.

Social and political factors have contributed to the limited acceptance of childbearing lesbians as a visible population within society. The power of the medical establishment, which has been dominated by patriarchal structures to control women, their health, and reproduction, has been challenged by social movements of feminism as well as that of gays and lesbians. Reproductive choices available to support childbearing lesbians have increased. However, barriers to care remain.

In the section which follows, a theoretical framework which includes aspects of democratic processes, caring and feminist perspectives, and invitational theory will be used to offer a context for addressing educational issues for expectant lesbian couples.

**Theoretical Base: An Articulation of Perspective**

Facilitating education which is relevant to childbearing lesbian women necessitates an understanding of the structural oppressions which shape their social context. In a postmodern world, there has been an acceptance of pluralism with regard to determining theories which can explain the complex nature of human experiences. It has been recognized that issues related to gender, race, class, and other factors affect one’s positioning in society, and hence shape one’s perspective at any historical moment. Understanding the factors that contribute to what
knowledge is considered legitimate and how this occurs within specific social and historical contexts in societies which work for democratic goals is an essential aspect of facilitating inviting educational change.

Invitational theory (Purkey & Novak, 1996) can be considered a framework which could be useful for inclusive educational practice with its integration of contributing self-construct, caring, and social democratic education theories. It offers a systematic way in which to discuss environments and interactions which promote or hinder culturally sensitive educational practice. Concepts from contributing theories will be noted as they apply to the lesbian parent perspective. Perceptual and self-concept approaches which relate to Kelly’s (1955) self-construct theory give insight into the impact of heterosexism and homophobia on disclosure issues and resulting choices perceived by lesbian women. Noddings (1984) presents an ethic of care that describes principles which contribute to inviting connections within educational contexts. Dewey’s (1916) social justice approach to education will be related in its contribution to inclusive education.

In order to frame issues related to childbearing lesbian women I will discuss some issues related to rights and democratic ideals related to knowledge claims and offer several perspectives informed by feminist theories, including DiLapi’s (1989) motherhood hierarchy and Eichler’s (1997) models of the family. A more detailed discussion of heterosexism, homophobia, and heteronormativity will be presented in the third section of this chapter.

**The Social Context of Education for Lesbian Mothers**

A liberal democratic society has at its roots, as John Dewey has noted, “a commitment to all goals which promote freedom and prosperity for all individuals” (cited in Seigfried, 1998). Promotion of individual rights to equality, autonomy, and self-determination are considered aims of society in which caring and social justice are fundamental.

Certain assumptions are often made with respect to such rights for childbearing women: that individuals are equally entitled to the freedom to exercise these rights and it is the moral
responsibility of society to provide for equal access to these rights. A belief in equality is fundamental to promoting social justice. Amy Guttmann (1980) states that, “human equality . . . . in its notion of equal respect for the human dignity of all people” (p. 18) has been promoted as integral to social democracies. Ken Strike (1982) indicates that “whatever fundamental rights everyone has as persons, they have equally” (p. 65).

However, for lesbian childbearing women, whose reproductive rights include the ability to live as lesbians and mothers (DiLapi, 1989), such public support, even in a democratic context, is unlikely. This discussion will provide support for the notion that there is not only a lack of awareness within society of those issues which interact to limit lesbian women’s freedom and access to societal rights, but the barriers are deeply entrenched in institutional functioning.

Certainly there has been an increasing awareness within many levels of society of the multiple oppressions structured by gender, class, race, ethnicity, age, and other factors which colour our interactions, our interpretations of information, and perceived opportunities for exercising rights to autonomy and self-determination and accessing resources. Although there is no hierarchy of such power relations, I will foreground patriarchy as it pertains to this discussion.

Patriarchal dominance remains a powerful influence over individuals and societal institutions. Women, regardless of sexual orientation, encounter oppression based on gender. Sexism assumes an inherent superiority of one gender over another. Lesbians experience heterosexism compounded by sexism (Boston Women’s Health Book Collective, 1992; Canadian AIDS Society, 1992). Rigid gender stereotypes which recognize heterosexual difference and reject same-sex orientation rank heterosexuality as inherently superior to homosexuality.

Heterosexism, like other oppressions, involves power and prejudice (Canadian AIDS Society, 1992). It operates as a dominant social value and permeates all societal institutions, including those which are involved in the education of expectant lesbians (DiLapi, 1989). That
heterosexism is accepted as the norm and not recognized by educators as a powerful influence on health, legal, media, and educational institutions, indicates the potential for its patriarchal influence to continue with limited resistance.

Heterosexism and sexism exert enormous influence over individual and group liberties within society. A discussion of education which promotes cultural sensitivity requires an understanding of how these values shape our freedoms to learn and influence how knowledge itself is constructed and valued within society.

Ken Strike (1982) stresses that “claims about the role of liberty in promoting inquiry assume some basic things about the nature of inquiry and the character of knowledge” (p. 6). There are traditional assumptions that knowledge is objective, abstract, and has universal meaning for all (Belenky, Clinchy, Goldberger, & Tarule, 1986; Crowley & Himmelweit, 1992; Shogan, 1993).

Postmodern perspectives maintain (Crowley & Himmelweit, 1992; Shogan, 1993) that the nature of reality (ontology) consists of multiple realities which are socially constructed and holistic (Belenky, et al., 1986; Lincoln & Guba, 1985). There is an awareness of the relationship of the knower to the known, who are interactive and inseparable (Abbey & O’ Reilly, 1998; Belenky et al., 1986; Crowley & Himmelweit, 1992; Lincoln & Guba, 1985). There are implications for respecting individuals as authorities based on their experiences (Belenky, et al., 1986).

An understanding of different positionings of privilege by class, gender, race, ethnicity, sexual orientation, and other issues (Abbey & O’Reilly, 1998; Shogan, 1993; Tong, 1998) which affect how knowledge is perceived and interpreted offer insight into inclusive educational practice. Mullett (1993) noted that a default reference point is a powerful tool for the exclusion of people as different. In a patriarchal society the male perspective (often privileged by class and race) is assumed to provide the reference point upon which others are categorized and rated.
according to the dominant heterosexist view.

Homophobic messages perpetuate heterosexist dominance and act on external and internal levels. Media and stigmatizing representations of homosexuality contribute to external homophobia through exclusion, stereotypes, and myths (Eliason et al., 1992). Internalized homophobia creates self-hatred related to same-sex orientation for lesbian women as these messages devalue one’s self-worth. As a result, self-acceptance of lesbian status is considered an ongoing struggle for lesbian women.

Bernstein (1960) emphasizes that Dewey’s philosophy of liberty recognized the role of social transactions on individuals’ potential to develop. As such, “freedom requires the effective power to act in accord with choice” (Bernstein, 1960, p. 140). Strike (1982) indicates that autonomy requires both the psychological and political precondition (p. 43) to choose and act. For lesbian women there is political oppression related to heterosexist norms as well as psychological struggle with disclosure issues to both self and others. The psychological oppression experienced by lesbian women related to lack of society’s acceptance of their sexual orientation is a major factor in limiting their freedom to act or make choices.

McLaren and Vanderbijl (as cited in Abbey and O’Reilly, 1998) describe self-determination as “involving individualized decisions and choice-making in the context of perceived opportunities already felt to be available to them” (p. 135). Opportunities for lesbian women may be perceived to be more accessible if disclosure of lesbian status has resulted in support and acceptance. The constant need to weigh the costs of either “passing” as a heterosexual (Boston Women’s Health Book Collective, 1992) or the costs of disclosure affect a lesbian woman’s perceived freedom to act. The constant vigilance within one’s environment when not “out” (Stevens, 1992) can be conceived as a barrier to freedom which is limited to those dealing with sexual orientation issues.

Strike (1982) states that “the resources to choose responsibly are of essentially two sorts.
First, responsible choice depends on information and evidence. One cannot consistently demand that a person make a responsible choice and at the same time withhold information relevant to that choice” (pp. 43-44). The limited freedom which curtails a lesbian woman’s freedom to disclose her lesbian status affects the quality of the education and knowledge she receives, as it restricts the inquiry process and her perceived ability to request information relevant to her situation.

Educational institutions not only offer knowledge, but also perform political functions (Strike, 1982). The resulting access to the common good or institutional resources within society is a reflection of the limited power accorded to those who reject the norm (DiLapi, 1989). Exclusion of the lesbian perspective by denial of options for parenthood creates invisibility. This denial of lesbian parenthood is facilitated by psychological oppression which is manifested in homophobic ways.

Morgan (1993) explains that institutional, systematic psychological oppression takes several forms: cultural domination, stereotyping, and sexual objectification. These contribute to fragmentation and devaluation of lesbian women’s identity as well as total denial of its existence— invisibility (p. 488).

Stereotypes which portray lesbian mothers as deviant, potential child abusers, mentally unstable, and less maternal than heterosexual women have been disproven (O’Hanlan, 1998; Patterson, 1997), but attitudes persist. As well, the myths which focus on the instability of lesbian relationships, an absent father figure, and inadequate time to parent as working mothers are considered standards that may be overlooked in males (DiLapi, 1989).

Access to parenthood is considered a basic democratic right. However, denial of fertility to lesbians is considered another method of coercion for lesbian women and others marginalized and stigmatized by patriarchal culture (Morgan, 1993, p. 500). This is considered a form of cultural domination in that the freedom to choose is actually a function of societal conditions.
which reflect lack of resources—hence, which reduce the opportunity to choose motherhood (DiLapi, 1989).

Morgan (1993) quotes Bartky’s (1979) definition of sexual objectification as “a mode of fragmentation that takes the form of an often-coerced and degrading identification of a person with her body” (p. 497). For lesbian women this works in two ways. There is a constant association of their identity with their sexual relationships, which undermines the holism and embodiment of their lives. Sensationalism which is promoted by the media and institutional resources which focus exclusively on sexual concerns of lesbian women deny the wholeness of their life experiences.

As well, an “underlying assumption of motherhood is that mothers are not or should not be sexual” (DiLapi, 1989, p. 112). Denial of motherhood for lesbian women is thus justified by society in relation to sexuality. Once again, the rationalization for denial of rights is defined by patriarchal values which privilege women according to their relation to heterosexual males.

The invisibility of lesbian mothers within society carries a strong message of powerlessness to lesbians who may perceive lesbian motherhood as an unavailable life choice. In fact, legislation in some American states prohibits homosexual activity (Abbey & O’Reilly, 1998; O’Hanlan, 1998). Women who may have a desire to parent may be robbed of the motherhood experience, which is considered a powerful life event by many females (Belenky et al., 1986, Simkin, 1997). Ken Strike (1982) interprets Albert Einstein who noted that “the desire to know cannot survive where there are forbidden questions of forbidden answers” (p. 4). Myths and stereotypes which portray lesbians as deviant parents are perpetuated through homophobia. Accurate and relevant information on parenting is considered a democratic right which denies lesbians autonomy and self-determination. This is despite the “liberty which provides for the right to participate in the life of a group or culture whose members share one’s values” (Strike, 1982, p. 66).
Heterosexism exerts its influence in reproductive health when motherhood is considered exclusively for heterosexual couples at the exclusion of lesbian mothers. The invisibility of the coparent and lack of recognition of her need for information and support are overlooked by social institutions and individual caregivers in reproductive or educational settings. Perceived lack of knowledge of lesbian parenting issues by one’s caregiver may be considered homophobic. This creates a psychological barrier which impairs effective communication. Hence, it impacts on the freedom available to lesbian women to request from caregivers information considered relevant to their experience as it affects the decision-making process regarding motherhood.

The political and intellectual components of the authority of the educator or institutions (Strike, 1982) to determine what curriculum, information, and process are important also denote a power to exclude. Although the goal of childbirth education is to increase knowledge, educators are most familiar with heterosexual families and may assume that the experience is similar for lesbians. This assumption of heterosexuality which does not recognize the unique issues of lesbians can be perceived as irrelevant to the expectant lesbian couple’s learning needs. Strike (1982) stresses that “education loses its legitimacy when students begin to believe that the values educators or educational institutions pursue are self-serving” (p. 50). This may prompt lesbian women to look outside the mainstream institutions for education that offers information that is perceived to be legitimate to them. This action on the part of lesbian women may reflect an acknowledgement of an inner authority (Belenky et al., 1986), which resists what may be perceived as the privilege of the institution or professional to exclude.

Professionals and educators have been socialized by educational institutions (Eliason et al., 1992; Robb, 1996a, 1996b; Robinson & Cohen, 1996; Sanders, 1997; Stevens, 1992) to accept the heterosexist norm. The nature of professionalism itself, which is earned on the basis of acquisition of information and skills, confers a “power over” others by the privileged status

“Professionals assert secret knowledge about human nature, knowledge which only they have the right to dispense. They claim a monopoly over the definition of deviance and the remedies needed” (p. 138). How this professionalism is shaped by patriarchal forces within society to determine the educational agenda for reproductive health may be overlooked when the heterosexist perspective is accepted as the “best way” or the “exclusive way” and the lesbian experience is discounted or considered “deviant” (Canadian AIDS Society, 1992; Stevens, 1992).

The power of patriarchal thought underwrites the education and reproductive health options available to lesbian women. The social and political context of education offered will determine how it is perceived (Strike, 1982). Strike adds that “a society that restricts the free flow of information denies to its citizens one of the conditions of responsible choice. In doing so, it, in effect, expresses a decision to refuse to regard its citizens as responsible moral agents” (p. 44). Despite the good intentions of educators to meet the educational needs of the childbearing lesbian woman, culturally sensitive education demands a comprehension of the barriers to disclosure which prevent educators from learning about their issues. Institutional barriers reflecting homophobia hinder genuine sharing by lesbian women and those who assume heterosexuality.

Institutionalized heterosexism has implications for educators when one role of the government in a liberal democracy is to offer equal access to health and education resources. Dewey, as cited in Bernstein (1960), states that "[t]he intimate connection between freedom as choice and freedom as the power to act in accord with choice requires the deliberate development of those institutions that will make choice intelligent and action effective" (p. 140).

The role of the public health institution in contributing to social justice involves actions which offer disadvantaged groups access to health resources. As an institution its policies reflect choices which are affected by political values. Strike (1982) emphasizes that, “liberty provides
for the right to participate in collective choice . . . . It is the working out of a policy that gives due regard to everyone's legitimate interests” (pp. 66-67). Heterosexualist assumptions influence institutional policies and individual interactions throughout society. There are implications for increasing awareness of inclusivity within institutions which will be discussed further with respect to invitational education.

In order to facilitate goals of social justice, human rights legislation has been enacted in several provinces to address inequality by sexual orientation (Canadian AIDS Society, 1992). Denial of rights based on sexual orientation is considered a violation of ethical and legal human rights. Lesbian women experience a violation of their right to access information and resources which facilitate choice of motherhood when the lesbian perspective is excluded. However, the most powerful deterrent to exercising this freedom to choose is the psychological oppression which operates constantly and contributes to invisibility of lesbian parenthood.

For lesbian childbearing women in a homophobic society, barriers to equality, autonomy, and self-determination are related to perceptions of homophobia which are a reflection of patriarchal oppression. Both political and psychological influences, which are facilitated by heterosexism, hinder equal access to reproductive rights for lesbian women. Education in the form of information and supports is also restricted to lesbian expectant women, as explained by DiLapi’s (1989) “motherhood hierarchy.”

**Lesbian Motherhood and the Nuclear Family**

Elena DiLapi (1989) argues that assumptions of compulsory heterosexuality and compulsory motherhood noted by Adrienne Rich (1980) shape society’s attitudes toward lesbian motherhood. These dynamics exert enormous social pressures for women to be heterosexual and mothers within society. Social expectations of women reflect patriarchal dominant values which reward women with heterosexual privilege and unique status reserved for reproducing and bearing children.
DiLapi (1989) explores the model of a hierarchy which is based on “gender, sexual orientation, and socially prescribed values which form the basis of socially constructed power relations” (p. 108). This is patterned on a similar hierarchy proposed by Rubin (1984) as cited by DiLapi. In this, Rubin, describes the interaction of sexual oppression, sexual values, and sexual practice which are also noted to be related to unequal sharing of power (p. 107).

In DiLapi’s (1989) model, mothers are categorized according to their family structures and sexual orientation and are legitimized by social institutions according to their fit with the heterosexual norms. Those mothers considered most acceptable according to social values are at the top of a pyramid, and nonnuclear, heterosexual mothers, including single or disabled mothers, deemed marginal, are situated beneath this because they receive less approval. Lesbian mothers, however, because of the implications for resisting society’s expectations of a male-female coupling and implied domination by the male, are considered the least appropriate for motherhood. They are thus accorded the lowest status, at the bottom of the hierarchy.

Nelson (1996) offers an additional interpretation. She explains that the regard granted to mothers in a patriarchal society is also based in terms of a “woman’s emotional and relational proximity to, or her intimacy with, a middle-class white male” (p. 136). Lesbian women are considered a threat to males by virtue of their rejection of patriarchal power.

Heterosexual assumptions are such that, according to this model, expectant lesbians who bear and raise children may be considered more valued—and perceive or receive more support—if lesbian status remains hidden. It is the same-sex orientation that stigmatizes them. Single mothers, by virtue of their assumed heterosexuality, are considered marginal mothers, but more valued than openly lesbian mothers. This has implications for both disclosure issues and lesbian coparents as they are even less visible than the biological mother. Passing as a single heterosexual mother, while reaping limited societal acceptance, contributes to “inauthentic mothering” (Abbey & O’Reilly, 1998, p. 329) in denial of lesbian identity.
The multiple realities of motherhood which reflect a diversity of situated experiences (Abbey & O'Reilly, 1998) and family configurations are recognized by heterosexist societal institutions in limited ways. Ann Oakley (1986) has noted that “at any historical moment, the dominant definition of motherhood asserts an exclusive morality--there is only one ‘right way’ to be a mother” (p. 127). According to DiLapi (1989), “traditionally the value of women in society (as prescribed by sex role stereotypes) has been defined and controlled by women’s unique ability to reproduce and bear children” (p. 104). The nuclear family has been idealized and stereotyped as the ideal family structure for reproduction. However, Suzanne Pharr, as cited in Clunis and Green (1995), stresses that “heterosexism and homophobia work together to enforce compulsory heterosexuality and that bastion of patriarchal power, the nuclear family” (p. 62). This renders alternative family structures less valuable and promotes their invisibility.

Approval of motherhood status is reflected in allocation of resources which include information, informal and institutional support systems, legitimization of partnership status, and visibility in mainstream media (Asten, 1997; DiLapi, 1989). Approval is highest for those mothers who fit the traditional heterosexual nuclear family stereotype, despite the statistics which indicate that only 36% of families can be categorized as such (DiLapi, 1989). Lesbian mothers are denied these resources and remain invisible within society.

Marginalization and invisibility of the lesbian parent are reflected in formal and informal social policies which promote the homophobic stereotypes which pervade society (DiLapi, 1989; Eichler, 1997). Although DiLapi (1989) indicates that cultural issues would determine which family structures are considered acceptable alternative models, she emphasizes that “mainstream institutions such as social service agencies, medical facilities, and legal systems control who has access to these alternative forms of parenthood” (p. 111). The limited access of lesbian couples, as single or openly lesbian parents, to resources for insemination are noted (Nelson, 1996) when these facilities may limit care to more traditional families: infertile, heterosexual couples.
Alternatives to the patriarchal family model have been proposed by Margrit Eichler (1997) with her description of three versions of the family as a reflection of societal values. Of the three, the patriarchal, individual, and social justice models, only the last validates same-sex couples in a way that approaches her vision of a minimally stratified society based on gender equality. She emphasizes that families defined by function, rather than structure, will be more inclusive of same-sex couples. Lesbian families in which spousal roles are blurred and economic and affective relationships are often nonhierarchical carry out tasks common to all families. These include: providing “genuine love and caring, [offering] emotional support from each family member to each member, and meeting the diverse needs of family members (residential, social, economic, sexual, procreational, etc.)” (Eichler, 1997, p. 8). As she notes, social policies based on such notions will affirm these family partnerships through more equitable sharing of public resources.

According to Eichler (1997), expectant and childbearing lesbian mothers challenge values based on patriarchal ideology through their same-sex union as described in DiLapi’s model. However, ironically, one of the premises upon which the purity of the nonnuclear same-sex relationship has been criticized is on the basis of its capacity for procreation. Eichler’s image of a gender equality which aims for a minimally stratified society is one that is congruent with Dewey’s notions of social democracy.

It is evident that social structures influence how lesbian motherhood is experienced. Socialization processes promote motherhood for females as a highly desired goal. The experience of motherhood is seen as a “peak” experience for many women (Simkin, 1997) or a turning point in their lives (Belenky et al., 1986). However, this experience is restricted for women who choose to identify as lesbian. The psychological oppression dictated by homophobic attitudes which affects decisions of lesbian identity and lesbian motherhood have been described.

motherhood and the “institution of motherhood.” The former describes the “potential relationship of any woman to her powers of reproduction and to children (p. 83) and is also known as “mothering” (Abbey & O’Reilly, 1998). In contrast, Rich defines the institution of motherhood “as the institution which aims at ensuring that that potential--and all women--shall remain under male control” (Tong, 1998, p. 83).

Lesbian parenting can be seen as a form of resistance to the dominant hegemony which recognizes traditional family stereotypes. By choosing to act on their societal right to motherhood, lesbian women are resisting the dominant patriarchy. With options of donor insemination and coparenting relationships which have the potential to be egalitarian, lesbian mothers are offering alternatives to traditional models. Abbey and O’Reilly (1998) describe gynocentric mothering as “characteristics and experiences of mother defined by women” (p. 329). This respects the authority of women to define their mothering experiences as opposed to that which defines reproductive health and social institutions, the authority of the male.

The narrow parameters within which a mother is defined within society has an impact on the value accorded the lesbian coparent. It is evident that DiLapi’s (1989) model addresses the lack of recognition of lesbian parenting by society. McMahon is cited in Abbey and O’Reilly (1998) with respect to her remarks on the limited status of women perceived to be childless. She notes that “patriarchal society classifies women as either mothers or non-mothers and invariably assigns more admirable and valued characteristics to mothers” (p. 21). There are implications for lesbian partnerships in which one mother may be chosen as the biological mother and deemed the primary parent by family or institutional providers (Clunis & Green, 1995). Despite society’s limited recognition of the lesbian biological mother, the power perceived to be inherent in the actual experiences of childbearing and breastfeeding may confer a higher status on the biological mother. The coparent’s freedom to claim a motherhood authority may be limited by these dynamics.
Morgan (1993) discusses the paradox in lesbian motherhood which indicates that "under patriarchy, pronatalist maternal ideology makes the conceiving and bearing of children the definition of the 'true' woman, the 'complete' woman" (p. 495). However, according to patriarchal thought, the lesbian woman is considered less of a woman by virtue of her sexual orientation. Lesbian mothers then challenge the universal meaning of mother (Abbey & O'Reilly, 1998).

Women situated in various political positions have espoused pronatal and antinatal perspectives which reflect the different perceptions of how motherhood empowers or oppresses women (Abbey & O'Reilly, 1998; Bryson, 1992; Tong, 1998). Abbey and O'Reilly (1998) define antinatal philosophy as "a feminist discursive strategy that resist notions of motherhood as enslavement that serve to oppress women and are directly opposed to emancipation and autonomy" (p. 327). A range of perspectives exist within the lesbian and feminist communities regarding motherhood (Bryson, 1992; Tong, 1998). However, this issue is relevant to a discussion of what perceived supports are available to lesbian mothers who choose pregnancy. A political stance which embraces resistance to patriarchy by opposing motherhood or lesbian motherhood may be reflected in community supports which fail to support the lesbian mother who has limited access to mainstream resources.

Community support can be considered an important societal resource for mothers. For lesbian mothers, locating support within societal institutions which assume heterosexuality may be difficult. Belenky et al. (1986) have noted that confirmation and experience are crucial to women's ways of knowing. They also note that "women's self-concepts and ways of knowing are intertwined" (p. 3). Lesbian women may seek acceptance of their same-sex status by others in order to be authentic with themselves and others: crucial elements of mental health and genuine communication with others.

Role models and peers who can share experiences which are common to lesbian women
provide knowledge and education which may be unavailable from traditional educational authorities. Learning is facilitated by access to information which is relevant. Developing confidence in one's internal mothering authority (Abbey & O'Reilly, 1998; Belenky et al., 1986; Nelson, 1996) which values experience garnered from motherhood promotes autonomy and self-determination.

Reproductive health care in mainstream institutions often reflects a heterosexist bias (Clunis & Green, 1995; DeMarco & Simkin, 1996; Kenney & Tash, 1992; Stevens, 1992). Women's health and alternative health providers, including midwives, have offered choices for childbearing women, including homebirth, which reflect resistance to the dominant political norm (Olesker & Walsh, 1984; Simkin, 1997; Van Wagner, 1988; Zeidenstein, 1990).

The institution of motherhood and reproductive health have been described as being controlled by patriarchal medical influences. As well, reproductive health education in an institutional setting often has a male authoritarian voice (Belenky et al., 1986) as a determinant of content, process, and resources (Oakley, 1986; Simkin, 1997). An acknowledgement of the existence of lesbian parents and their unique issues, as well as an understanding of curriculum which focuses on institutionalized birthing processes--excluding the home birth or alternative provider options--requires an understanding of the political influences which shape educational content.

Lesbian motherhood can be viewed as an empowering phenomenon (Arnup, 1998; Asten, 1997; Epstein, 1996a, 1996b; Nelson, 1996), a form of agency which resists the dominant patriarchal control of reproductive health and motherhood. Societal institutions have a democratic responsibility to recognize lesbian women's rights to resources which legitimize their choice of motherhood. Providing environments which facilitate disclosure will promote caring communities for lesbian mothers.

A discussion of equality, autonomy, and self-determination has indicated that lesbians are
denied rights to motherhood based on sexual orientation status as a result of homophobic influences which reflect a dominant patriarchal hegemony. The ways in which lesbian women and educators perceive information, interpret it, and act on it are related to how conscious and unconscious messages are interpreted. Invitational theory will provide insight into interactions and environments which are considered supportive or nonsupportive of the lesbian parent experience. As well, the implications for development of education which promotes caring and social justice will be discussed with respect to the learning process and factors which facilitate more inclusive practice.

**Invitational Theory**

The invitational perspective (Purkey & Novak, 1996) maintains that all people are able, valuable, and responsible. The quality of interaction between people is related to its intention and inviting or disinviting aspects. The intentionality of messages sent is crucial to an understanding of how conscious and unconscious elements contribute to interpersonal interactions. Interactions that are intentionally inviting are empowering and facilitate self-esteem. They promote mutual sharing of concerns. Trust and consistency facilitate this dialogue.

Disclosure issues related to stigma have been noted to be a fundamental barrier to exercising the right to self-determination, claiming lesbian identity, and achieving lesbian parenthood. Communication between lesbian women and educators is limited because of disinviting messages from environments and educators which exclude and marginalize the lesbian perspective. An awareness both of the dynamics of interpersonal relationships and strategies that facilitate disclosure is integral to supporting access to educational information and resources for lesbian parenthood.

Self-concept theory, with its perceptual base, allows us to construe the world from the perspective of the expectant couple living in a homophobic world, as well as from that of the childbirth educator whose approaches and attitudes are patterned by the heterosexist assumptions
of societal institutions. The implications for disclosure to self and others, and associated
behaviours by those interacting with lesbian women, including educators and support persons,
are described using perceptual self-concept theory.

The ability to claim sexual identity as a lesbian to herself or others is a crucial element in
developing a woman’s self-concept. This also affects her potential behaviours and interactions
with others. For a lesbian woman, “choice is involved in the degree of openness in which a
lesbian can live her life, not in being a lesbian, which is inherent” (DeMarco & Simkin, 1996, p.
271). Internalized homophobia acts on one’s self-concept in a way which causes conflict
between disinviting homophobic messages and internal messages which reflect same-sex
orientation. The resulting cognitive dissonance accounts for conflict within lesbian women to
self-disclose and attempts at disclosure to others. Passing as heterosexual is a common strategy
to deal with a homophobic world. However, Cynthia Rich as cited by Crowley and Himmelweit
(1992) explains that “‘passing’—except as a consciously political tactic for carefully limited
purposes—is one of the most serious threats to selfhood” (p. 56).

How we perceive experiences and make sense of them from a self-concept perspective
and the “complex, multifaceted, and conservative nature of a person’s self-concept” (Purkey,
1992, p. 18), offer a way to explain the pervasiveness of homophobic and heterosexist attitudes
and values within society. The consistency of a self-concept which has internalized heterosexist
attitudes is such that possible acceptance of lesbian parenthood is unlikely without deep
reflection or consistently gay-positive messages. There are implications for education which
attempts to promote inclusive education through workshops or other strategies which neglect the
pervasive nature of homophobia.

The dominant heterosexist perspective is internalized by the self-concept and results in
“tunnel vision.” This affects both educators and lesbian women in their interactions. The tunnel
vision which focuses educators on prenatal education exclusively for heterosexual couples also
limits lesbians’ interactions because of the constant scanning of the environment for disinviting messages which confirm their negative self-concept and oppression. The limited acceptance and critical view of those inviting messages by lesbian women—which may be deemed to be inclusive by educators—are often perceived as at odds with the vast numbers of disinviting messages which support their internalized homophobia. The need for environments and interactions which more than incidentally invite are those which will encourage the development of trust and genuine communication. Without an understanding of heterosexism and its impact on the expectant lesbian, behaviours which reflect a forced tolerance and tokenism may be considered homophobic.

Learning is facilitated by the process of self-inquiry or reflection. Reflection or consciousness are considered essential to the process of learning (Abbey & O’Reilly, 1998; Belenky et al., 1986; Bunch & Pollack, 1983; McLaren & Leonard, 1993; Lynn, 1999; Purkey & Novak, 1996; Taylor, 1993, Tong, 1998). Information which is considered relevant to the self-concept or previous experience will be considered meaningful, and hence incorporated into one’s current experiences. Strike (1982) notes that “when students lack a commitment to the value of what they learn, the consequences of learning on their values and their view of the world—the things that matter—will be minimal” (p. 50). This offers an explanation for lesbian women who access nontraditional providers of care in an attempt to locate relevant information.

There are implications for a maternal epistemology which respects the authority of mothers based on their experience (Abbey & O’Reilly, 1998). Belenky et al. (1986) note the importance of processes which allow for the development of an internal authority which can question the external societal authorities.

Invitational theory offers strategies for developing inclusive educational interactions and environments. Socratic dialogue (Purkey & Novak, 1996; Shogan, 1993), consciousness raising (Lynn, 1999; Miles, 1996), or discourse (Abbey & O’Reilly, 1998; McRobbie, 1994) aimed at
eliciting thick descriptions (Glesne & Peshkin, 1992) and development of empathy with the goal of greater "understanding of the perspectives of those who are situated differently" (Mullett, 1993, p.75).

Empathy involves a genuine engagement with another. Communication strategies which reflect openness, responsiveness, and sensitivity encourage receptivity and reciprocity (Noddings, 1984). Congruence between nonverbal and verbal behaviour facilitates genuine sharing. An emphasis on respect for others' viewpoints and unconditional acceptance of others is congruent with processes which promote development of empathy.

As well, environments give similar messages by virtue of the policies, places, processes, persons, and programs which are involved (Purkey & Novak, 1996). Purkey and Novak offer a systematic way to assess and modify environments with respect to lesbian-positive settings. By critically reflecting on these issues, educators facilitate access to affirming information and processes which encourage disclosure. In this way, childbirth education promotes the goals of increasing relevant knowledge and confidence related to the childbearing experience.

Dean Fink (1992) notes that Invitational Education's focus on assessing the "5 Ps" of programs, persons, policies, places, and processes must consider the political dimension, "the 6th P." This has relevance for inclusive issues in education. Educators and lesbian parents both require an understanding of the political forces in their worlds. Naming the oppressions of sexism and heterosexism (Canadian AIDS Society, 1992) contributes to an informed understanding of the world. This enables them to make informed decisions and choices. Genuine dialogue and empathy are required for educators to assess their practice with lesbian parents' perspectives in mind.

According to Seigfried (1998), John Dewey (1937) maintained that the goal of philosophy is to emancipate us from prejudice. His belief in "linking knowledge with action, and thinking with emancipation" (Seigfried, 1992, p. 194) supports a concept of social justice which
requires action with consciousness. Susan Sherwin (1993) stresses that in order to speak meaningfully about justice, it is necessary to examine the actual forces that undermine it, as well as those that support it. Feminism is not . . . interested solely in issues of oppression . . . but also with the possibilities of women's agency, despite their oppression. (p. 21)

Elizabeth Gross (in Crowley & Himmelweit, 1992) stresses that autonomy "implies the right to accept or reject such norms or standards according to their appropriateness to one's self-definition" (pp. 357-8). Resistance to hegemonic forces requires confidence and support in order to overcome the constant negativity of lesbian status.

Noddings (1984) speaks of a "moral agency to care." She summarizes components of caring behaviour which fit the invitational framework: modelling, dialogue, practice, validation, and confirmation. Invitational interactions are modelled by consistency in how we treat each other. Lesbian women experience overt negativity, exclusion, or mere tolerance from educators, while heterosexual couples celebrate parenthood. Noddings also implies that consistently gay-positive messages sent to others can facilitate trust and dialogue.

Dialogue and mutual sharing are key elements to inclusive education. According to Seigfried (1998), "Dewey was commit[ted] to a philosophy in which individual growth can only develop and thrive in an atmosphere [where] all of society supports these goals for growth collectively; individual growth occurs through interaction with others in society" (p. 189). The value of establishing trusting relationships and environments which facilitate disclosure has been mentioned.

Validation of lesbian identity and lesbian parenthood has been noted as essential to establishing an authentic motherhood and facilitating individual rights to self-determination. Confirmation of experience and knowledge gained through genuine dialogue and provision of relevant resources for lesbian women will promote caring communities.
The role of the government, then, has a commitment to demonstrate caring, in the development of caring institutions that are considered inclusive from the lesbian couple’s perspective. Caring involves a moral consistency which implies a responsibility to a larger community (Noddings, 1984). Communities which are considered caring validate and affirm diversity within humanity. Leck (1995), in a discussion of gay issues, quotes Iris Young (1990): “The primary meaning of public is what is open and accesssible” (p. 190). Exclusion of lesbian mothers from public awareness creates a strong message of powerlessness from the dominant groups.

Alongside of a masculine ethic which espouses rights (Shogan, 1993), a caring ethic which focuses on a responsibility ethic has been put forth in order to promote social justice (Belenky et al., 1986; Noddings, 1984; Shogan, 1993) This requires development of a collective empathy for others which is attained by critical reflection of our position within society and more than token support for those whose voices are weakened by their relative value to those who purport to speak for all.

A discussion of the barriers which hinder expectant lesbians’ rights to access information and resources which promote acceptance of lesbian identity and facilitate opportunities for motherhood has identified the pervasive influence of heterosexism and homphobia within society. These barriers preclude genuine communication and reflection which offer opportunities to imagine possibilities for change.

According to Purkey and Novak (1996), “democratic practice is a guiding ideal that focuses on developing continuous dialogue and mutual respect among people regarding shared aspects of their lives . . . . [It] is founded on open and free dialogue which promotes social responsibility” (p. 37).

Summary

Understanding the social context in which lesbian women seek information and
connections with others in ways that meet their needs for childbearing education facilitates the development of intentionally inviting environments. Respect for the embodied and experiential nature of understanding for the diverse lesbian women who mother contributes to the development of a maternal epistemology (Abbey & O’Reilly, 1998) which at once enables and resists the social constraints within their everyday worlds.

Invitational theory’s systematic approach of assessing educational structures offers a means of critically examining current people, places, programs, processes, and policies within institutional communities with respect to expectant lesbian women. Public health educators must critically reflect and become aware of those political influences which inform their practice.

Belenky et al. (1986) have noted that motherhood is a concept which evokes “care, connection, and human development” (p. 157). These theories offer frameworks in which to consider each of these as priorities in the education of expectant lesbian mothers.

Heterosexism, Homophobia, and Heteronormativity

In order to understand the social context in which lesbian mothers create their families, an appreciation of the intersections of oppressive relations of power that structure their everyday lives is important. Various theoretical approaches derived from an analysis of gender and/or sexuality have been espoused by lesbian, feminist, and queer theorists, although these have often been the source of political tension among groups and continue to evolve (Martindale, 1998). In this section I will briefly note some of the perspectives related to homophobia, heterosexism, and heteronormativity which have influenced discourses and support with respect to lesbian mothering. I will then relate how strategies, variously named homophobic or heterosexist, contribute to the ways in which lesbian childbearing women constitute their worlds in a dominantly heteronormative environment and touch on issues of resistance in this context.

The socially constructed nature of homosexuality (Eliaison et al., 1992) and the language used to describe it reflect cultural and historical meanings, as issues of power emerge related to
those who have the power to name or exclude same-sex identities within a specific context.

Michel Foucault (1978) in The History of Sexuality described the extreme sanctions against homosexual behaviour perpetuated by medical and religious institutions of social control since the 17th century and the development of classification of homosexual as a medical and psychiatric category of sexual perversion in 1870. Heterosexuality, which is often equated in a heterosexist society with sexuality, was originally coined at the turn of the 20th century as a term of deviance for excessive attraction to the opposite sex (Martindale, 1998). Such discourses of deviance continue to be supported and have their legacies in modern institutions (Canadian AIDS Society, 1992; Onken, 1998).

According to the Canadian AIDS Society (1992), heterosexism is "continual promotion by institutions of the superiority of heterosexuality and the simultaneous subordination of homosexuality" (p. 6). It is also the "assumption that every one is heterosexual unless known otherwise" (Clunis & Green, 1995, p. 62). Since the early 1990s the term heterosexism is preferred to homophobia (Canadian AIDS Society, 1992) as it emphasizes the institutionalized nature of the power like other oppressions such as racism and classism.

Homophobia can be considered an irrational fear of, hatred, or negative attitudes directed towards homosexuals (Gentry, 1992). According to McLaren (1995), the use of the word "homophobia" itself implies that

homosexuality is considered unlivable because it is constructed as the antithesis of what heterosexual communities consider 'normal.' It is based upon elements of identity expelled and disavowed and projected into the always already subordinate terms: gay, lesbian, or homosexual . . . . [This continues a pattern of power denoted in language which is reflected by similar] binary terms: civilized/deviant; natural/unnatural; legal/illegal . . . . The terms are continually and culturally negotiated within diverse historical and social arenas and in terms of competing vectors of power. (p. 112)
Homophobia affects everyone “raised in the same heterosexually dominant atmosphere, however not everyone experiences it in the same way” (Clunis & Green, 1995, p. 62). Lesbian women experience oppression both as homosexuals and as women. Race, disability, class, and other factors will compound the effect.

A dominant patriarchal perspective shaped by historical, economic, social, and cultural forces (Mandell, 1998) is produced and reproduced within all societal institutions through mechanisms of heterosexist values and homophobia. The roots of this pervasive heterosexist thought within society are “founded on the subordination of women’s needs, issues, and perspectives to those of men and on the denial of the potential bonds of love and friendship between women” (Eliason et al., 1992, p. 32).

Adrienne Rich (1980), in her landmark article, “Compulsory Heterosexuality and Lesbian Existence,” identified enforced heterosexuality as an insidious and persistent power structuring all societal relationships. Normative patriarchal values ensured that all women were socially conditioned to accept subordination and limits on their everyday life choices through strategies of direct and indirect violence. This not only accounted for the erasure, invisibility, and diminishment of lesbian women, but prevented nonlesbian identified women from supporting and celebrating lesbian women through a common women-identified-experience. That patriarchal power could unconsciously shape everyday institutions and narratives was an important understanding in establishing how women in diverse locations experience their lives. Lesbian women’s rejection of the economic, physical, and emotional dependence on patriarchal authority ensconced in the nuclear family accounts for the extensive social repercussions they encounter (DiLapi, 1989; Eichler, 1997).

While Rich’s (1980) perspective is widely accepted in many feminist circles as one which has the potential to enable women to connect across differences in sexual identity to counter patriarchal and other oppressions, her premise of the women-identified lesbian spectrum
has been criticized for the way in which it desexualizes lesbian women by focusing on their emotional affiliations in order to increase lesbian respectability to women/feminists. In fact, Martindale (1998) explains that tensions among lesbians and/or feminists, which surfaced in the Sex Wars of the 1980s, relate to questions of who has the power to define lesbian women, and represent the boundaries of their expression.

These tensions are endemic to postmodern shifts in which knowledge claims, margins, and representations based on binary ways of thinking are explored as they contribute to oppressive understandings and practices with respect to social and cultural difference. Queer theory, as named by DeLaurentis in 1991 (as cited by Martindale, 1998), reclaimed the term “queer,” deconstructed the rigid binaries of hetero/homosexuality, and hence offered a counterpoint to the dichotomous split. Martindale (1998) stresses how Michael Warner’s term “heteronormativity” (coined in 1990) is “useful because it makes it clear how heterosexist ‘normalcy’ normalizes itself through making homosexuality ‘deviant’” (pp. 55-6).

However, even within the queer continuum of nondichotomous and fluid sexual identities, relations of power surface through language and the ways in which representations of race, ability, and bisexuality are centered or marginalized (Goldman, 1996; Martindale, 1998). Ruth Goldman addresses how the terms, “queer” and “lesbian” may be perceived to represent dominant groups. She explains that some women of colour perceive that “lesbian” represents “Anglo-European roots and associations” (p. 171). Identification as “queer” may be chosen in part because it blurs—and some would argue erases—boundaries . . . but as queer gains currency, it is increasingly being appropriated and commodified and thus increasingly risks collapsing into another term for white lesbians and gays, and ultimately white gay men. (p. 171)

The power of language to convey meanings related to dominance extends beyond an
understanding of locating “gender-neutral” or nonoffensive terms for sexual identity. The
Canadian AIDS Society (1992) notes that language within societal institutions and adopted by
the media conveys an “otherness” to the gay and lesbian population with its use of terms like
“the general population” which is a code for “respectable.” Because of the pervasiveness of this
view, homosexuals have been largely invisible within society, and when they have been
recognized, it is with respect to specific “homosexual issues” which have offered them a
semblance of legitimacy within institutions of education and health. Thus, concern for
“populations at risk”--teens, for suicide and substance abuse, and gay men with HIV/AIDS
concerns--has been a mixed blessing for lesbian women and gays. Along with the caring and
funding which have been offered, with resultant educational and health resources allotted to their
needs, has been publicity which has sensationalized the same-sex issues within the media
(Canadian AIDS Society, 1992), further contributing to negative stereotypes.

The ways in which difference is created by dominant groups shape their vested interest in
maintaining this hierarchical power. Homophobic strategies to preserve the heterosexist
perspective of hegemonic institutions at the expense of other ways of knowing which are
excluded or minimized produce power and reproduce dominance.

Although hegemony has recently been used as static and overpowering concept, Weiler
(1988) notes that Gramci (1971) saw it as a process of oppression and counteroppression:
hegemony “is never complete, always in the process of being reimposed, always capable of
being resisted, and the dominant classes are always struggling to reimpose an hegemony” (p. 13).

Issues of access to knowledge and legitimization of knowledge claims by societal
groupings reflect relations of power which Weiler (1988) discusses with respect to class
difference. However, such analyses are also relevant to how knowledge is made available on the
basis of same-sex difference. Weiler, in her discussion of traditional and critical education,
summarizes social and cultural reproduction theories which explain the way in which “class
structure is reproduced and normed by (1) variable access to knowledge and use of language and
(2) subcultural knowledge and modes which match the valued knowledge of the educational
system which gives success” (p. 9). There are implications for inclusive education which
acknowledges the very existence of lesbianism and the language used by institutions to confer
value upon this group. This also has relevance in explaining ways in which lesbians publicly or
privately deny their status for societal acceptance.

Weiler (1988) describes production theories which
address how both individuals and classes assert their own experience to contest or resist
the ideological and material forces imposed upon them, i.e., how teachers and students
produce meaning and culture through their own resistance and their own individual and
collective consciousness . . . . Resistance theory from the late 70's explains that actions
and cultural patterns that have been labelled deviant can be viewed instead as acts of
resistance by individuals and groups against a dominant culture that has exploited and
devalued them . . . Subcultures become the site of the active production of meaning in
opposition to the hegemonic ideology of the dominant groups. (p. 19)

With respect to same-sex discourses, Foucault (1978) noted that the extreme sanctions on
homosexual behaviour from the 18th century led to social controls in which homosexuality was
medicalized and regulated, yet struggles by individuals from multiple locations within this
society to legitimize same-sex behaviours and regain control of their lives emerged at the same
time. In his view, these counter discourses were not opposite to dominant discourses regarding
the deviance of homosexuality, but simultaneous, contradictory, and indicating “plurality of
resistance, . . . not . . . only a reaction or rebound, forming with respect to the basic
domination” (p. 96). Foucault’s focus for resistance was the effect of local actions within a
specific context which “[made] possible [certain] . . . discourses and how these discourses were
used to support power relations” (p. 97).
Heterosexist discourses are implicated in how diversity among women is acknowledged and valued within society. "Institutionalized heterosexuality simultaneously helps to create gender and thus difference, and set limits on that difference. Lesbians and straight women alike, we are members and participants in all sorts of heterosexual institutions-economic, educational, cultural and commercial--which construct our identity" (Gordon as cited in Crowley and Himmelweit, 1992, p. 40). Thus women, as well as men, act on the basis of assumed heterosexuality (Eliaison et al., 1992) and reflect this in interpersonal interactions.

Homophobia is used as a basis for strategies which promote the heterosexist perspective. It exists in internal and external forms (Clunis & Green, 1995) which promote the invisibility of the lesbian experience by posing enormous social sanctions on disclosure or resistance to patriarchal thought (Eliaison et al., 1992). The use of stereotypes, myths, and exclusion are powerful strategies which maintain the status quo (Eliaison et al., 1992; Robertson, 1992). Patterson (1997) notes that the [negative] beliefs held generally in society are culturally transmitted and are often not based in personal experience.

Internalized homophobia is an ongoing battle for many lesbians who wrestle with self-hatred caused by belief in the negative stereotypes perpetuated by the media and other institutions (Eliaison et al., 1992; Olesker & Walsh, 1984). This results in low self-esteem (Clunis & Green, 1995, p. 62) which limits self-acceptance and perceived options, including those of parenthood (Clunis & Green, 1995). Asten (1997) notes that lesbians and the general public alike base their knowledge of lesbian families on mainly negative stereotypes, as they have no other visual images. This is exacerbated by the homophobia which prevents disclosure to others and limits access of lesbian women to each other (Nelson, 1996).

Homophobic messages create anxiety in lesbian women as a result of the anticipated negative reaction if disclosure occurs. The constant disinviting messages from self-talk and others restricts the possibility of disclosure to others and results in limited meaningful
communication. Anticipated homophobic reaction to disclosure to friends and family is a critical issue in determining the extent of “outness” to others (Kenney & Tash, 1992). Homophobic control between lesbian partners can also occur, with power struggles which use threatened disclosure of lesbian status to one’s advantage (Gentry, 1992).

Even when lesbians do not disclose, Stevens (1992) indicates that “the patterns of civil liberties violations and abuse are similar whether the sexual orientation is assumed, based on rumor and opinion, or known, based on public record or verbal acknowledgement” (p. 113). Although homophobic attitudes are often assumed to be demonstrated in overt ways, subtle tolerance is often considered even more damaging to homosexuals and perpetuates a disregard for the importance of the gay/lesbian perspective and democratic rights within society.

Blumenfeld and Raymond (1988) as quoted in Eliason et al. (1992) argue that mere tolerance actually promotes lesbian invisibility and allows for discriminatory practices to occur. They suggested that tolerance masks a basic underlying fear or hatred in individuals who cognitively support civil rights, but emotionally cannot accept lesbian sexuality. Tolerance is extended to children or immature individuals, thus often representing a condescending attitude. (pp. 139-140)

Dorothy Riddle’s (1991) continuum, as cited by the Canadian AIDS Society (1992), describes levels of homophobia ranging from repulsion and pity at one end to tolerance and acceptance in the middle. Individuals who are functioning at the level of tolerance and acceptance still deny the social and legal realities of lesbians’ everyday lives. Support, admiration, appreciation, and nurturance, however, reflect active work to examine attitudes and values, and a willingness to celebrate and advocate for lesbians and gays.

The exclusive focus on the heterosexual norm by exclusion, and minimizing, of same-sex perspectives have implications for health and educational institutions. O’Hanlan (1997) notes that “when hatred keeps the oppressed group limited, the dominant group also suffers from the
constrictions and limitations” (p. 28). Health-care providers and educators are affected by heterosexism in their institutions of work and in their own education which limits information about lesbianism to them (Coalition for Lesbian and Gay Rights in Ontario, 1997; Eliason et al., 1992; Robertson, 1992; Stevens, 1992). As Stevens (1992) indicates, “[Heterosexual] assumptions also rob providers of access to practical knowledge about lesbian life experiences, health concerns, community resources, and support networks” (p. 110) with possible implications for quality of care.

Homophobia in providers of care has been indicated by mistreatment, breach of confidentiality, limited or lack of acknowledgement of partner, and outright abuse (Boston Women’s Health Book Collective, 1992; Coalition for Lesbian and Gay Rights in Ontario, 1997; DeMarco & Simkin, 1996; Eliason et al., 1992; Johnson et al., 1981; Jones, 1988; Matheison, 1998; C. O’Brien et al., 1993; Simpson, 1994; Vida, 1996; White & Martinez, 1997; Zeidenstein, 1990). Jones (1988) describes low-grade homophobia as “hostility and discomfort when caring for lesbian patients and ignorance about lesbianism in general” (p. 48).

Eliason et al. (1992) indicate that attempts have been made to isolate attributes like gender, age, or value systems which are associated with homophobia. Although findings vary, they point out that there is some evidence which may indicate that males may be more threatened by gays and females by lesbians. Women attracted to nursing, considered a traditional female career, especially if they reflect traditional “feminine” qualities like caringness, yieldingness, sympathy, sensitivity, and compassion, may be at high risk for negative attitudes toward lesbians (p. 134).

As well, Eliason et al. (1992), in their study of negative attitudes by nursing students, note how the stereotypic attitudes are “clearly contradictory to [the] code of nursing ethics” (p. 141). The Canadian AIDS Society (1992), and CLGRO (1997) stress that gays and lesbians are protected by human discrimination legislation, but in reality, subtle homophobia and exclusion
may be difficult to prove in a heterosexist environment—and are often ignored. Eliason et al. (1992) underline the enormous difficulty in addressing this concern with the current conservative religious and political climate that exerts its influence on all institutions.

Homophobic reaction may occur when advocates support changes to the status quo. Ramsay (1994), Shroff (1997), Stevens (1992), and Onken (1998) note that assumptions of same-sex orientation or advocacy in this area may precipitate disinviting reaction including violations of civil rights, loss of personal friendships, professional discrimination, and other consequences of stigmatization based on such a stance.

Gayle MacDonald (1999), in her discussion of equity legislation, notes that “there has been an unprecedented backlash to the concerns and needs of the disadvantaged [including lesbians] in Canada. This backlash has taken many forms” (p. 155). According to patriarchal theory, lesbianism’s subculture of women-with-women is a threat to patriarchal power because of lesbian women’s little regard for males and male authority (Eliason et al., 1992; Nelson, 1996). Women identified as feminists or who have “overstepped the bounds” for questioning the sanctity of current structures can be subject to threats of violence on different levels (Amin et al., 1999; Harris, 1999; Onken, 1998; D. E. Smith, 1999).

Current discussion of same-sex issues within mainstream institutions challenges long-held moral values about relationships. Barbara Rumscheidt (1990) has described the emotional and homophobic response provoked by discussion of same-sex couples’ rights even within a Canadian religious institution often touted as liberal and tolerant: “The mood of anxiety, hostility and hate in which this demand [for compulsory heterosexuality as a Christian standard] is made creates a hazardous climate for women—especially feminist and lesbian feminist women” (p. 76). Current media headlines continue to describe political battles which highlight the vocal and organized opposition of social conservative groups to accepting same-sex relationships in ways
that are validated for heterosexuals (Gay rights, 2000; Giese, 2000; Harper, 2000; Hebert, 2000).

Since recent struggles to offer antihomophobia curriculum and same-sex legislation, even within large urban centers with openly lesbian communities, have been affected by such response, the conservative environment ( Arnup, 1998 ), feminist backlash ( Harris, 1999 ), and well-publicized vocal opposition by community groups regarding public support for lesbian positive programming ( Sullivan, 1999; Lesbian Mothering, 1999 ) are important considerations for understanding the social contexts in which change may occur through advocacy or other venues.

The exclusion of lesbian women in mainstream communities promotes invisibility and isolation. Lesbian women have formed communities and created supportive networks in response to the social settings which marginalize them. Finding support within an accepting gay/lesbian community is often crucial to overcoming isolation engendered by homophobic society. Asten (1997) uses this point to demonstrate the need for resources which address this invisibility.

Lesbians cannot survive as a formless faceless people who fear discovery so much that we are not visible --even to each other. Without a visual identity we have no community, no support network, no movement. Making ourselves visible is a political act. Making ourselves visible is a continual process. (p. 3)

In a society dominated by heterosexist and homophobic values, individuals, straight and gay, as well as institutions, cannot assume that their actions and policies reflect inclusive perspectives. Paolo Freire (as cited by Weiler, 1988), a noted educational theorist whose work is committed to praxis, noted the importance of having teachers and students both “seek to understand the forces of hegemony within their own consciousness, as well as the structured, historical circumstances in which they find themselves” (p. 18). An awareness of the sociopolitical structures in place which maintain the dominant attitudes requires critical reflection in order to understand the various ways in which exclusion and marginalization of
diverse lesbian perspectives are wrought and perceived—and the possibilities for change.

**Research Contexts Which Shape Care for Lesbian Women**

Undertaking research with childbearing lesbian women requires an understanding of the complex forces within society which render them invisible and which impose such strong sanctions on their existence. Lesbian identity and disclosure, methodological dilemmas, researcher issues, and research supports will be considered.

Studying issues related to lesbian women is limited by the use of the term used for “women who love women”: lesbian. The National Gay and Lesbian Task Force (NGLTF), as indicated in White and Martinez (1997), developed a broad definition which has been included in the glossary.

O’Hanlan (1998) emphasizes that “orientational identity and sexual behavior are not synonymous and require separate and specific inquiry in research protocols” (p. 20). Women may consider themselves lesbian, bisexual, or heterosexual (if they consciously identify with any one group), and this can vary over a lifetime (Stevens, 1992; White & Martinez, 1997). Disclosure to self and others, in its effect on identification with the terms “lesbian” or “gay” and the lengthy process which it entails, can take years (White & Martinez, 1997). There is a continuum of sexual orientation which includes “women-loving-women” (Bass & Kaufman, 1996; Boston Women’s Health Book Collective, 1992; White & Martinez, 1997), yet conventional research reflects heterosexist influences which categorize sexuality as a dichotomous variable (Eliason et al., 1992; McLaren, 1995; Onken, 1998). Behaviour may not accurately reflect identification with the “lesbian” label, and may in fact be categorized as “bisexual” by some researchers (Patterson, 1997).

These factors impede quantification of the lesbian “population”—continuing to promote its invisible status within the “general population” and limiting reliable data collection and analysis. The limitations of using words like “population” which can be perceived as
epidemiological and dehumanizing to women who may be sensitive to such perspectives is recognized in this discussion. Few large studies include any attempt to capture the sexual orientation status of participants (O’Hanlan, 1998; Stevens, 1992). One American study, the Women’s Health Initiative, has attempted to include sexual orientation as a standard demographic question like race or income on its questionnaire (Bowen et al., 1997). O’Hanlan (1998) stresses that in the United States “no federally funded population study has ever been stratified by orientation” (p. 18). Several American studies have been undertaken on lesbian issues by public health departments with a focus on AIDS and lesbian health (O’Hanlan, 1998). However, the next federal census in Canada will have a category for same-sex orientation included.

Available research varies in its attempts to locate lesbian women; however those associated with the visible lesbian community reflect women who are “half-out” or “completely out” (Coalition for Lesbian and Gay Rights in Ontario, 1997; Waitkevicz, 1996). O’Hanlan (1998) stresses that it is “difficult to do research on a population whose ‘lifestyles’ are unrecognized in 50 states and frankly illegal in 22 states” (p. 18). Finding women who are representative of the diversity of lesbian women in terms of age, culture, disability, race, and ethnicity is difficult (O’Hanlan, 1998; Stevens, 1992; Waitkevicz, 1996).

There is disagreement over research methodology. Until the last decade, most lesbian research studies which addressed health or parenting issues were quantitative (Stevens, 1992). An article which examined the representativeness of samples of homosexuals, bisexuals, gays, and lesbians obtained for public health research in the United States noted that journal articles published between 1990 and 1992 rarely used probability sampling, sampled from settings representative of dramatically different populations, used a range of incomparable methods to identify and select subjects, and rarely conceptually defined the population being sampled (Sell & Petrulio, 1996). However, Stevens (1992) emphasizes that, “samples must be drawn from a
universe whose limits, units, and locales are largely unknown. Conventional mathematical sampling techniques that strive for random composition, representativeness, and/or structured comparison groups are simply not scientifically feasible in studying this population” (p. 117).

Trippet and Bain (1992) stress that “numerous strategies have been explored to modify the methodological problem, without success. As long as homophobia exists or is perceived, methodological problems will continue to exist” (p. 152). Patterson (1997), who represents the American Psychological Association, emphasizes that the often touted criticisms of these published studies with regard to sampling and sample size limitations do not invalidate the findings available (p. 2).

In order to study lesbian health and lesbian childbearing, sampling methods have largely focused on snow-ball technique. This method relies on participant referrals (McMillan & Schumacher, 1997) and convenience methods (Buenting, 1992; Coalition for Lesbian and Gay Rights in Ontario, 1997; Johnson et al., 1981; Lucas, 1992; Olesker & Walsh 1984; Robertson, 1992; Trippet & Bain, 1992; Zeidenstein, 1990) for sampling. Questionnaires (Buenting, 1992; Coalition for Lesbian and Gay Rights in Ontario, 1997; Harvey et al., 1989; Johnson et al., 1981; Lucas, 1992; Olesker & Walsh, 1984; Trippet & Bain, 1992) have been used, and recently semistructured interviewing (Asten, 1997; Mathieson, 1998; Nelson, 1996; C. O’Brien et al., 1993; Simpson, 1994).

In order to obtain rich data which can be analyzed in depth, researchers have utilized qualitative and ethnographic approaches. Certainly the limitations of this approach also are apparent, as often findings cannot be generalized beyond the context of the study. However, the qualitative approach is apt for researching populations and issues which may be sensitive. It also offers a way to respect the complexity of the relationship issues of both the participants and researcher(s) which are inherent in the research process.

The power relationship of the researcher to the studied is reflected in the use of language
to describe the participant or subject, research approach, and attempts to explain researcher positioning or reference point in order to contextualize the study and results.

Asten (1997) and Nelson (1996), in their in-depth studies of lesbian parent issues, employed feminist participatory methodology. In this approach, the findings are often written with a priority of providing a voice for those involved. According to Asten (1997), “traditionally, research tends to eliminate the informants’ voices by summarizing and analyzing their comments, thereby emphasizing the researcher’s voice at the expense of the informants” (p. 2). This is especially relevant for the invisible parenting lesbian women who are struggling with societal attitudes and interactions which are difficult to capture in an objective questionnaire.

Feminist participatory research uses techniques which purposely seek out the narrative and particular in order to analyze it in a deeper and broader context (Mullett, 1993) which is often related to structures of oppression which position women’s lives. As such, it reflects an often identified feminist political stance. Asten (1997) explains that “this method of empowering the voices of the informants reflects a radical feminist approach to the research” (p. 2). Asten notes that Reinharz (1992) defines the goals of feminist ethnography as threefold: “1) to document the lives and activities of women; 2) to understand the experience of women from their own point of view; and 3) to conceptualize women’s behavior as an expression of social contexts” (p. 2).

Several researchers have emphasized that there are research issues which affect the study in terms of the researcher him/herself. Both Asten (1997) and Nelson (1996) indicate the importance of having the researcher identified as a feminist/lesbian in order to gain access to the real issues. However, this has not prevented constant questioning of the motives of a group of lesbian researchers who planned to study lesbian women in a health context—by the lesbian community itself (Bowen, et al., 1997; Nelson, 1996). There may be a perception that even lesbian advocates have been coopted by mainstream institutions (Bowen, et al., 1997).
The longstanding mistrust that has pervaded relations between lesbians and providers of care, institutions, and communities has resulted in understandable hesitance of lesbian women to participate in research which many worry could be detrimental to them—related again to the tendency for the media to sensationalize instead of support, the reluctance to be yet again deemed “the other” group and further marginalized (Canadian AIDS Society, 1992; O’Hanlan, 1998; Bowen et al., 1997). Audre Lorde (as quoted in Crowley & Himmelweit, 1992) explained that “when the need for some pretence of communication arises, those who profit from our oppression call upon us to share our knowledge with them. In other words, it is the responsibility of the oppressed to teach the oppressors their mistakes” (p. 47).

Stevens (1992) stresses that “research is a very powerful political tool” (p. 117). As such, it can be used to identify issues and secure funding or resources for those who have been excluded, like lesbian women. The editor of Health Care for Women International (1992) was strongly encouraged by lesbians themselves to edit an issue dedicated to lesbian health. The findings, as the editor noted, “the prejudice, mistreatment and downright ignorance held by even college-educated nurses” (Stern, 1992, p. vi), evident in the articles of that special issue reflect a recurring theme throughout my review of the literature of the exclusive and discriminatory messages which are conveyed to lesbians today.

Stevens (1992) emphasizes that “although the political climate is changing, many scholars . . . have been deterred from researching and writing about lesbian topics because their association with lesbian populations posed risks of personal stigmatization” (p. 108). The stigma associated with lesbian issues affects how much research is done in this area, but there are other concerns. Karen Harbeck (1992), as cited by O’Conor (1995), notes that scholars, both heterosexual and gay identified, involved in research related to homophobia and heterosexism have been influenced by “threats to their tenure, promotion, reputation and personal safety” (p. 14).
Denenberg (1997) attributes many of the methodological difficulties to a “lack of access to the resources necessary for conducting research and publishing scientific data” (p. 15). Few studies available have been funded by institutional, municipal, or extramural grants or have been part of large-scale team efforts (O’Hanlan, 1998, Stevens, 1992; Waitkevicz, 1996). Olesker and Walsh (1984) and Stevens (1992) point out that many sources of information on lesbian health are from nontraditional or underground sources. As Denenberg (1997) emphasizes, the “problem is not a lack of inquiry or investigation (almost exclusively by lesbian researchers), but rather . . . . [that findings] have not been mainstreamed into the body of knowledge about women’s health” (p. 14). This marginalization of lesbian health research parallels research in both women’s health and minority health struggles (Bowen, et al., 1997; O’Hanlan, 1998). There are implications for funding, publishing, and mainstream support for lesbian health research.

Stigma resulting from heterosexist and homophobic societal values has a great impact on researching lesbians’ concerns. Acknowledgement of the gap in lesbian health research by mainstream institutions and researchers is important. Concrete support in the form of resource allocation to support research on more than a small scale is necessary. Recognition of lesbian identity and lesbian behaviour issues, the nature of selective disclosure of same-sex orientation, and its effect on sampling are crucial. Choice of methodology which facilitates sensitivity in sharing of information, and sensitive handling of information obtained and published, can be construed as efforts to respect the culture of the participants.

Research is a political tool which has the power to identify gaps and barriers which hinder inclusive or culturally sensitive education. Understanding the barriers to undertaking this research is important for educators in order to be aware of dynamics which can facilitate caring research environments.

Lesbian Health Issues

Despite increased invisibility in society with the gains made by social activists through
the feminist and lesbian movements in the 1970s, lesbians two decades later continue to encounter lack of recognition in health-related matters. O'Hanlan (1998) has adapted the "definition of women's health issues as employed by the [American] Office of Research on Women's Health as those issues to which lesbians are more susceptible, may have greater prevalence, or may be unique in developing, or be affected by differently than heterosexual women" (p. 8).

Lesbian women have been estimated to comprise from 2% (Kinsey, 1953) to 12% (Hall, 1988) of all women (cited in Zeidenstein, 1990). Numerous investigators have estimated that 2-6% of the female population is exclusively homosexual, and that 20% of all women have some lesbian contact before the age of 40 (Lucas, 1992, pp. 227-8). O'Hanlan (1998) indicates that the "rates of lesbians in primary relationships, typically 60-72%, is [sic] similar to the U. S. Census statistic for heterosexual women who are married, nearly 62%" (p. 20). Accurate information is limited by disclosure issues and access to representative research samples as noted in the previous section on lesbian research issues.

The lack of the recognition of nondichotomous nature of sexual orientation (McLaren, 1995) as well as assumption of homogeneity in sexual practices (Waitkevicz, 1996) have contributed to attitudes which support stereotypes and which neglect the diversity of human sexual experience--which resists simple categorization. According to Waitkevicz (1996), 25-46% of lesbians as identified in mainstream surveys, have had sex with a man in the past three years; they are more likely to choose a gay or bisexual man because he is a friend and are less likely to use a condom because it wasn't planned. (p. 93)

Identification with a lesbian or bisexual identity may not be fixed and may vary over a lifetime. There are implications for providers who will often assume consistency and heterosexuality.

The spectrum of same-sex attraction has been described by Kinsey's (as cited in Bass &
Kaufman, 1996, p. 6) scale of same-sex attraction and experience. The range of potential
behaviour or attraction for individuals may limit self-identification as lesbian. Self-disclosure has
implications for verbal or implied disclosure to providers. The coming-out process may take
years to fully acknowledge and has been described by a number of studies in terms of stages
(Bass & Kaufmann, 1996; Clunis & Green, 1995; Morris, 1996). These include: identification of
persistent same-sex sexual preference, self-identification with a lesbian label, and gradual
disclosure to others. An unknown number of women never act on or accept their attractions
(Clunis & Green, 1995). Participation in the larger lesbian community is seen as evidence of
acceptance and declaration of lesbian identity (Clunis & Green, 1995; Jordan & Deluty, 1998;
Morris, 1996; Vida, 1996). However, many lesbians remain isolated because of homophobic
messages, and disclosure to others often remains limited.

Stevens (1992) describes the process of concealing lesbian identity as a “tremendous loss
of time, energy, self-worth, and authenticity [which is] exacted by the vigilant monitoring
process involved . . . . [It is] extremely complex, and nonparalleled in the experiences of
nonlesbian women” (p. 112). Audre Lorde, noted black lesbian feminist, as quoted in Crowley &
Himmelweit (1992), remarked that

In order to survive, those of us for whom oppression is as American as apple pie have
always had to be watchers, to become familiar with the language and manners of the
oppressor, even sometimes adopting them for some illusion of protection. (p. 47)

Despite an increase in publications which signal a realization of some of the
overwhelming issues of lesbians, heterosexist and homophobic attitudes persist in health care.
These are reflected in exclusion from printed health resources which are geared to a heterosexual
population (DeMarco & Simkin, 1996). As well, interactions with health-care providers are
frequently perceived by lesbian women as nonsupportive of their needs (DeMarco & Simkin,
1996; Denenberg, 1997; Lehmann, Lehmann, & Kelly, 1998; Lucas, 1992; Mathieson, 1998;
O'Hanlan, 1998; Olesker & Walsh, 1984; S. J. Roberts & Sorensen, 1995; Robertson, 1992; Stevens, 1992; Trippet & Bain, 1993; Waitkevicz, 1996; Zeidenstein, 1990). Stevens (1992), in her review of the literature from 1970 to 1990, reported findings of 19 studies of lesbians’ perspectives about health care. She noted that “instead of respect and regard, lesbians reported atmospheres of intimidation and humiliation which encumbered their interactions with health care providers” (p. 109).

As disclosure by lesbians to others around them is selective and dependent on various factors related to trust or threat to perceived safety (Stevens, 1992; Zeidenstein, 1990), health care providers require information which can facilitate communication in order to provide an environment which is considered supportive. The literature offers providers information on providing lesbian-positive health care.

Several factors have been deemed important to qualify as a lesbian-affirmative health care provider. A female provider is more likely than a male to be seen as supportive (Lucas, 1992; Robertson, 1992; Trippet & Bain, 1992, 1993), although it is agreed that the sexual orientation of the provider is not as important as the nonjudgemental attitude of the provider (Boston Women’s Health Book Collective, 1992; Olesker & Walsh, 1984). Qualities such as nonjudgemental listening (Gentry, 1992; Robertson, 1992; Waitkevicz, 1996), sharing of information, anticipating unasked questions and fears, not assuming homosexuality (DeMarco & Simkin, 1996; Gentry, 1992; Jones, 1988; Robertson, 1992; Trippet & Bain, 1993), and knowledge or caring about lesbian health concerns are essential (S. J. Roberts & Sorensen, 1995; Trippet & Bain, 1993). According to O’Hanlan (1997), it is “not enough to have a nonjudgmental, nonhomophobic attitude. The responsible practitioner must convey a nonjudgmental attitude to all patients” (pp. 30-31).

Use of supportive language by providers indicates a possible comfort level with lesbian issues (Regan, 1981). Because of the power inherent in language, sensitivity is essential when
using terms for lesbian women and their partners. For some, the terms “queer” and “dyke” are deemed more offensive than gay/lesbian (Regan), however a number of feminist and lesbian publications use these expressions informally, with affection (Boston Women’s Health Book Collective, 1992; Vida, 1996; White & Martinez, 1997). O’Hanlan (1998) has noted that general assumptions cannot be made as the preferred words may vary with political affiliation, “outness,” and age (p. 8). The use of gender-neutral language and establishing terms acceptable to clients is important.

Verbal and nonverbal clues which may offer clues intended to disclose lesbian status (Stevens, 1992; Zeidenstein, 1990) may be ignored by providers who lack knowledge, display discomfort, or who feel specialized knowledge is necessary to provide support. However, stereotyping of lesbian status by appearance (O’Hanlan, 1998; Robertson, 1992) is considered homophobic. Sensitivity in communication is essential, including how relevant questions are asked verbally or on questionnaires (Gentry, 1992; Lehmann et al., 1998; Mathieson, 1998; O’Hanlan, 1998; Olesker & Walsh, 1984; S. J. Roberts & Sorensen, 1995; White & Martinez, 1995; Zeidenstein, 1990).

A crucial aspect of interactions with health care providers is the provider’s response to disclosure of lesbian status. Negative reactions and less than optimal care have affected so many lesbians’ experiences with disclosure that many avoid this completely and providers remain unaware of their role in the interaction (Coalition for Lesbian and Gay Rights in Ontario, 1997; Lehmann et al., 1998; C. O’Brien et al., 1993; O’Hanlan, 1998; Ramsay, 1994; Robertson, 1992; Simpson, 1994; Stevens, 1992, 1998; Trippet & Bain, 1992). According to Zeidenstein (1990), disclosure to a provider rarely produces a reaction that celebrates lesbian status.

Confidentiality is an important concern for lesbians, especially regarding medical records. The decision to disclose to providers not only depends on the anticipated response during the interaction, but a concern for how that information will be used. Providers can respect
lesbian clients’ wishes regarding how information will be shared, verbally or written (Gentry, 1992; Harvey et al., 1989; Kenney & Tash, 1992; Johnson et al., 1981; Jones, 1988; Lucas, 1992; Zeidenstein, 1990), or if it is to be shared at all (Lucas, 1992).

Demonstrating sensitivity to health topics with lesbian issues in mind is considered important. Even when lesbians have “come out,” the provider’s lack of understanding of parenting options for lesbians may preclude a discussion of preconceptual health and related relationship stresses in planning a pregnancy (Gentry, 1992; Olesker & Walsh, 1984). According to O’Hanlan (1998), “major lesbian health surveys consistently observed that between 6 and 46% of lesbians are parous [have had a viable infant] and with another 30-62% interested in undergoing insemination at a later time” (p. 20). The importance of discussing preventive health education was seen as positive and supportive for many lesbians (Lucas, 1992; S. J. Roberts & Sorensen, 1995; Trippet & Bain, 1992).

An understanding of health risks for lesbians identified in the literature is essential. Several sources emphasize that the major health risk for lesbians is related to “homophobic fallout” (O’Hanlan, 1998) which affects both their self-concepts (Bass & Kaufman, 1996) and the decisions they make in relation to their health (O’Hanlan, 1998). The most significant risk for lesbians is avoidance of routine health care (Boston Women’s Health Book Collective, 1992; Coalition for Lesbian and Gay Rights in Ontario, 1997; DeMarco & Simkin, 1996; Robertson, 1992). Lesbians’ tendency to delay or avoid health care in general is related to anticipation of interactions which are not considered supportive based on previous experiences.

As a population, lesbian women may be at increased risk for breast, cervical, and endometrial cancer (Lucas, 1992; O’Hanlan, 1998; Ramsay, 1994; Waitkevicz, 1996). Although research on lesbian health is limited, risk factors for breast cancer which have been identified in all women, such as nulliparity or having a first pregnancy after age 30, excessive alcohol use, obesity, and a high-fat diet may be particularly relevant to the lesbian population (O’Hanlan,
As well, breastfeeding, which may confer some protection from breast cancer, may be less likely to be experienced by lesbian women (Zeidenstein, 1990). The higher incidence of smoking within the lesbian population in addition to those risks mentioned may also increase the risk of other cancers and heart disease. There are implications for addressing barriers to obtaining adequate and supportive routine health assessments, as well as gynecological and obstetrical care (Boston Women’s Health Book Collective, 1992; DeMarco & Simkin, 1996; Lucas, 1992; Matheison, 1998; O’Hanlan, 1998; Waitkevicz, 1996; Zeidenstein, 1990).

A discussion of the gynaecological needs of lesbians now includes a discussion of AI options for lesbians (Boston Women’s Health Book Collective, 1992; DeMarco & Simkin, 1996; Harvey et al., 1989; O’Hanlan, 1998; Olesker & Walsh, 1984; Simkin, 1997), more recently within a context of the HIV/AIDS issues for screening potential donors (Boston Women’s Health Book Collective, 1992; Clunis & Green, 1995; Kenney & Tash, 1992; Lucas, 1992; Nelson, 1996; O’Hanlan, 1998; Vida, 1996; Zeidenstein, 1990). This concern about HIV/AIDS is valid, although the prevalence of HIV/AIDS in the lesbian population is considered low as long as their partnering is limited to those of the same sex. However, accurate information is limited (O’Hanlan, 1998; Waitkevicz, 1996; White & Martinez, 1997). Heterosexual contacts and intravenous drug use increase the risk (O’Hanlan, 1998; Waitkevicz, 1996; White & Martinez, 1997).

Depression, suicide, anxiety, and substance abuse issues have been identified by lesbians as priority concerns (Lehmann et al., 1998; Lucas, 1992, O’Hanlan, 1998; Waitkevicz, 1996; White & Martinez, 1997), ostensibly related to the stressful conditions imposed by a heterosexist and homophobic world. Vida (1996) and O’Hanlan (1998) have stressed the need for supportive psychological treatment and rehabilitation services which address same-sex orientation for women. The sampling bias of earlier surveys on lesbian women which depended on women in bars for information has contributed to the controversy of whether alcohol and drug use are truly
more prevalent in lesbian women than in heterosexual women (O’Hanlan, 1998; White & Martinez, 1997).

Relationship issues are a crucial issue for women identifying same-sex orientation, whether closeted or “out” (Boston Women’s Health Book Collective, 1992; DeMarco & Simkin, 1996; O’Hanlan, 1998; Vida, 1996; Waitkevicz, 1996). Providers are perceived as encouraging when they express concern regarding support networks, including family and partners (Coalition for Lesbian and Gay Rights in Ontario, 1997; Matheison, 1998; O’Hanlan, 1998; Stevens, 1992; Zeidenstein, 1990). Young lesbian women have identified sexual assault counselling as a priority issue for health services (Lucas, 1992). Violence in lesbian relationships is beginning to be acknowledged (Boston Women’s Health Book Collective, 1992; DeMarco & Simkin, 1996; O’Hanlan, 1998; Vida, 1996; Waitkevicz, 1996).

Stereotyping by health care providers is not limited to sexuality concerns. Because same-sex orientation crosses all socioeconomic levels, ethnic, and cultural groups, abled and differently abled, women may be primarily identified by providers in a context other than that of sexual-orientation (Boston Women’s Health Book Collective, 1992; Stevens, 1992; White & Martinez, 1997). An awareness of the need to regard women holistically (Boston Women’s Health Book Collective, 1992; Lucas, 1992) cannot be overstated. In fact, one source recommended that educators regard all women as lesbian unless otherwise specified (Degan & Waitkevicz as cited in Jones, 1988). In order to provide the respect that is sought in a lesbian supportive provider, health care providers must reflect on their knowledge base of same-sex issues and awareness of communication strategies (Coalition for Lesbian and Gay Rights in Ontario, 1997; Lehmann et al., 1998; Matheison, 1998; Ramsay, 1994; Robertson, 1992; Trippet & Bain, 1992).

Determining which providers are lesbian positive has been demonstrated to be difficult. Several sources mentioned informal listings and networks of “out” lesbian physicians and
counsellors (Boston Women’s Health Book Collective, 1992; Clunis & Green, 1995; DeMarco & Simkin, 1996; White & Martinez, 1997).

In an attempt to seek more supportive health care, it has been noted in a number of sources that nontraditional or alternative providers may be used (Trippet & Bain, 1992; O’Hanlan, 1998; White & Martinez, 1997). A holistic orientation in lesbian health (Buenting, 1992; Lucas, 1992) was noted, which appeared to be another reason for contacts with nontraditional providers. Alternative providers, including herbal and natural therapies, creative visualization, biofeedback, and massage have been described as supportive nontraditional options (Boston Women’s Health Book Collective, 1992; Lucas, 1992).

In addition to interactions with health care providers, lesbians have identified that institutional practices contribute to fears and negative health experiences (Boston Women’s Health Book Collective, 1992; Canadian AIDS Society, 1992; Coalition for Lesbian and Gay Rights in Ontario, 1997; O’Hanlan, 1998; C. O’Brien et al., 1993; Simkin, 1997; Simpson, 1994; Stevens, 1992; White & Martinez, 1997). Stevens (1992), in her review of the literature, found that

institutional structures and policies . . . inhibited lesbians’ access to health care services, including those that denied visitation and involvement of lesbians’ significant others, located women’s preventive health services exclusively in birth control and obstetrical clinics, ignored outreach to lesbian communities, and inhibited lesbian nurses and physicians from coming out. (p. 113)

Olesker & Walsh (1984), as researchers who are nurse-midwives in the United States, note that the best source of education is the lesbian community itself. They suggest looking “beyond the traditional medical literature . . . to the good base of information in the underground press” (p. 326). Kenney & Tash (1992) encourage providers to attend gay and lesbian workshops.
Lesbian health issues continue to be marginalized by health care professionals, many of whom remain unaware of their role in facilitating culturally-sensitive environments for this population.

**Lesbian Parenting**

Despite the lesbian baby boom in the 1980s, which the lesbian community itself has recognized (Clunis & Green, 1995; Lucas, 1992; Zeidenstein, 1990), lesbian pregnancy and parenting have remained largely invisible within society (Asten, 1997; Kenney & Tash, 1992; Nelson, 1996). This is ironic, considering that many lesbians move closest to mainstream culture by the childbearing experience (Boggis, 1996).

It is estimated that about one third of the lesbians in the United States are mothers (Hall as cited in Olesker & Walsh, 1984), although it is difficult to know how this number was gauged, as the diversity of parenting arrangements within the lesbian community may involve invisible coparents and bisexual parents who contribute to this population (Abbey & O’Reilly, 1998). Penny Simkin (1997) quotes statistics from The Lesbian and Gay Parenting Handbook (1993) that indicate that “six to fourteen million children in the United States are estimated to have at least one gay parent” (p. 6).

Lesbian parenting arrangements have changed over time. Olesker and Walsh (1984) note that, “until recently, most lesbians conceived and gave birth while in a heterosexual marriage. In the past three to five years, however, increasing numbers of lesbians chose to become pregnant outside the traditional heterosexual family structure” (p. 322). Kenney and Tash (1992) indicate that the number of lesbian couples choosing to bear children has increased. Zeidenstein (1990) confirmed that the “fastest growing family type in the United States is the female single-headed household, and this is where lesbian families are statistically hidden” (p. 17).

The variety of lesbian expectant and parenting families include: blended families, adoptive lesbian couples, and those who choose donor insemination (DI) or heterosexual
intercourse within the lesbian relationship (Abbey & O'Reilly, 1998; Buenting, 1992; Clunis & Green, 1995; Nelson, 1996;). My focus will be on issues which affect the expectant lesbian couple, although the literature reflects experiences from diverse lesbian families.

Lesbians often feel the need to justify their motives for pregnancy to themselves and others, in an attempt to defend themselves against stereotypes which exclude lesbian parenting (Asten, 1997; Boston Women’s Health Book Collective, 1992; Hanscombe & Forster, 1981; Harvey et al., 1989; Nelson, 1996), despite their insistence that it is a right (Nelson, 1996).

Nelson (1996) describes the phenomenon of lesbian mothers who are "consciously reproductive" in Canada today as potential parents who must scrutinize pregnancy and parenting issues closely in their decision to parent in a homophobic environment. Clunis and Green (1995) strongly encourage lesbian couples to consider other options which may fulfil their parenting urge, like coaching or volunteer work, instead of threatening the lesbian relationship with childbearing concerns. Considerations for planning of the pregnancy include insemination issues, discussion of role determination, that is, who will be chosen to be the birth mother (Kenney & Tash, 1992; Nelson, 1996; Simkin, 1997), as well as support systems (Nelson, 1996).

Access to AI using a known or unknown sperm donor has increased the options for lesbian women in control of pregnancy planning (Buenting, 1992; Johnson et al., 1981). However, there continue to be barriers. These include locating health care providers supportive of their decision, and prohibitive costs (Kenney & Tash, 1992; Nelson, 1996). Lesbian communities have developed support groups and publications to assist lesbian women in artificial insemination and childbearing (Boston Women’s Health Book Collective, 1992; Buenting, 1992; Vida, 1996; White and Martinez, 1997; Zeidenstein, 1990).

Health care providers are considered lesbian positive and supportive when they do not assume heterosexuality. However, lesbian pregnancy is often overlooked as a consideration for the “single” lesbian who is considering pregnancy. Awareness of stereotypes which are relevant
to the expectant lesbian couple experience and actions perceived as supportive have been described, as have disclosure issues.

Gender-neutral language is considered essential for health providers in order to demonstrate respect for sexual orientation considerations. However, when two lesbian women are involved in a pregnancy or parenting relationship, the issue of language has other implications. In fact there is a range of preferred terms for the “mothers” involved in an expectant lesbian relationship: “co-parent,” “co-mother,” “othermother,” (Clunis & Green, 1995, p. 42) and “partner” which can vary over time and reflect societal status, or power imbalance even within the lesbian relationship itself (Clunis & Green). As well, the couple may anticipate concerns for language that the child would use for each parent—which may indicate the child’s preference in parents (Nelson, 1996).

This potential power imbalance between lesbian parents is paradoxical in view of the evidence that points to the egalitarian nature of sharing of tasks and flexibility within the relationship (Arnup, 1998; Asten, 1997; Epstein, 1993; Nelson, 1996; Olesker & Walsh, 1984). Lesbian parents offer a “challenge to sexism, providing positive role models for children . . . lesbians have shown amazing adaptability, flexibility, and responsiveness in creating families” (Clunis & Green, 1995, p.15).

Nelson (1996) identifies the culture of motherhood which permits mothers an authority—which includes knowledge and power—that is the only legitimate authority that women have traditionally been allowed in Western society (p. 99). This has a potential impact on shared lesbian mothering in which one partner is the biological mother. Aldrich (1994), in her study of “stepfamilies,” indicates that birth mothers must surrender their sole authority over children and partners must establish identities as parents in order for partners to achieve parenthood.

Several factors influence the lesbian parent’s relationships. When the baby arrives, breastfeeding can be a major stressor. “Breastfeeding was seen as the time when the difference
between the biological and non-biological parent was most marked" (Epstein, 1993, p. 20). Nursing concerns may be precipitated by involvement of both partners in the process (Epstein, 1993; Simkin, 1997). "The non-biological mother can use a supplemental nursing system with breastmilk or formula" (Clunis & Green, 1995, p. 182). She may also offer nonnutritive suckling which may enhance the bonding between them (Epstein, 1993; Simkin, 1997). The available literature on breastfeeding lesbian women, although limited, indicates an interest and commitment to breastfeeding experience (Clunis & Green, 1995; Harvey et al., 1989; Kenney & Tash, 1992).

Recognizing the importance of relationship concerns which are common to both heterosexual and same-sex relationships is often overlooked, although some are exclusive to same-sex relationships. Jealousy, with the focus on the expectant biological partner (Clunis & Green, 1995; Simkin, 1997), and arrival of the new baby, shifts in roles and role definition, as well as conflict in parenting styles (Clunis & Green, 1995; Simkin, 1997; Vida, 1996) are all frequent occurrences. However with diverse and often less traditionally defined gender roles found within lesbian partnerships, parenting may require an extra effort to maintain effective communication (Asten, 1997; Epstein, 1993). Awareness that abusive relationships in a lesbian parent family are possible despite the egalitarian potential of same-sex relationships is important (Boggis, 1996).

To complicate matters, the lesbian parent family may also include ex-partners, and a complex array of relationships (Asten, 1997; Clunis & Green, 1995). A formal or informal parenting arrangement with the biological father (Asten, 1997; Clunis & Green, 1995) or the male (possibly biologically related to one of the coparents) who contributed to the pregnancy in an alternative insemination process may be included.

This has implications for the nonbiological lesbian coparent whose parenting role may be discounted by coworkers (Clunis & Green, 1995; Kenney & Tash, 1992; Simkin, 1997), even if
she has disclosed her lesbian parenting status. She may also be denied maternity benefits and/or parental leave for bereavement or parenting reasons (DeMarco & Simkin, 1996). Identification by health care and education providers of a primary parent can upset the prearranged coparenting arrangement, and many providers will assume a male associated with the household is the “father.” Nelson (1996) indicates that the potential rejection of lesbian status by those in the community forces selective disclosure to others, and this limits authority-sharing within the family. When parenting has occurred by adoption or through step-parent arrangements, coparenting issues may be perceived to be more egalitarian (Clunis & Green, 1995), although Asten’s (1997) study noted that the coparent’s role varied considerably throughout the family experience.

There is evidence to indicate that support systems which are traditionally available to parents in a heterosexual relationship, like grandparents and community parenting groups, may not be available for lesbian parents (Clunis & Green, 1995; Epstein, 1993; Kenney & Tash, 1992; Nelson, 1996). Disclosure of same-sex orientation to potential grandparents is often avoided if there is a risk of perceived negativity. Even if these potential grandparents have accepted the same-sex relationship to some degree, the news that the coupling is producing a child, by whatever means, adoption or birthing, brings no guarantees of support for the couple (Asten, 1997; Clunis & Green, 1995; Nelson, 1996). There may be an ongoing struggle for recognition of the legitimacy of the nonbiological parent by the extended family (Epstein, 1993). It is difficult to know just how supportive grandparents can be if they have not come to terms with their daughter’s lesbianism (Asten, 1997). Because family and friends rarely expect a lesbian couple to have children, that decision is rarely greeted positively according to Nelson (1996). This is reminiscent of the reaction to disclosure of lesbian status itself, and supports its low societal status. Rodriguez (1991), however, indicates that families of origin could be quite supportive, and Steeno (1998) notes that those lesbian mothers who live in smaller communities
may relate or communicate better within their families.

Friends, both homosexual and heterosexual, may become lesbian families’ primary extended family, although whether this is related to conflict around the lesbian issue or to geographic considerations of the extended family is unclear (Nelson, 1996). Kenney and Tash (1992) emphasize the effort needed to find acceptance in both groups. Steeno (1998) indicates that lesbian mothers have relied on socialization and activism as a means of coping with life stressors. Kellogg (1998) describes specific strategies which reflect lesbian feminist social practices to facilitate family adjustment and mainstream acceptance of their parenting. These include support groups in which analytical dialogue focuses on personal and political issues, use of birth teams, and original ceremonies to celebrate relationship commitments.

There is often an even greater reliance on a network of lesbian friends in order to deal with the demands of parenting within the lesbian relationship (Boston Women’s Health Book Collective, 1992; Clunis & Green, 1995), although the literature suggests that lesbian mothers often receive more support from their cohabiting partners in child care and household duties than other couples, straight or gay (Clunis & Green, 1995; DiLapi, 1989; Patterson, 1997).

Despite their positive view of lesbian parenting, Clunis and Green (1995) stress that “not all lesbians in the community understand or support this need to parent possibly because dealing with pregnancy is a relatively new phenomenon in the lesbian community” (p. 166). Nelson (1996) notes that pregnancy can symbolize an affirmation of the couple’s commitment to each other. This is important when language for heterosexual relationships and societal institutions ignore the lesbian experience. In this way, some in the lesbian community celebrate lesbian parents as pioneers in publicly establishing their relationship.

However, when a lesbian couple becomes pregnant, others perceive this as increasing the invisibility of the lesbian couple relationship because of the assumption of heterosexuality inherent in pregnancy and parenting. Asten (1997) notes that “only certain aspects of lesbian
families are supported by the lesbian community while other facets remain unacknowledged and ignored” (p. 126), although this is not elaborated upon. In choosing to bear a child, the lesbian community may “oppose the decision and withdraw their support for fear that the lesbian couple will reduce political activism [and] favor friendships with heterosexual mothers, thus weakening the solidarity of their association with the gay community” (Kenney & Tash, 1992, p. 213).

Boggis (1996) stresses that “lesbian institutions, regardless of the professed and certainly politically correct support of lesbians’ right to choose, have little in their structure to support family life--events and organizations for gay people still presume childlessness in their planning and design” (p. 57). Although lesbian mothers may find their own needs for affirmation and positive support met within the lesbian community, their children may encounter only hostility or indifference (Neuman, 1998).

Formal support groups for lesbian parents within the lesbian community are available in some locations; however this information may not be available to lesbian parents who are not affiliated with the local community (Olesker & Walsh, 1984), who are isolated by geographic location, or who do not self-identify as “lesbians,” but who share issues with those who do. Support may be found in a women’s group which is open to the diversity of the lesbian experience (Asten, 1997).

Lesbian families are unique in that the support offered to them as parents often depends entirely on the parents’ sexual orientation (Asten, 1997). Nelson (1996) observes that many of the challenges for lesbian couples with a child can be traced to lack of acknowledgement of the couple as a family by society.

DiLapi (1989) developed a model to demonstrate the value society gives to mothers. She noted that one’s placement in the hierarchy is determined by one’s sexual orientation and family status. However, Nelson (1996) explains that the regard accorded mothers in a patriarchal society is also based in terms of a “woman’s emotional and relational proximity to, or her intimacy with,
a middle-class white male” (p. 136). According to this model, lesbian mothers are considered least appropriate when compared with heterosexual women or those marginalized by disability or culture. Differently abled lesbians or lesbians of colour may have even more difficulty being accepted by society or even their own community when they decide to bear and raise a child (Boston Women’s Health Book Collective, 1992). Asten (1997) also stresses that society does not respect children or childhood, and that has a bearing on the oppression of the mother role.

The negative stereotypes that persist around gay and lesbian parenthood have been disputed (Patterson, 1997), yet access to resources which deal with pregnancy and parenting issues for lesbians is limited. “The structure of mandated programs and services, coupled in the [health] sector with continued discretionary powers over the determination of eligibility [for determining resources and service], forces many helping professionals into a “power over” role that reinforces this hierarchy of deservedness” (Labonte, 1990, p. 64). Mainstream institutions (i.e., social service agencies, medical facilities, and legal systems) offer lesbians limited access to reproductive rights and maternal health services (DiLapi, 1989; Waitkevicz, 1996).

Midwifery services in Ontario may offer lesbians access to supportive maternity care (DeMarco & Simkin, 1996; Ford, 1993; Shroff, 1997; Van Wagner, 1988). Because midwives may be more likely than traditional birth attendants to offer the option of a home birth setting, and it may be easier to control the factors that promote a lesbian-positive environment there, midwives may offer another advantage for childbearing lesbian women (Clunis & Green, 1995; Van Wagner, 1988; White & Martinez, 1997). As midwives deal with normal, “low-risk” births, they may normalize birth for a woman who feels defined by a societal label, especially if she is marginalized by it (Ford, 1993).

Prenatal class education support varies with the comfort of the group and facilitator (Clunis & Green, 1995; Olesker & Walsh, 1984). “The more these folks [the other parents and instructor] are uncomfortable with a pregnant lesbian, the more outside support you will need
from friends and family” (Clunis & Green, 1995, p. 172).

Prenatal, childbirth education, or birthing classes were mentioned in several sources (Boggis, 1996; Clunis & Green, 1995; Harvey et al., 1989; Kenney & Tash, 1992; Martinez, 1997; Olesker & Walsh, 1984; Zeidenstein, 1990). However, specific descriptions of classes varied, making comparison difficult. Descriptions included “couple-oriented” (Olesker & Walsh, 1984) and “all-hetero” (Boggis, 1996). Olesker & Walsh (1984) noted “that the classes attract and then tend to be geared toward middle-class couples in fairly typical lifestyles” (p. 325). Zeidenstein (1990) mentioned classes that referred to “homebirth,” which is not considered a mainstream choice, but which is associated with midwifery (Kenney & Tash, 1992; Van Wagner, 1988).

Although a high percentage of lesbians studied in several surveys (Harvey et al., 1989; Olesker & Walsh, 1984; Nelson, 1996) attended childbirth classes, often none of the lesbian couples felt comfortable disclosing same-sex orientation within the class or with the educator. As such, they “were perceived and accepted as single mothers” (Kenney & Tash, 1992; Olesker & Walsh, 1984).

The decision to assimilate into traditional classes affects the experience. In one of the few Canadian studies, Nelson (1996) noted that couples who attended prenatal classes were received “with enthusiasm and friendliness from the instructors and often from the other participants” (p. 63). It has been previously demonstrated that how lesbians identify themselves to others varies with the context and their comfort level with lesbianism and anticipated reaction to disclosure.

The invisibility of the nonbiological mother in class settings has been noted to be a difficult issue for lesbian couples because some, but not all, concerns that fathers have are also relevant to the coparent. The coparent issue presents difficulty for couples who attend classes which separate male and female parents for discussion (Dundas, 1999; Nelson, 1996).
Clunis and Green (1995) and Enkin et al. (1991) emphasize that the goal of birth preparation classes is to give the pregnant couple confidence and knowledge. Couples who remain closeted and are perceived as single may experience “discomfort along with denial of self” (Kenney & Tash, 1992).

Simkin (1997) notes that expectant lesbian parents may be unique in the case of lesbians who lack information about the birth process because they are virgins. As well, at different stages of a woman’s life, she could be the biological mother of one child and the coparent of another (Epstein, 1993; Olesker & Walsh, 1984). There are implications for caregivers and educators who may offer information based on stereotypes and assumptions.

Hospitals tend to be slow moving in their acceptance of lesbian couples as legitimate families, and the nonpregnant parent may not be accepted fully (Clunis & Green, 1995; Trippet & Bain, 1993). Encouraging health care providers who recognize and respect both lesbian women facilitate positive birthing experiences (Clunis & Green, 1995; Nelson, 1996; Simkin, 1997; Zeidenstein, 1990).

There may be a tendency for lesbians to access nonmedical providers of care rather than risk negative response with disclosure of same-sex orientation (Harvey et al., 1989; Kenney & Tash, 1992; O’Hanlan, 1998; Olesker & Walsh, 1984; Trippet & Bain, 1993). In the maternity area this may include doulas, homeopaths, acupuncture, aromatherapy, and chiropractors. Midwives are named as alternative providers in some references (Harvey et al., 1989; Olesker & Walsh, 1984). If a women is considered to be in a high-risk category during pregnancy, she may have limitations imposed on her choice of provider or place of birth (Kenny & Tash, 1992; Neilans, 1992; Van Wagner, 1988; Zeidenstein, 1990).

When pregnancy is discussed in the available literature for lesbians, it is often discussed with respect to decision-making and guidelines for becoming pregnant. However, Lucas (1992) notes that in her survey of health care preferences of lesbians surveyed, none indicated that
obstetrical services were desired, although pregnancy counselling, pregnancy confirmation, and artificial insemination were chosen by a minority of the sample studied. She surmises that lesbians may perceive the need for a broader based form of care, and indicates that previous negative experiences with obstetricians and gynecologists could account for this. This conclusion is consistent with studies that indicate that lesbian women frequently experience homophobia with traditional care providers and seek alternative health care instead (Kenny & Tash, 1992; Trippet & Bain, 1992).

Buenting (1992) remarks on the fact that several lesbians in her study had previously been pregnant and had either terminated the pregnancy or had had full-term pregnancies. Few studies indicate the pregnancy history of the women sampled, which limits the information available to health care providers about factors influencing the decision to carry a pregnancy to term. There are implications for educators in terms of offering information and services relevant to the lesbian woman.

The positive tone of many of the anecdotes shared by women in lesbian parent resource books may reflect an often identified feminist perspective of the authors and narrators of the stories told (Epstein, 1993; White & Martinez, 1997). Whether this reflects all lesbian experiences is doubtful. There is a diversity of experience (Arnup, 1998; Asten, 1997; Boston Women’s Health Book Collective, 1992; DeMarco & Simkin, 1996; Patterson, 1997) across lesbian communities which may not be reflected by the over 25, white, upper-income, monogamous, and generally healthier than heterosexual who is often surveyed (Waitkevicz, 1996, p. 93).

Even within the lesbian community, lesbians can be marginalized in other ways as an ethnic minority (Boston Women’s Health Book Collective, 1992; Clunis & Green, 1995; Shogan, 1993; Vida, 1996; White & Martinez, 1997), or disabled lesbian (Boston Women’s Health Book Collective, 1992; Clunis & Green, 1995; Shogan, 1993; Vida, 1996).
In order to support informed choice for lesbians regarding parenting issues, educators and health care providers must acknowledge lesbian women as a legitimate group which is involved in pregnancy and parenting issues from a unique perspective. Addressing the barriers which limit access of lesbian women to relevant information within the health care system and those which restrict educators' and providers' knowledge regarding meaningful and supportive care is crucial to this issue. Recognizing the many ways in which knowledge is created and respecting the diverse ways in which needs for support and education are fulfilled will support the development of inclusive, caring communities.

**Summary of Literature Reviewed**

The literature offers implications for childbirth and parenting educators for providing care to expectant lesbian communities.

An understanding of sociopolitical influences on education is essential to appreciate how knowledge is produced and valued in a democratic society in which individual rights are regarded as important. The heterosexist and homophobic underpinnings of our dominant culture are discussed with regard to society's legitimation of heterosexual culture in its reproduction of institutional values that focus on more traditional family structures which value male-female relationships.

Perpetuation of stigma through marginalization and exclusion of diverse lesbian perspectives has been discussed with respect to access to knowledge and resources for both lesbian couples and often well-intentioned mainstream educators--with resulting limits in choices available to both. Acknowledgement of lesbian parenthood and its potential invisibility are paramount in order to facilitate a supportive environment for lesbian couples. Expanding educators' knowledge of lesbian issues and allocating sufficient resources increases the likelihood of appropriate support for couples.

Understanding diversity within the lesbian population, and the complex family systems
and dynamics that face lesbians who choose to parent, promotes acceptance. Sensitivity regarding coparent relationships and concerns, prenatally and after the baby arrives, as well as the use of supportive language and communication strategies, are encouraged. Respecting the lesbian parent’s (or parents’) desire for maintaining confidentiality, if that is desired, and advocating for her (or them) within the systems which ignore or reject her (or them), can be an important role for the health care provider.

Identifying and addressing barriers to undertaking research which respects lesbian culture is paramount in order to increase the knowledge base of lesbian health issues and hence, improve the quality of care available to all women. An understanding of the complex factors which promote inclusive, caring environments necessitates communication of mainstream educators with the lesbian community, alternative health providers, and underground networks. This collaboration could facilitate identification of meaningful strategies which meet expectant lesbian women’s needs.

Research on lesbian health issues which accurately reflects the prevalence of lesbian priorities regarding pregnancy and parenting issues is limited. Heterosexist values permeate societal institutions and limit access to and knowledge of lesbian health issues. In order to determine appropriate programming for pregnant lesbian women and their families, more information is required. In the meantime, health care providers who can provide support and advocacy for expectant lesbian women are needed.
CHAPTER THREE: RESEARCH METHODOLOGY

Introduction and Overview of the Chapter

The literature has provided insight into the unique educational needs of expectant lesbian couples. Disinviting interactions with health care providers, institutions, and communities have contributed to the invisibility of lesbian childbearing in mainstream reproductive health, which is perceived by the lesbian community to be heterosexist in its approach to education. Despite an increasing volume of published information on expectant lesbians’ priorities for education which include coparent concerns, choice of health care provider, disclosure issues, support systems, and accessibility of health, education, legal, and social resources, public health educators often remain unaware of these needs.

This study explored one expectant lesbian couple’s perspectives of educational issues in order to increase educators’ insight into how childbearing lesbian women access inviting support, with a goal of enabling community care in a public health context. In this chapter I will briefly explain the feminist ethnographic methodology which provided a context for the case study of one childbearing lesbian couple. I will explain the methods used, how the participants were selected, and the ways in which the proposed methods were modified in favour of a case study approach. Both the assumptions of this approach and limitations encountered will be noted. The process of collecting, recording, and processing of the data will follow. Thematic analysis of the narrative findings and interpretation of these in relation to the theoretical literature will be described as they provide support or diverge from the literature base.

Research Methodology

This study process reflects the principles of feminist ethnographic research in which there is a focus on relations of power as they constitute and are produced within the research context. My primary consideration was that this was research “for” lesbian women as opposed to research
"about" lesbian women (Harding, 1987): that it reflected the participants’ perspectives and participation in the process in a way that might contribute to improving their everyday lives and those of other women considering childbearing. This ethnographic dialogue was premised on processes that were congruent with doing-with invitational processes (Purkey & Novak, 1996) in which the collaboration of participants and researcher and the positionality of all are valued as they contribute to the interactions.

As such, this feminist participatory perspective can be construed as a form of advocacy and action (Lather, 1992): the very undertaking of the study, of asking the questions, is considered political in its aim to make visible and give a voice to those who have less opportunity to be heard as a consequence of oppressive power structures (Abbey & O’Reilly, 1998; Asten, 1997; Kirby & McKenna, 1989; Shogan, 1993). This political stance seeks to name, and therefore legitimize, the issues raised through the research venue.

The positionality of those participating in the study is a principal concern. The social context and nature of the information shared by the participants are an important component of the meaning attributed to significant events in their lives. As well, how the researcher is situated in the study foregrounds the historical and cultural contexts which shape researchers’ preconceptions and thus how the issues within the study affect both the researcher and participants.

This study emerged from my position as a public health nurse involved in childbearing education. Although my original premise was to become more aware of what information was relevant to childbearing lesbian women, and processes that would be deemed supportive of this, as the study progressed I realized that examining my own heterosexist assumptions was a key piece of understanding the deeply entrenched barriers to enabling such educational processes. So, despite my realization on a cognitive level that this study was addressing systemic heterosexism,
there was an emotional component to this research process which linked my personal and professional “selves” in a way I had not anticipated.

The focus on reflexivity is a hallmark of ethnographic feminist work which values the research process as one in which meaning-making is a priority, but which is not exclusively the domain of the participants. Instead, ongoing self-reflection is a valued contribution to the research process. This calls attention to researcher bias (McMillan & Schumacher, 1997) or conceptual baggage (Kirby & McKenna, 1989): the motivations, understandings, and context of interactions which shape the decisions, analysis, interpretations, and presentation of the both the process and findings.

The feminist attention to relations of power sets priorities for a study process in which there is a respect for participant choice throughout the process, an awareness of potential for the researcher to impose meanings in ways contrary to those of the participants (hence anticipating how to minimize this), as well as an accountability to the participants in terms of how they are represented and the information is used. All of these qualities are compatible with invitational endeavours.

**Methodological Assumptions and Limitations**

This study has been premised on a view that knowledge is socially constructed and that relations of power inform knowledge claims. There is a recognition of the multiple nature of realities, and the particular, contextual character of ethnographic research. Ethnographic and feminist approaches value and honour everyday lived experiences which mirror larger cultural, political, and social relations (Abbey & O’Reilly, 1998; Kirby & McKenna, 1989; McMillan & Schumacher, 1997; D.E. Smith, 1999; Shogan, 1993)

As a public health nurse with limited connections to the lesbian communities, my access to participants who fit the study criteria was limited. The majority of research studies which have
addressed expectant lesbian women’s perspectives have interviewed or surveyed single lesbian women or couples at some point postpartum, often many years after the birth. The potential difficulty in locating lesbian women within the specified geographic area who were pregnant, prepared to disclose their lesbian status, willing to participate, and who could conceivably participate in a group setting (couple interview) with the implications for sharing potentially personal issues has shaped the study design. In fact, one premise upon which I planned for a focus group of key informants in the proposed study was that my tenuous connections to the lesbian community might limit the availability of participants. Since several researchers (Asten, 1997; Nelson, 1996) had identified that lesbian women might hesitate to become involved in research unless the researcher self-identified as lesbian, I was particularly sensitive to such concerns.

A case study design was chosen. In order to locate couples who had not yet given birth, I chose to focus on developing connections with diverse community providers of care including midwives and women’s centers. Reviewing my journal entries, it is evident that despite my links as public health nurse to potential community contacts, my limited personal affiliations to the lesbian communities as a nonlesbian/bi-identified researcher prompted phone contacts with many community providers of care in an effort to locate potential participants and understand some of the issues. However, Fiona Nelson (1996), herself lesbian identified, described her inability to connect with childbearing lesbian women for her study of childbearing lesbian women for quite a period of time until her first participants linked her to others by word of mouth. In both of these cases we were working in communities in which conditions for advocacy could be very different from those in large cities where lesbian family supports are openly available.

Since the literature had indicated the barriers to disclosure, and as a nurse with extensive experience in individual and group interactions, I was particularly aware of the need to develop trust within such relationships, as well as provide an environment which maintained
confidentiality. I paid particular attention to my use of language, and frequently sought feedback from the participants regarding the understanding of how the process was proceeding.

**Research Design and Methods**

In order to gain insight into the educational needs of expectant lesbian women as they perceived them, a qualitative research design was chosen. There is a gap in the literature with respect to identifying educational strategies that would facilitate educational support for childbearing lesbian women. A case study design was appropriate given the exploratory nature of such a study. However, there were several other reasons for such a design.

The barriers to undertaking lesbian health research in view of dominant homophobic societal values have been documented by many researchers (Coalition for Lesbian and Gay Rights in Ontario, 1997; Mathieson, 1998; O’Hanlan, 1998; Stevens, 1992; Waitkevicz, 1996; White & Martinez, 1997). Ethnographic interviewing of lesbian childbearing couples seemed apt for gaining insight into daily experiences of childbearing lesbian women and ways in which they constructed meanings through their educational interactions. In this way, the complexity of issues could be recognized, sensitivity to issues of disclosure and identity respected, as well as meaningful connections with childbearing lesbian women established.

This is a descriptive, exploratory case study of one expectant lesbian couple, each of whom has birthed as biological mother and coparent in this relationship. Two couple interviews, one prenatally and one postnatally were completed. The second was scheduled 4-8 weeks postpartum to facilitate data collection relevant to the delivery and early postpartum periods. One visit to the couple’s home was scheduled towards the end of the couple’s second pregnancy, and another 2 months postpartum. In-depth open-ended interviews based on interview guides were chosen in order to obtain thick descriptions and rich data of everyday experiences. Demographic information describing the participants was obtained to clarify the context of the study and inform their social location.
Because of the particular, contextual, and emergent nature of the case study design and the need to ensure the trustworthiness of the findings, I addressed three issues in the design: validity, disciplined subjectivity, and extension of findings (McMillan & Schumacher, 1997. p. 404) which may ensure transferability, credibility, dependability, and confirmability (Lincoln & Guba, 1985). As Seidman (1998) notes, the goal of ethnographic research is to understand how the participants understand and make meaning of their experience (p. 17). Several techniques contributed to ensuring this occurred:

1. Triangulation by source and by time ensured consistency of data. Two childbearing women participated in each of two in-depth interviews. Each had birthed as coparent and biological mother in this relationship and shared their reflections of childbearing. Building in an initial and subsequent interview also contributed to internal consistency.

2. Prolonged contact with the research setting is recommended to enhance validity. My contacts with the participants, formal and informal, in this study context have spanned 18 months. Although the two interviews were 4 months apart, the continuing engagement with the couple through the period of thematic analysis was an important component of the participatory nature of this work. From that point, almost one year after the initial contact, the couple chose pseudonyms and stated their preference that they be involved only in the reading of the final presentation. As the document has become quite lengthy, a recent call to them indicated that they would prefer to read a summary of the work.

3. Interviewing was done to encourage the sharing of rich, detailed information with a goal of contextualizing the day-to-day experiences of this couple. Although the choice of the location for the interview was at the convenience and preference of the participants, the natural setting in their home environment with their children’s contributions reflects the daily reality of
their lived experiences in a way that a neutral setting in a more clinical atmosphere could not.

4. In order to respect the focus on meaning-making within this study and to ensure credibility of the data, I have used extensive verbatim accounts in the reporting of the findings. This contributes to confirmability of research process and also offers insight into the interactive nature of the reflective process. Because this was a group ethnographic dialogue, some of these excerpts include all participants and offer some indication of the flow of interaction and how the participants and researcher each contributed to the understandings and meaning-making within the dialogue.

5. In order to record data which reflected the attention to detail that I felt was warranted in this in-depth approach, audiotaping of the interviews was done, and the tapes were transcribed over several weeks. The participants appeared to feel quite comfortable with this; however, we were all conscious of the taping in a setting with young children. The recorder was turned on and off periodically as the couple took time to attend to the children’s needs, an important issue given these prolonged interviews. The couple felt that completing a longer second interview was preferable to attempting a third meeting when our chats overlapped with the children’s naps or bedtime. Because of the limited quality of parts of the initial taping, given our shifts within and to different rooms over time, I used a high-quality tape recorder with a microphone for the second meeting, and this improved the transcription. On several occasions during the interviews I had the opportunity to chat with the women individually as the other spoke on the phone or tended to the child(ren) upstairs, and either she or I would summarize the context of what we had shared with the partner when she returned.

6. Member checking through verbatim and thematic checks increases the credibility of the findings. Confirming my observations and interpretations as a researcher was ongoing during
the interviews and analysis stages. This occurred in several ways: During the postpartum interview I purposely rephrased questions asked at the initial interview, restated my interpretation of their experiences, and probed more deeply into particular issues raised. I personally delivered the transcribed verbatim transcripts to the couple’s home for their review and they returned them with clarifications and edits.

• I made a point of recording as well as possible the pauses, “ums” and phrases which were repeated as reflective sharing occurred. Devault (1990) has emphasized how the inclusion of such information in the accounts indicates a researcher awareness of the difficulty that women may have in finding language to describe experiences and the implications this may have for the inadequacy of the available language for women and the meanings they ascribe to their lives. It also denotes a researcher respect for the implications of power relations in the participant-researcher relationship in which “cleaning up the data” is a form of imposition of power by the researcher. The couple themselves, reading the verbatim narratives during member checking, requested that I delete and edit such information in order to facilitate coherent written accounts of the dialogue. However, on several occasions, when long pauses were particularly significant, I noted this in the transcript.

• In addition to member checking which prioritized the participant privilege to edit the verbatim findings, as well as sharing the verbatim accounts of the interviews with the couple, I sent them a listing of the themes that emerged from my analysis of the two revised transcripts. At that stage I felt comfortable with nine of these themes, but was having difficulty incorporating several other issues under thematic categories with the amount of overlap between categories. I briefly jotted down the issues that each thematic category addressed along with a few questions that had occurred to me as I read the
verbatim accounts, asking them to clarify the context of such statements. The couple returned the questions and listing by mail with their comments, and in addition to approving of the themes listed, offered suggestions for the phrasing of the final two themes. The participant language thus also influenced the thematic analysis.

7. An ongoing activity in the study was documentation in my personal research reflection journal. In this I recorded all contacts with participants, community agencies, as well as my personal reflections on this process. As will be described in a later section, this included both affective and process concerns, as the original study design was modified and I encountered issues related to both theoretical perspectives and the social context of working as an “outsider” from the lesbian community on this study topic.

8. The potential for extension of the findings was facilitated through the development of a conceptual framework grounded in the thematic analysis of the findings. The narrative findings are extremely valuable in themselves as they contribute to understandings of issues identified, feelings experienced, and strategies chosen by the participants. However, they are particular to the described context. By framing these particular experiences in terms of both existing theory and by offering a new understanding of concepts related to access, consequences of lack of access and future strategies through the substantive theory described in Chapter Five, further investigation of other such ethnographic dialogues are structured in a way that such particular cases may be understood, compared and contrasted, through the concepts that link them. Such abstraction is sensitive to the socio-political context, yet enhances the possibility of social action.

Ethical considerations were priorities throughout the study. Because of the nature of the research with human participants, approval was obtained from Brock University and Health Department ethics review committees (Appendixes A and B). In order to connect with expectant lesbian couples, I posted flyers describing the study geared to both childbearing couples and midwives (Appendixes C and D) with various community contacts, including midwifery
practices. In anticipation of a focus group of midwives, public health nursing services and community midwives were formally linked with a letter from the Community Support and Research Branch of the City of Hamilton and Regional Municipality of Hamilton Wentworth, Social and Public Health Services Division (Appendix E).

Given the sensitive nature of issues related to same-sex identity and the sharing of confidential information in couple interviews, establishing opportunities to develop trust with the participants was a priority. Although the study topic focused on prenatal education, I felt that structuring a postpartum interview into the study in addition to a prenatal meeting might provide an opportunity to reconnect with participants and build on the comfort or trust potentially built prenatally. In retrospect, since intranatal and postpartum issues are relevant to prenatal education, this second interview offered rich data. This could be attributed to both of the reasons cited: development of comfort and of trust, as well as the relevance of childbirth and postpartum experiences to the study topic.

In preparation for each of the prenatal and postnatal interviews, I prepared interview guides based on the literature (Appendixes F and G). I had originally planned to pilot these with key informants or lesbian mothers, but because of my limited connections with lesbian women at that stage of the process, I modified the guides slightly on the basis of issues which emerged through my contacts with various community advocates. These changes influenced my sensitivity to the language in the dialogues. Once the prenatal interview had been completed however, the postnatal focus did change somewhat based on my continued engagement with the literature. The postpartum guide included is the revised version. This will be discussed under data collection.

I had prepared a listing of lesbian-positive community resources in anticipation of the potential for issues related to either disclosure or couple conflict arising from sharing of information within the research dialogue. However, it was apparent during the first interview
that, not only was the couple better acquainted with the community resources for lesbian women than I was, but there appeared to be few resources that would have been available to address such issues in inviting ways.

This case study approach was not intended to offer generalizability; however, it has the potential to generate extension of the findings (McMillan & Schumacher, 1997, p. 412). In addition to the points listed above, the feminist ethnographic process, situating the findings in the social and historical context of the literature, and interpreting the findings with respect to theory can facilitate this process.

**Selection of Participants**

Participants were selected through purposeful convenience sampling of expectant lesbian couples who felt comfortable disclosing their lesbian couple status. I sought couples in which one partner was at any stage of pregnancy and the other would identify as the coparent (or use a similar partner term), and who would be comfortable participating in prenatal and postnatal interviews as a couple. In order to obtain potentially rich data, a decision was made to choose a small select sampling of expectant lesbian couples and (in the initial stages) caregivers. For feasibility reasons, I limited my search for participants to those who lived or worked in the Hamilton-Toronto region of Ontario.

This case study design of one lesbian childbearing couple emerged through the research process, although my original intent was to undertake a focus group of midwives in addition to two couple case studies with prenatal and postnatal interviews. There were several reasons that the original proposal was modified.

Linking with midwives to locate expectant lesbian couples seemed an appropriate approach with my few connections to the lesbian community, since the literature had confirmed
that midwives had often been care providers for lesbian women. I also connected with the local public health network and community resources in order to publicize my search for potential participants. Shortly after I had started posting information on my study in the community, I received a call from an expectant lesbian couple who lived in the local area. As it happened each of the partners in this couple had been involved in birthing as a biological mother and coparent within this relationship. They had a young son conceived through an alternative insemination process (AI), and the coparent within that pregnancy was now expecting a child through AI.

With the first prenatal contact, I discovered that these women were involved with both the midwifery and medical professions in a way that also provided insight usually offered by key informants. However, I made provision for carrying out the focus group, postponing it from the spring to the fall, given other commitments which delayed my contacts with these groups. There was midwifery support for participating in the focus group; however, given the considerable unpredictability and time commitment of midwifery work and on-call work schedules, it was suggested that I either consider aiming for 15 potential midwife participants or carry out a teleconference group interview. Based on my experiences with group facilitation and acknowledging my concern for the sensitive nature of this study, I felt that face-to-face contact was warranted for such communication. After discussion with my advisors, I decided to forego the midwifery focus group approach in this study context. I did continue to be in touch with individual midwives or other community contacts closely involved in lesbian childbearing at various times.

My original plan was to aim for interviews with two couples who could potentially offer insight into the diversity of childbearing lesbian experiences with respect to the impacts of
geographic location for women birthing in Hamilton or Toronto, and home birth versus hospital birth, while acknowledging the particular contexts of these experiences.

I did have several e-mail and phone contacts with a couple that resided in Toronto. At the initial contact, however, they cited fatigue as an important consideration for planning the prenatal interview. The couple and I agreed that in order to maintain confidentiality I would seek a public space for our meeting. Numerous delays in locating such a space resulted in a cancellation of the couple’s participation in the study. Once again they stressed the fatigue of midpregnancy as an issue. As they noted, as a mother I could empathize with the physical demands of pregnancy as well as the anticipated energy that this study participation could require.

As a result of the limited time frame for locating potentially interested and expectant couples, given the issues that have been documented, the participant couple was the one that was available and fit the criteria I sought. Since each woman had experienced biological motherhood and coparenting, this study was not only a prospective study of an expectant couple, but also an ex-post facto study of an expectant couple. That they could also offer insight into the childbearing professions, given their social locations, contributed to my decision to limit this study to two interviews with these women as a couple: one prenatal and one postnatal.

In order to maintain confidentiality as the couple requested, I have used the pseudonyms they chose for themselves and their sons. Although the participants at first suggested nonidentifying initials in place of their names, this seemed confusing and dehumanizing, so they came up with creative names. Readers acquainted with the lesbian culture may recognize the significance of the names chosen as those of women who have been celebrated in North American lesbian life. In keeping with the women’s preference for androgynous, culturally
significant names, their sons are identified by the surnames of two lesbian women.

Having been invited to participate in this couple’s lives and share in their reflections on intimate experiences of childbearing, I am indebted for their willingness to respect my requests for feedback and clarification along the way. I have certainly been welcomed into their home and family, and this has, in a large part, contributed to the dialogue we shared. It is no mean task, I can say as a mother, to commit to lengthy discussions of such a sensitive nature while juggling the demands of work inside and outside of the home, as well as those of very young children who were important participants. In fact, at times their vocal contributions highlighted the nature of our childbearing discussion in a way that clinical research environments cannot capture.

Sharon and Ellen demonstrated their mothering of Etheridge during these times together: caring for a youngster who is waking from a nap, playing in the backyard pool, or chatting and painting away while the tape recorder rolled. As well, they also negotiated the care of their newborn Lang as he nursed at the breast, cuddled, and fussed away. Their sons, then, were also very much a part of our dialogue. Certainly we reveled in the toddler’s antics, commiserated over the intensive work of raising young children, and shared some humorous moments along with the work of reflection. It was a delight to share such times with them.

Both women were involved in the dialogue for the most part, while they also managed the care of their child or children who were also present as we spoke. There was an informal atmosphere as the older child often played nearby and interacted with us all, the mothers comforted or nursed the baby, the dog watched the proceedings, and a mouse scurried by the dog dish.

Participants
These two women, Sharon and Ellen, have been involved in a couple relationship for 5 years. They are in their early 30s, describe themselves as white, middle-class, English-speaking, and feminists. They are professionally educated: one is a family physician and the other has participated in support and teaching capacities at the university. They reside in a large city of 400,000 people in southern Ontario and consider themselves 100% out in their lives as childbearing lesbian women.

At the time of the initial interview, the couple had conceived a male child, Etheridge, a year and a half old, through an alternative insemination process, and Ellen was the biological mother in that process. When I first met with the family, Sharon was 7 months pregnant, having conceived through AI. At the time of the postpartum interview, Lang, their second son, was 9 weeks of age, and Etheridge was almost 2.

**Data Collection, Recording, and Analysis**

As I have emphasized, the process of data collection in this qualitative study began with the first journal entry about reflections on this study shortly after I received approval from the institutional ethics committees. The collection and analysis of data have been intertwined, as have been my own interactions with study participants and the larger community as I became familiar with the study issues.

There is no question, however, that just as the preconceptual period of childbearing encompasses more than the immediate period before conception occurs, the nature of this study and my reflections on it include an examination of beliefs, attitudes, and experiences which have engaged my professional and personal lives over many years. I will first describe the process of collection and recording of data through direct contact with the participants and then share some
thoughts from my journal as they pertained to this process. Issues relevant to the analysis of data will follow.

**Prenatal and Postnatal Interview Processes**

My initial contact with one of the participants, Sharon, was by phone in response to my flyer which had been posted in the community. During that conversation she expressed interest in participating, I clarified the nature of the study, and we arranged for me to phone back within a couple of weeks to set up a meeting time. Within several weeks I had phoned to confirm that both women were receptive to participating in the couple interviews, and we arranged a time to meet at the couple’s home.

Because of the sensitive nature of the focus of study and the interactive process involved in the case study approach, I obtained informed consent (Appendix H) from participants after discussion of ethical considerations. This included an emphasis on confidentiality with all participants, participant review of, and opportunity to revise, transcribed discussion, and an opportunity for participants to obtain study findings. Since the participants considered themselves 100% out as lesbian women, their main precautions for confidentiality were with respect to using pseudonyms and protecting identifying information of those health care providers, friends, and institutions cited in the final version of the study.

At the time of the initial interview with the participants, they completed an information form (Appendix I) which offered demographic context for the study: date of birth, contact information, educational background, current occupation, and experiences of mothering. This latter information addressed the mothering role in this relationship (e.g., birth mother, coparent, the duration of this partnership relationship, and any previous parent role). I collected signed consents and information sheets, left a copy of the consent with the couple, and shortly before we
began our formal taping, offered them a token gift for participating, a voucher for a women's bookstore.

The prenatal and postnatal interviews had been scheduled at the participants' convenience at their home where they would be able to manage the care of their young child(ren) as we chatted. In total, the audiotaping yielded approximately 6 hours of couple interviews which were transcribed over several weeks and delivered to the participants for review. In addition to the tapes, I made journal notations about the context of the interviews shortly after each meeting with them.

In addition to these formalized and audiotaped meetings, we chatted briefly on several occasions by phone or had quick conversations when verbatim transcripts had been dropped off or during a quick visit with the couple shortly after their second son was born. At these times and during the taped conversations, we shared parenting issues as mothers or common ground working in the health care field. Information that was not taped was documented shortly after such informal contacts in my research journal. This information from interactions between the pre- and postnatal interviews was later transcribed and added to the verbatim transcripts for member checking with the postnatal transcript.

At the time of the first prenatal interview, Sharon was 7 months pregnant and the couple's toddler was active and chatting with us as we discussed the issues informally over pizza in the backyard. The interview process began with an establishment of day-to-day experiences of raising a young child and preparing for the arrival of a second.

This occurred through a fairly unstructured dialogue using for the most part open-ended questions (Seidman, 1998; Stevens, 1998) with two women who were committed to critical reflection and thoughtful consideration of strategies for surviving as childbearing women. In fact, at the end of the prenatal interview the participants both commented on how few questions I had
asked. The women themselves had carried the discussion, often through ideas that built upon a partner’s remark or response to an earlier point. Stevens (1998) remarked on how the lesbian women in her study were so articulate and eager to relate their stories of health care encounters that at times she listened for an hour without inserting follow-up questions (p. 81). However, at the end of the prenatal interview, I reviewed the subject areas I had anticipated would be issues, based on the literature, and most of these had emerged.

I believe that the couple’s comfort with their relationship, their openmindedness to the researcher positionality with regard to the research focus, their personal interest and commitment to this issue, and their ongoing analysis of their experiences were factors in how this interview proceeded. Issues which dominated this first dialogue were: disclosure related to available support and choices made in relation to pregnancy support, as well as those which focused on parenting.

The prenatal transcript which had been reviewed by the couple was returned to me and the revised transcript was used to begin an analysis of themes approximately one month before the second interview began. By the time of the postpartum interview 4 months after the first, we had shared more informal chats face to face or by phone, and this contributed to the focus and comfort level of that dialogue. As well, the relative proximity and emotional intensity of their second shared childbirth, just over 2 months postpartum, were important contexts to the issues shared. Having been privy to many prenatal and postpartum class sessions with parents, as well as having access to both adoptive and biological childbearing experiences myself, their emotional involvement with childbearing at this particular time in their lives resonated with the other interactions which focused on sharing of such intimate times in their lives.
I was influenced in this second interview by a focus on Freedman and Combs (1996) use of externalization of problems, a concept which they had based on White, Epston, and Tomm’s work, and which they found helpful in framing alternative or preferred realities in counseling contexts. Having established some understanding of their day-to-day realities through the sharing of the details of their interactions, I was interested in how the couple imagined alternative realities as childbearing lesbian women. Although I had asked open-ended questions and used probes during the first interview, midway through the 4-hour second conversation I began focusing on questions which prompted them to reflect on meaning of their concrete childbearing experiences and those which questioned how things might be different. A key feature of this discussion addressed their reflections on their privilege in relation to accessing support and the implications for other childbearing women with respect to their various privileges and disadvantages.

Because of the interactive nature of the couple interview with respect to participant review, I discussed use of pseudonyms with the women and they suggested nonidentifying initials. However, initials, and later pseudonyms, were not used in the transcripts until the second transcript had been revised. No other party had access to the information during that time. Working transcripts used initials and were stored in my home office. Computer files were copied and stored with original audiotapes and transcripts, both original and revised, in a locked filing cabinet in my home study. All material will be kept for 5 years and then destroyed.

**Personal Research Reflection Journal**

This journal captured the day-to-day or weekly notes that I have made through this research process. I will initially focus on some issues that pertained directly to the participants
and approaches chosen, and then those that emerged as personally relevant to the larger study context.

What seems to be apparent at this stage, almost 2 years after I began this journal, is my increasing comfort being visible and public with lesbian childbearing issues. Given the dominant negativity in discourses around lesbian childbearing and the conservative environment in which I reside, this has not been easy. The tremendous emotional turmoil that has been part of this work has contributed to an understanding of the realities of homophobia and heterosexism in a way that is on more than an intellectual level.

One aspect of undertaking this study which I had anticipated was the fact that as educators we are dealing with our own homophobia, whether straight or gay, female or male. My readings in the area of lesbian health and lesbian parenting had alerted me to the fact that my own discomforts and assumptions would have a bearing on the study process. However, I am uncertain that I was prepared for the depth of emotional rollercoaster within my personal and professional spheres. Understanding my own complicity in heterosexist practices from my situated experiences has been the point from which I have worked as I have engaged critically with the participants, community, study findings, and literature.

In addition to examining my own homophobia, an important part of understanding the social context of this study was learning more about the political context of working on a topic related to same-sex programming with potential implications for change in the public domain. I found myself becoming more politically aware of how change has occurred in various contexts for lesbian women.

Yet, there were many affirming moments. Locating two lesbian couples who were pregnant and living within the geographic region I had selected for locating participants—and
who were receptive to participating in the study—was encouraging under these circumstances. Adoptive and nonexpectant lesbian mothers also expressed interest. A variety of community contacts have affirmed the potential value of doing this work, while at times noting inherent difficulties. One in particular noted that she and I both had limitations connecting with respect to this study because her community is closed. However, she offered me an important insight through this discussion as I became quite aware that the public and private points of access were very relevant for me as an educator, as well as for the lesbian women who were seeking information on childbearing. This prompted me to consider the difficulty with which I accessed information myself—as a connection to the multiple layers of power relations in this research process: access issues for participants and as well for educators.

Heterosexual and lesbian communities alike may assume that given the well-documented stigma of such work, researchers are lesbian identified (Onken, 1998; Shroff, 1997). This undercurrent, and the stigmatization it incurs, would have been unlikely to have shaped research related to any other cultural group with so many influences on both my personal and public environments. Despite my limited connections with the lesbian community as I began this work, at times I have perceived much more support from lesbian women and their advocates than from the heterosexual community.

Yet, this process, too, piqued insight into the contradictory and fluid nature of subject positions that shape claimed and assumed identities, as well as privilege. Working in this area of lesbian health as a nonlesbian-identified woman prompted me to look deeper and more broadly into issues of alliance building and working across difference within communities, themes which contextualized this study analysis in a way that would not have occurred without these experiences or reflection.
Data Analysis

In order to locate themes within this ethnographic dialogue, I used Kirby and McKenna's (1989) approach to data analysis. The two transcribed verbatim interviews which had been revised after participant checks were scanned a total of four times during this thematic analysis.

I examined the revised transcripts for identification of descriptive narrative sections of information, phrases, or paragraphs which could be identified under a minitheme. These were then grouped under broader thematic categories and organized on cue-cards. During the final scan for themes, I colour-coded the working copy of the revised transcripts to ensure that all data had been accounted for under the themes.

Thematic categories which emerged were informed by my familiarity with the literature and theories, as well as communication with key informants throughout this study. At times narrative sections fit under several categories. For instance, biological mothering and coparenting experiences were broad themes under which other thematic issues could be labeled with several themes. However, given the nature of this narrative in which descriptions of the childbirth process were often detailed, I felt quite comfortable with such overlapping thematic categories.

Thematic analysis structured the presentation of the findings. After spending some time situating the findings in the context of related theoretical literature however, further analysis was warranted. In this step of the process I interpreted the themes in terms of underlying theory which offered an opportunity to develop concepts and frame them in terms of the theory base. The grounded nature of this process was congruent with a substantive theory developed from the categorized data (Kirby & McKenna, 1989). This will be discussed in Chapter Five.
CHAPTER FOUR: FINDINGS

Introduction

Despite the recognition that providing education and support for families has significant benefits in contemporary society, lesbian childbearing couples are bombarded with stigmatizing messages which exclude them from public support in a way that marks heterosexual couples as the only legitimate family relationship. Very recent changes to federal and provincial legislation acknowledge that lesbian families are entitled to benefits as common-law couples, yet public resources which are designed for childbearing women partnering with a woman are very limited. This study explored those educational needs perceived by expectant lesbian women in order to facilitate the development of inviting informational and community support for childbearing lesbian women.

Research Context

Ethnographic interviewing of two childbearing lesbian women in a couple relationship has focused on how they access, interpret, and act on information that is meaningful to their lives. With their experiences as professionals within the reproductive health systems, as well as mothers who each have birthed in capacities of biological mother and coparent, they offered their perceptions of changes which could contribute to a more supportive community for lesbian women.

Two interviews with a public health nurse researcher took place in the couple’s home in a large urban center within southern Ontario. One visit to the couple’s home was scheduled towards the end of the couple’s second pregnancy, and another 2 months postpartum. The initial interview was during the summer of 1999, and the second was 4 months later.

The sharing of information during these couple dialogues occurred as the participants
also cared for their young child(ren). Their toddler often contentedly coloured or hammered nearby and interacted with us all while his newborn brother nursed, fusses, and slept in his mothers’ arms. This contributed to a comfortable and conversational atmosphere which at times was interspersed with the vocalizations of the children whose everyday needs took precedence over the point of the moment.

**Participants**

At the time of the initial interview, the two women who agreed to be involved in the couple interviews had been together for 5 years. They had conceived a male child, Etheridge, 19 months old, through AI, and Ellen was the biological mother in that process. When I first met with the family, Sharon was 7 months pregnant, having conceived through AI. At the time of the postpartum interview, Lang, their second son, was 9 weeks of age, and Etheridge was 23 months old.

The particular experiences of these women who describe themselves as a white, professional, middle-class, English-speaking lesbian couple are related to their lives in which they are 100% out as a childbearing couple. They reside in a large city of 400,000 people in southern Ontario. Sharon is a family physician and a long-time resident of the city. Ellen is a professional in women’s health and has worked at the university in teaching and support capacities. She is currently home full-time with their sons.

**Findings**

I will report the findings of this study as they relate to the eight questions posed in the problem statement. After each question I will briefly present the relevant themes that emerged from the data and which applied to each question. Following this, I will summarize the 11 themes in an overall discussion section which incorporates a summary of thematic analysis and
introduces the theoretical framework which will be used to interpret these findings in the following chapter.

The study questions are presented as follows:

1. What are the day-to-day realities of these childbearing lesbian women?
2. What do these childbearing lesbian women identify as educational needs and effective support?
3. How do they access education and support that is relevant to their childbearing experiences?
4. What support is readily available?
5. What support is not readily available?
6. What support do they create themselves?
7. What impact does the decision to bear a child have on these lesbian women?
8. What inviting possibilities have they imagined for the future?

**Question 1: What are the day-to-day realities of these childbearing lesbian women?**

Ellen (to Etheridge): "Just over on the chair you can do it" (motioning to hammer). "How both of you are socialized as women contribute to make life different around parenting."

Etheridge (looking at Ellen): "Momma, Momma."

Ellen: "Women are socialized to be the caregivers, to do everything, to be the most nurturing, and here we have two great nurturers! So—how to negotiate around that."

Etheridge sits on the floor blissfully engrossed in play, looks over at Sharon, who is holding his baby brother, and offers Ellen the hammer.

Ellen: "He’s trading with me."
Sharon: “I know” (p. II-44).¹

I will describe aspects of this couple’s lives which speak to the emotional and behavioural realities of their childbearing experiences. In order to facilitate a sense of the interactive discussion during these interviews I have included substantial verbatim pieces of their narrative. In a later section I will expand on how they interpreted their interactions with individuals and caregivers in terms of support. Where appropriate, I have used subheadings to describe the particular time frame of the childbearing process under discussion: preconception, pregnancy, labour and delivery, and postpartum.

**Preconception**

For expectant lesbian couples, childbearing is often a planned and conscious process. Sharon and Ellen, after years of education, establishing themselves as professionals, travelling and renovating, chose to expand their family. Ellen notes that when she first disclosed as lesbian as a teen, she assumed for years that lesbians could not have children, although she had always thought she would love to have them—in fact perceived that disclosing her same-sex orientation effectively closed that avenue to her. She notes that something changed when she was in her mid-20s.

Even for these lesbian women who have close ties to women’s health resources and the lesbian community, expectant lesbian women are virtually invisible in this city, and so this couple speaks of the profound isolation that shapes their daily lives. As Ellen notes, “I don’t think there’s been more than one other lesbian besides you and me who have given birth at [this hospital]” (p. II-19).

As they considered having a child they occasionally spoke with other lesbian women

¹ To distinguish references to prenatal and postpartum interviews, I have assigned a Roman Numeral I to the prenatal interview and II to the postnatal interview. Page numbering is separate for each interview (e.g., citation from postnatal interview, page number three: (p. II-3).
about their experiences. Although Sharon and Ellen describe the local lesbian community as a small group in which there are about 10 women who have children through a male partnering, they also recognize the diversity of women who partner with another woman. They note that age, marital status, cultural, political and identity affiliations, and disclosure contribute to multiple situated lives of lesbian women who parent.

In their experience, by the time women have struggled with their lesbian identity and have formed relationships, they are older when the children arrive. However, they are aware that this is not the case for all lesbian women. They speak of one lesbian woman who had two children by the time she was 24, and is living with a gay man—raising the children together and also leading separate lives. So, although most of the lesbian parents they have met are over 25, Ellen states, “It wouldn’t be surprising to find lots of women pregnant with boyfriends, or who are still struggling with their sexuality, especially from the ages of 15 to 25, and I think you have a lot of grey-area people” (p. I-19). They are aware of women who are with a male for one night, and “lots of women [who] just come out later in life” (Ellen, p. I-25).

Their understanding from contacts with the Toronto community is that a number of women who identify as single are also involved in pregnancy through AI. As well, although they describe themselves as having a feminist analysis, they recognize that “there are lots of lesbians who are interested in having kids and [don’t consider themselves to be feminist]. They just don’t want to look at that aspect’” (Sharon, p. I-22).

As they reflect on the fact that statistics indicate that increasing numbers of lesbian women are birthing, but that they are not personally familiar with many expectant lesbian women locally, they surmise that a number of these women may not be identifying as lesbian or are overwhelmingly closeted. In fact, they have had a number of requests to provide support for
other expectant lesbian women, but few have contacted them.

The choice to disclose selectively, if at all, is related to the potentially punitive consequences of assuming the pervasive negative images of lesbian women—hence many women hesitate to self-identify. This invisibility contributes to stereotypes which mark lesbian women as child molesters and unfit parents. Sharon and Ellen experienced variable reactions from their families of origin when they chose to disclose as a couple.

It is also a common thought in terms of when you come out as a gay or lesbian they think, “Oh, you molest kids,” or that if you come out you are almost certain to lose access or custody to your children. It happened to Ellen in her own family. It happened once to me in my own family. My sister once said that she feels pretty good about my lesbianism now, and that she feels safe enough to let me bathe her girls. (Sharon, p. I-7)

Ellen notes that the raw sex promoted in the Gay Pride parade which is sensationalized by the media shapes the way her family reacted to their disclosure. Although she notes that the sexual element is part of the issue, for many lesbian families there is no other aspect of lesbian culture portrayed. The couple explains:

Ellen: “I was the evil one for quite a while . . .”

Sharon: “Ellen was the influencing one, and . . .”

Ellen: “And she [Sharon] was vulnerable” (p. I-4).

With this awareness of the risks of disclosure, Sharon remained closeted to her family and to all but a small group of friends until their first pregnancy.

**Pregnancy**

As they navigated through the AI process they found themselves faced with the possibility that after expending time and energy locating services that met their needs for
conception, pregnancy might not occur.

Even when we were discussing having him, I think that we were sixty-forty sure that we wanted to have kids, that we would undergo the process and see what it felt like, to not get pregnant or get pregnant every month. To get pregnant, the first time would have been an abrupt decision, but we did this when we started to see if I could get pregnant. We would see what we felt like, month to month. Were we really disappointed, or were we really relieved? We found out that the first month that we were earth-shatteringingly devastated! So, that’s what made us go from 60:40 to 90:10. (Ellen, p. I-19)

Both women were pregnant by the third month of AI, although they have four or five friends in lesbian relationships who have been trying to get pregnant for years. Each had spotting during early pregnancy, and Ellen also had emergency abdominal surgery at 7 months gestation when she was prepared to lose the baby.

**Labour and Delivery**

Yet after these problems, Ellen’s pregnancy went to term. They had chosen to have a home birth with midwifery caregivers, but after a really fast, hard labour, the baby was positioned such that they transferred her to hospital for a possible caesarean section. Instead, Ellen explains,

They introduced some suction and he came out in one big rush. We went home 3 to 4 hours later. We were home by 10 o’clock at night. It was great. The midwives came by at 8 o’clock in the morning and it was just a small blip in time when they had to leave. The transfer of care was to a resident and an obstetrician who were fabulous. She was considerate of Sharon. I don’t think we could have asked for more. Not a single solitary thing! (p. I-13)
Sharon planned to labour at home as long as possible before heading to hospital to deliver. The couple laboured together at home with midwifery support for 22 hours. At this point they agreed that a transfer to hospital which offered the options of the epidural and augmentation of labour contractions with intravenous medication would facilitate progress. After several hours of medication and sleep, she was able to participate in the delivery stage, rested and pain free—"natural," Ellen recalls, "I just instinctively picked him up and gave him a great big hug, and I gave him to Sharon!" (p. II-6).

**Postpartum**

For this couple, postpartum was a time of both joy and frustration—which they attribute partly to role issues.

Suddenly I'm a biological mother. I'm a stay-at-home mother. I've given up my career. Sharon is a provider, a financial provider, and a mother, but a nonbiological parent. It was just ridiculous. We both had totally new roles at the same time. (Ellen, I, p. 18)

Sharon and Ellen speak of parenting day-to-day in which they have a fair amount of role flexibility in the coparent/birth mother roles. Sharon attributes a biological basis to the difference in the way she mothers for the child she carried, as opposed to the cerebral way in which she acted as coparent for their first child.

I think I feel a lot more responsible for Lang than I did for Etheridge, around nourishing him, nurturing him, and around leaving him, that sort of thing. I think it's more related to the biology than it is to anything else. It was a different experience for me altogether, being the one going through the pregnancy, and delivering, and postpartum, and all that—not that I certainly wasn’t emotional during Etheridge’s birth and whatnot, but I wasn’t instinctive. (p. II-12)
Sharon continues,

I don’t feel like that our roles are very different. I think that we both share an awful lot. I don’t know if you measured it, you could say, well, ‘x, y, z.’ There are certain aspects of parenting Etheridge where Ellen has to take a much more of an active role, and much more of a nurturing role, for example around bedtime. That’s because Etheridge needs to go to sleep by breastfeeding, and he won’t breastfeed from me now.

Ellen: “He begged her for a year and half.”

Sharon: “To breastfeed. Well, as soon as I start lactating, he doesn’t want to have anything to do with it. Definitely. He’s very clear. That’s Lang’s.”

Ellen: “Although, Etheridge offers Lang to me all the time” (pp. II-14-15).

As well, Sharon describes Lang as a fussy baby, who has “periods of time during the day—mostly at night and in the evening—when he’s really uncomfortable, agitated. There’s nothing really you can do” (p. II-10). Her recollection of postpartum with their first child is influenced by the fact she was working after the first couple of weeks he was born, and then took a 2-month parental leave when he was 6 months old, at the end of her residency.

Ellen recalls that Etheridge had less frequent fussy periods at a similar age. She maintains that “he’s [Lang’s] not difficult. He’s somewhere between difficult and easy, don’t you think? Because difficult for me, is inconsolable, and he’s not. You just have to find the right thing, and he’s fine” (p. II-10). They each stress the other partner’s strengths in caring for the children.

Both women find that dealing with everyday questions consumes energy as they remain committed to being open about their lesbian family relationship. Ellen states,

It can be as simple as going to the grocery store and someone saying like, “He’s a
beautiful boy—what does your husband look like?” And I’m sure that most women who have gone through AI have the same struggle, but research shows most women lie, and most of these families never disclose to their children. They just pretend that they’re biological offspring of the male in the relationship. Well, we can’t pretend. So when someone asks me, “How tall is your husband?” 12 million issues come rising to the surface. Do I have the energy to deal with this right now? Do I not have the energy? Do I have the confidence? Am I willing to face their homophobia and hatred? A million things happen at the grocery store because there, or somewhere similar to that, someone asks you. (p. I-2)

Even with friends who share their interests and who may be lesbian themselves, they note that “it’s so new what we’re doing that they don’t even know the issues. It’s a matter of identifying them for them. They’re wonderful, but I feel like we spend all our time explaining our life” (Ellen, p. II-38).

However, there are times when their family relationship is validated in ways that feel good to them. They shared such a moment in the postpartum interview. Ellen explained, “Etheridge just this week learned to say mommy! We just about cried! I was taking him upstairs to bed at night and he said, ‘mommy’ and we both looked at each other!”

Sharon: “He could always say ‘momma,’ but not ‘mommy.’”

Ellen: “And he knows me as ‘mommy’ and her [Sharon] as ‘momma,’ but he only ever called us ‘momma’” (pp. II-29-30).

At this time in their lives, Etheridge has been attending a progressive nursery school program, and the couple’s time is focused on caring for the children. Both women are breastfeeding, are involved with family and friends, and are hoping to travel as they did when
Sharon was on parental leave with their first child.

**Thematic Summary for Question 1**

The daily life experiences of this couple reflect a number of themes which emerged from this ethnographic dialogue. Two themes, support and lack of support, perceived as inviting and disinventing messages from people, places, programs, processes, policies, and politics, influence all of these themes. However, for the purposes of this thematic summary they will not be described, but will be elaborated on in later sections.

- Biological mothering experiences
- Coparenting experiences.

These issues described by these two themes overlap in many ways. Throughout this section the participants related how their childbearing and coparenting experiences encompassed a number of time periods: the preconceptual, pregnancy, labour and delivery, and postpartum periods.

The participants' emotional and behavioural lives on a day-to-day basis were shaped by the decisions related to becoming an openly childbearing lesbian couple, the AI process, and their positive labour and delivery experiences. As well, they negotiated postpartum role adjustments through which they identified different ways of experiencing mothering as biological and nonbiological parents. Dealing with breastfeeding and infant care issues, and ongoing pressures to explain their lives as a lesbian family were continuing aspects of their daily lives. Validation by health care providers, acquaintances, and family with respect to their particular mothering roles and their lesbianism was important to them.

- Isolation
- Determination
• Strategies

The participants emphasized their sense of isolation as a lesbian couple openly birthing through the AI process in this city because of the lack of other visible lesbian women birthing in the same way. However, they described their determination to be open about their lesbian family and stressed the ongoing energy they must devote to locating support by educating those around them about issues they often encounter. Media stereotypes and the lack of accurate information about lesbian parenting shape the perceptions of their well-meaning lesbian friends, heterosexual individuals, and families of origin.

• Diversity of lesbian community.

This couple indicated that lesbian women are involved in diverse parenting forms. Through their connections with the local and Toronto lesbian communities they have discovered that many lesbian parents have partnered with a male in various ways, while others are choosing the AI route as single women. They identified that barriers to disclosure influence how lesbian women name themselves in this process and that a range of women who differ by age, culture, politics, and other variables are part of the communities. Although the participants identified this theme as “diversity of lesbian community,” they did address various “communities.” Throughout this discussion I will use diversity of lesbian community or communities as relevant.

**Question 2: What do these childbearing lesbian women identify as educational needs and effective support?**

When lesbian women identify needs for support and information for their childbearing, they do this in the context of how this support will protect their safety and validate their lives as childbearing lesbian women in the process.

For women consciously planning a pregnancy, issues relevant to the preconceptual period
are an important component of education. As this couple considered the possibility of childbearing, they required information which offered insight into the implications of choosing pregnancy and parenting in their lives.

Ellen: “We had discussions as a couple. Do we want to have children? It was not automatic. What do you think?”

Sharon: “I agree. We both wanted to have kids at some point. I don’t think we entered the relationship saying, ‘Oh, we would have children together’” (p. I-5).

As pregnancy in a lesbian relationship can be a contentious issue, both in the lesbian community and within the largely heterosexual community of parents, the participants described their need for information which would contribute to an informed decision-making process. This included the legal and ethical issues of using reproductive technologies in addition to the mechanics of assisted conception. “We both read the Royal Commission document on reproductive technology in Canada and this generated a list of questions about that” (Sharon, p. I-8). Issues could include AI resources: sperm donors and lesbian-positive care provider networks. Ellen described their decision to tap into the lesbian community network in Toronto for information. “We also talked to the Hassle Free clinic in Toronto and they gave us two or three pages of clinics: individual doctors’ names, and feedback on each of them” (p. I-9).

However, their need for support in terms of health care providers was also related to the priority they placed on safety. “We heard that the [hospital in Toronto] had a great reputation for being very lesbian positive, and we knew that [another] didn’t” (Ellen, p. I-9). They sought lesbian-positive care providers who were perceived to be inviting when they exhibited the following behaviours: The language used was inclusive of both partners and did not assume heterosexual relationships. However, when Sharon clarified that, although the language used in
interactions is an important indicator of whether the encounter is perceived as inviting, she emphasized, "It isn't a language thing. It's a matter of shifting the thinking, [the whole perspective]" (p. II-33). This includes an understanding of the perceived difficulties encountered by lesbian women as they interact with the health care system and a willingness to advocate for these women.

Sensitivity to disclosure issues is crucial. In fact, Ellen noted that a number of women come out later in life, and stressed that a fixed sexual orientation cannot be assumed. "There are lots of . . . single women, who are probably having children during their fertility years and are going to realize 5 years later, the reason that it wasn't that they didn't find the right man, it's just that they didn't want a man" (p. II-25).

Relevant information involves open discussion of birthing options and information around choice in childbearing which reflects an understanding of the impact of power within the health systems which can influence a favourable outcome—which for these women was equated with a safe outcome. Ellen stresses that "I feel like the safest place was at home . . . outside of all of the medical stuff" (p. II-18). As well, this includes information on noninstitutionalized birth and alternative care providers. Ellen notes that "there are so many variables for us that perhaps play a role in: Do we go to the hospital? Do we stay at home? And the risks, costs, benefits of both" (p. II-19).

For lesbian women the childbearing experience requires more than token acknowledgement or tolerance of partner and family in their interactions and inclusion of all family members—whether kin or extended family. Ellen described her perception of the obstetrician's involvement with Sharon, the coparent. "She was considerate of Sharon . . . . She made sure that Sharon was there to cut the cord" (p. I-13).
As well, for women involved in a shared lesbian parenting relationship, resources that do not reinforce the rigid stereotypes and individuals that respect alternatives to the nuclear family type in verbal and written ways offer inviting support. This would explicitly address issues relevant to coparents. The couple referred to how their midwife ensured that transfer of care to a physician included a mention of the partner’s involvement in the relationship. This was in contrast to feedback from heterosexual friends who attended a prenatal class in which they perceived the educator’s language to be very homophobic and stereotypical in her use of “Dr. this and Mr. that” (Ellen, p. II-45).

For families with children, instrumental support in the form of child care and lesbian-positive educational programs is essential. Sharon noted that with respect to their decision around day-care, “if it was about need, and not choice, some sort of caregiving experience for him that was different from the generic daycare in Hamilton would have been wonderful” (p. I-1). Ellen explained that they are “desperate for books that have female characters that are not just cooking, and aren’t in dresses” (p. II-27). Sharon added that even the most progressive place for preschool children locally has circle time about the nuclear family.

Providers deemed inviting indicate an awareness of lesbian-positive resources or a willingness to seek out more information. Inherent in their validation of lesbian family possibilities is a celebration of lesbian culture and respect for the diversity of lesbian women who share in these communities. A range of situated experiences of lesbian mothers has been described under Question 1.

Ellen considered how affirming it would be for schools, for example, to recognize these families in positive ways. “Imagine, if it was as easy as ring-a-ding-ding! I’m moving into Briar Park neighbourhood, and my kids are going to that school that totally celebrates me and my
partner!” (p. II-28). She noted that Gay Pride celebrations offer a range of validating experiences including a lesbian-oriented and family-oriented parade, but which has not been funded or publicized to the extent that the main parade has.

The issue of maintaining confidentiality in obtaining information and services was an important factor in their lives. For this couple, who considered themselves 100% out at the time of the birth of their first child, confidentiality was a priority during the preconceptual time and early pregnancy. Inviting support in this case is perceived as protecting identity in both written and verbal communication as well as offering relevant information which does not require disclosure of identifying information or same-sex orientation. Ellen indicated that “there are a lot of people who are closeted . . . because they’re uneasy, and they’re probably closeted to institutions” (p. II-41).

The women identified a priority for information that was relevant to their chosen childbearing process and recognized that meaningful support would include the experiential knowledge gained from sharing of experiences with women who had birthed in similar ways. Providing opportunities to share experiences—events, perceptions through networking—is essential to counter the isolation that childbearing lesbian women identify as all too common. “We are very involved in the [local lesbian] community and . . . we don’t have anyone else who we know went and got pregnant” (Ellen, p. I-20).

With their backgrounds in the medical field, the participants did not identify a personal need for information on nutrition or the labour and delivery process. However, they did maintain that childbearing lesbian women require access to that generic reproductive health information, as well as the psycho-social and political dimensions of childbearing. Providing support regarding decision-making around breastfeeding, partner roles and expectations, as well as
homophobic reaction from family and friends, are specific issues for lesbian partners.

Inviting support takes into account access issues. Although safety issues are paramount as they relate to all aspects of education perceived to be important to these lesbian women, they acknowledge that geographical accessibility, convenience, and cost are also important for women attempting to locate support. Ellen wondered: “Imagine being a lesbian in Red Lake . . . and you want a child. We’re in a city of 400,000 people” (p. II-26). Although they live within 45 minutes of Toronto, they described how the inviting resources there are essentially unavailable for them with two young children. “We just haven’t had time to go to the [Toronto drop-in]. It adds a lot . . . an hour each way . . . parking . . . two kids” (Sharon and Ellen, p. II-39). The prohibitive costs of purchasing sperm in an unregulated system, and expensive fertility medications which are not covered by health insurance also limit access to women for whom the financial aspect of conceiving is a factor.

As they shared their experiences, this couple alluded to the ways in which nonthreatening larger organizations affirmed visibility and voice for lesbian childbearing women through their policies and communications and in their accessibility of resources. This aspect will be further discussed in the section under future possibilities.

**Thematic Summary for Question 2**

The themes which emerged from the question of educational needs perceived by this lesbian couple focused on both the content and process of types of support perceived to be inviting.

- Support perceived as inviting people, places, programs, processes, policies, and politics
- Biological mothering experiences
- Coparent experiences
The priority for this couple was a need to locate supportive resources: those which would facilitate safety, validation, and celebration of lesbian mothering for both biological and nonbiological mothers. Once again, the stages of preconceptual through to postpartum time frames were noted as relevant to both of the childbearing and coparent roles.

Identified topics included informed decision-making, support networks, information on bio-psycho-social and political issues around pregnancy and parenting, as well as concerns about providers, individuals and organizations, which could communicate respect and sensitivity throughout this process. Needs for expectant mothering education and support were not limited to the prenatal period or even health parameters, but included day-care and a range of public educational institutions within the community.

- Diversity of lesbian community
- Public and private availability of information and support

Providers who were knowledgeable and who offered resources which acknowledge the diversity of lesbian parent community and which avoid stereotypical family structures might be deemed inviting. The participants emphasized the need for information to be conveyed in an inviting way in order for it to be considered a supportive interaction.

The participants acknowledged the diversity of lesbian parent community in their discussion of ways in which lesbian issues could become relevant to women as their partnerships change over time. Moreover, they noted that resources that had been deemed lesbian positive by others in the lesbian community were not always perceived to be inviting to them.

This couple indicated that relevant support might not be accessible to the range of women whose situated experiences vary in terms of issues of disclosure, cost, geographic location, or availability, without extensive knowledge of personal or professional networks. In their
acknowledgement of both safety and access issues, the participants stressed the scope of issues related to the provision of quality support.

**Question 3: How do they access education and support that is relevant to their childbearing experiences?**

It became evident that in order to meet these needs for information and support for their childbearing, the participants relied on various points of access to individuals and institutions within the community. There were four components to this access: perceived safety, privilege of situated lives, disclosure status, and the private or public availability of relevant information.

The participants described themselves as extremely privileged women: English speaking, white, well educated, middle class, with professional ties to both medical and midwifery communities. As well, on a personal level, they had a number of friends who were family doctors.

As women who were financially secure and who had the option of travelling to Toronto for services, this couple could tap into resources which were not locally accessible and which required private means of payment. They were familiar with medical terminology and reproductive health clinical resources. Sharon, as a physician, was familiar with the variety of mainstream health supports for childbearing women, and both were well acquainted with the midwifery system.

As out lesbians who had been active together in the local lesbian community for 5 years, they were acquainted with other childbearing lesbian women, all of whom had birthed in a heterosexual relationship. By virtue of their acceptance within this lesbian community, they could also seek out networking and informational support which quite possibly might not be shared publicly in order to protect the safety of individuals involved. As women who indicated
that they have a feminist analysis and who have worked professionally with women’s issues, their lesbian-positive network also included public organizations that were women focused, like women’s bookstores and women’s centers.

Their decision to be out 100% by the time of the birth of their first child meant that they had the opportunity to locate information and support as openly lesbian women. They were committed to making this a priority in their lives. Verbal or written disclosure to any providers of care would potentially offer them the kinds of meaningful material that they sought. Their situated lives then offered them professional and personal access to mainstream and academic information, as well as private underground resources that could be useful as they created their families.

However, even with their immense privilege and their pledge to remain out, they chose to access information in terms of whether they perceived it provided safety. As has been noted, this encompassed aspects of maintaining confidentiality, as well as how it validated their lives as lesbian women. As the participants considered their options for locating safety, they sought clues as to whether organizations and individuals invite or disinvite in their interactions, and therefore mark them as potentially safe spaces. Their reliance on a personal network with its access to professionals and lesbian community was dependent on others’ perceptions of inviting or disinviting interactions with these mainstream or alternative sources of support.

Public information on childbearing issues may be found through health and educational organizations, the media, and in community resource information sources which include the library systems and phone directories. Formal prenatal classes are considered a frequent source of reliable information for expectant couples.

The participants were also aware of one newspaper article on a childbearing lesbian
couple who birthed locally. This was published several years ago when this couple made news as the first area same-sex couple to register as parents. The article exuded a positive tone as the women described the immense support they had from family and friends with the birth of their daughter (Davy, 1995).

In order to access information about the alternative insemination process and donor sperm, the participants were familiar with local AI clinics as health professionals and feedback from the lesbian community. However, as they had selectively disclosed their lesbian status only to family members and the small local lesbian community, their need for confidentiality within the larger urban community necessitated access to other resources. Ellen used their personal and professional networks to locate lesbian-positive resources in Toronto.

With their many ties to educational and health organizations and involvement in the local lesbian community in a city of 400,000 people, it would be surprising that this couple had to expend vast amounts of energy locating information and supports that were meaningful to them. They reiterate that they feel isolated from other women who choose to become pregnant through AI.

Ellen maintained that to access information locally on lesbian childbearing, word of mouth is the only way. She and her partner have fielded several calls from medical and community colleagues who have referred women to them. To their knowledge, these women are closeted, and only one followed up to contact them.

It is evident that as couples sought support for their childbearing, several factors interacted to influence how they accessed relevant support: perceived safety of resources, privilege of situated lives, disclosure status, and public and private availability of support. The following section will describe what support these women found readily available.
Thematic Summary for Question 3

The themes which shape the question of how this couple located support are those which address the four components of access identified in this section: perceived safety of resources, privilege of situated lives, disclosure status, and public and private availability of support.

The eight themes that follow are related to the components of access as they interact:

- Strategies
- Determination
- Diversity of lesbian communities.
- Public or private availability of support
- Perceived inviting messages
- Perceived disinviting messages
- Coparent experiences
- Biological mothering experiences

This couple was very familiar with public resources and the health systems which offered reproductive health information because of their professional privilege as well as their familiarity with women’s issues as self-identified feminists. The level of privilege which offers private access to information and support available through the lesbian community networks is dependent on disclosure to self and others. Whether this occurs is related to how interactions between individuals and/or institutions are perceived as inviting or disinviting.

These women were highly privileged in terms of race, language, education, and class, with options of overcoming geographic and financial barriers, and access to professional, medical, alternative care provider, and lesbian networks, yet locating support still presented challenges for them. As openly lesbian childbearing women it took concerted effort on this
couple's part to find information and support through either public or private points of access: that which would maintain safety through confidentiality and validation of their childbearing.

Differences between geographically diverse lesbian communities in terms of how they provided resources for pregnancy and parenting became evident as the women experienced childbearing. Although this couple continued to find support from lesbians who are not mothers, they discovered various comfort levels with the issues of lesbian childbearing within their local community. This occurred through exclusion of either the biological mother or coparent or lack of support for couples with a male child. As well, there was some indication that a number of closeted women involved in childbearing might not be connecting with the organized lesbian community locally.

The last two themes relate to the consequences of attempts to locate support:

- Isolation
- Impact on their lives as childbearing women

The lack of relevant information or support for lesbian childbearing located by this couple through public venues reinforced feelings of isolation from other families who were experiencing pregnancy and childbearing. As well, the limited support within the lesbian community locally for expectant women or those with young children distanced them from those on whom they previously relied for support.

**Question 4: What support is readily available?**

As these women sought information through their personal and professional networks they tapped into both public mainstream resources and informal networks which were available to them as part of the lesbian community. These interactions with individuals and organizations can be systematically described in terms of people, places, processes, programs, policies, and
politics. Support that was found to be available to these women was that in which interactions were inviting—and which they perceived promoted safety, validation, and/or celebration in their childbearing lives.

Even as the women located support in the inviting messages, there were aspects of situations that offered mixed messages—those that were both inviting and disinviting. This presented potential barriers. As well, the personal support available to this couple was very much related to the efforts they made to make choices that would support them.

**People**

**Preconception.** Preconceptually they found inviting individuals in the lesbian community’s support for their childbearing. The participants were encouraged in their journey by “experienced older lesbians saying to us, ‘You are so lucky that you have different choices . . . . don’t have to be with a male partner to experience pregnancy’” (Ellen, p. I-8). In the small community there were older lesbians with teenage kids, “10 of them at least with whom [they] all share society’s judgement, . . . hatred and oppression” (Ellen, p. I-21), and they noted this was inviting at times.

Health care providers also offered inviting messages. Their family doctor was very supportive. In fact, they mentioned that if she had been involved with deliveries, they would have considered that route, but there was no role for her except to provide a physical exam. As they looked for a practitioner who could provide the authority to offer donor sperm through a clinic process (as they had decided for safety reasons). Ellen contacted a colleague, a lesbian physician, “who was practising in Toronto, and asked her what she was doing to assist lesbians who want to have children. She said that she didn’t have a clue” (p. I-9). However, she followed up with a search on their behalf and recommended the physician who provided AI support for
both pregnancies. That this specialist was personally inviting as well as offering significant support to childbearing lesbian women was positive: “20% of her work is with lesbians within the AI population” (Sharon, p. I-10).

**Pregnancy.** When Sharon made a decision to disclose her couple relationship to the larger community, Ellen was expecting their first child. Ellen commented,

Your peer group was extremely supportive. Sometimes I wonder if that was because at the same time you came out to them, I was pregnant, and many of their partners were pregnant? I think in a way it normalized us, since we were all reproducing at the same time. (p. I-4)

Sharon remarked that her work environment was inviting, and she attributed this to the progressive workplace, as well as the accepting colleagues there. “I am in family medicine. There are public health nurses, plus the staff there. Everyone is great, wonderful to myself and Ellen. It’s unique. I don’t know whether it is just because there is inherent power in my position. Regardless, it still feels wonderful” (p. I-2).

As we, the couple and I, reflected on their lives as a lesbian couple, Sharon and Ellen often provided positive comments to each other and expressed their desire to be inviting with each other. When speaking about postpartum, Ellen remarked to Sharon, “Things I feel strongly about: If you think it’s happening I need to support you 100%” (p. II-36).

Over the years their families of origin have been sources of both inviting and disinviting messages. Currently Ellen’s family has been fairly involved with them, and in fact her siblings were visiting when Sharon was in labour. Her parents (grandparents to their children) accompanied them on a vacation south a few months after Lang was born.

**Labour and Delivery.** In order to facilitate an atmosphere at home in which the couple
could focus on the labour process, they required instrumental support to assist with the care of their 19-month-old son. The friends who provided this support had spent time with him weekly during the summer. Ellen recounted the ways in which they helped.

We called some friends of ours. We had a system set up where they were prepared—they went out and bought cell phones—and they were prepared at any moment.

Somewhere in there our friends came over that night around 6. And they were spectacular! 'Cause they just took over Etheridge, and when I needed to put Etheridge to bed [breastfeeding], Zena, one of the women who was here, stayed with Sharon, and Chandra ran the house—so everything was a 10 out of 10. (pp. II-2-3)

Sharon and Ellen agreed that the health care providers involved with their labours and deliveries were all inviting. “We had a good team both times and they were very respectful, decent, and wonderful” (Ellen, p. II-19). One midwife was involved with both labours at home and in the hospital along with the medical staff who were involved to provide medical interventions, and a second midwife provided support each time as well.

Throughout the childbearing experience they noted that their midwives advocated for them, as other professionals were involved with statements like, “Oh, her partner’s name is Ellen, and she’s a woman.’ And that’s a closed door comment” (Ellen, p. II-21). In fact, at some point during each of their pregnancies the participants were referred to a high-risk physician. In each case the midwife appeared to have some say in how that referral was made.

For the birth of their first child, they related that:

The transfer of care [in hospital] was to a resident and an obstetrician who were fabulous.

We both knew the resident which was just a fluke . . . . She was considerate of Sharon.

They made sure that when he came out (the obstetrician who we never met before
because the hospital was just amalgamated, so she was new to our hospital) . . . she made sure that Sharon was there to cut the cord and they were great! I don’t think we could have asked for more. Not a single solitary thing. (Ellen, p. II-13)

As Sharon laboured at home with their second child, Lin, the midwife, offered honest feedback, reassurance, and was both available and present for most of the labour at home and in hospital. At one point she spent time teaching Ellen how to administer the midnight dose of antibiotics, but at the same time “lectured them” about roles. “So, Lin gave me all this lesson about this and that: Sharon as a doctor, Sharon as a mother, Sharon as a patient, didn’t we . . . (laughing)—remember?” (Ellen, p. II-2).

Ellen speaks of how present Lin was—involved personally in offering support at home—“So now, she [Sharon] was in labour for 22 hours, and the pain is getting really bad, so we spent the rest of the night, Sharon and I, and Lin, lying on the bed, labouring, all three of us (laughing)” (Ellen, p. II-3).

Sharon stressed that,

She was always reassuring, and I think Ellen spoke to her at one point and said, “She needs to hear that the baby’s okay.” Lin spoke directly to that with me and said, “[Look], home is no place for this if you’re feeling insecure.” And I said, “You know, Lin, I feel that everything’s fine, but my thoughts take right over, and I worry. I think it’s because of what I know.” And she said, “That’s probably what’s holding you back, in terms of relaxing you enough to dilate more than 3-4 cm.” “So,” she said, “Let’s go into the hospital and we’ll go from there. You’ll go quick[ly].” And so she was right. She’s had a lot more experience at this than I have. (p. II-12)

In hospital, Lin continued to provide personal labour support, even with the involvement
of medical staff. Sharon recalls, “Although, she stayed. We both fell asleep, but she stayed. She did the oxytocin. She did my IV. She had a lot of paperwork to do. She didn’t leave my side. She was absolutely wonderful! Just wonderful” (p. II-5).

At the delivery itself, Ellen describes how their midwives, friends, and son were all present.

They had brought Etheridge in, so Etheridge was there and they brought toys for him. There was both of our midwives, both of us, Etheridge, and our two friends. We had cameras, we had arranged and taught them our camera, bought film, and so the incredible thing, was she [Sharon] was so happy! She was so—no pain! This is kinda neat! This is exciting! I’m conscious, I’m rested, and I don’t hurt! (p. II-5)

The birth was an extraordinary experience for the couple.

Sharon: “Lin just took her time. She left him at the perineum—just to restitute for—it felt like a minute!”

Ellen: “His head was out for a long time and I was looking at him!”

Sharon:

His eyes opened up. His hands were right over his face. He was wriggling his fingers. His eyes were opening, and he would kind of do this … (motioning) and you could see his brow and the little wrinkles . . . . It was incredible! And she left him there, just to restitute . . . . and she said, “Can you move down a little bit?”—in the middle of that—he’s right there restituting, and I’m moving down a little bit! It was incredible!

Judy: “Like slow motion!”

Sharon: “It was slow motion.”

Ellen:
It was slow motion! I had my face down there rubbing his hair and cheeks, and kissing him. We didn’t know if it was a boy or girl, or if he had five legs or whatever—for the longest time. Just sort of hung there. (p. II-6)

They celebrated with champagne and pizza.

**Postpartum.** Ellen noted that they “had a great deal of support [from the lesbian community]—the first week he was born—and that was it” (p. I-22). Their midwives came to the house postpartum.

Ellen made a point of calling her parents when Sharon went into labour and again when he was born. The whole family made a 4-hour drive 2 days later. “I think that my father was quite touched that we gave Lang his name: my last name” (Ellen, p. II-35).

Most of their close friends are lesbian couples. “We do have a couple of close heterosexual couples, but they’ve basically got kids as well, so in terms of . . . we have their support. We definitely have their support” (Sharon, p. II-37).

At times family and friends indicate their acceptance of the family in their comments about their children. Ellen remarked,

Your sister or both my sisters say things like, “He’s so cute, but he looks so much like Ellen. He doesn’t look anything like Sharon.” Because they forget he’s not our shared biological child, and it’s kind of nice, because they see us as this family and they forget the gene pool didn’t get so mixed. (p. I-15)

**Places**

When discussing places that invite, the participants often referred to Toronto. Because there are so many visible childbearing lesbian women there, they note that it is organized. Ellen learned from an acquaintance that it was:
very clear that growing up in Toronto their children knew tons of kids, AI kids. It’s a very common experience, that one woman was saying, for her children to know children born from AI, children who [have] gay fathers who are donors, who are gay men, who are in their lives. She was saying that down the street there’s so and so next door. (p. I-23)

The visibility of lesbian families, in their diversity, is considered supportive as it publicly validates for both the parents and children their family structure.

The gay and lesbian communities have a number of well-known resources in Toronto. In their search for information on AI, the couple “talked to the Hassle Free Clinic in Toronto and they gave us two or three pages of clinics: individual doctors’ names and feedback on each of them” (Ellen p. I-9). As well, certain hospitals and clinic facilities had reputations for being lesbian positive. Their chosen AI clinic was inviting in the information on donor selection. “They provided a lot more information about their donors. They also used Canadian donors and . . . we were looking for cultural diversity . . . Sharon has some native background” (Ellen, pp. I-10-11; II-7).

Processes

The process of labour and delivery for these women was inviting in many ways. From Ellen’s perspective, one of the crucial elements in facilitating a positive birth experience was that Sharon had access to an epidural in a hospital setting. “It was the most beautiful birth! I couldn’t have fairy-taled it any better from the point she got the epidural, because, you (to Sharon) were so present, (Sharon, nodding, ‘um hum’) and keen and awake and comfortable” (p. II-5).

Ellen, herself, experienced a very painful birth. She had taken steps to avoid hospitalization, although she realized that this limited her options for pain management.
Although these women anticipated encountering disinviting homophobic experiences in the hospital setting, Ellen emphasized that,

I don’t think we could have asked for more. Not a single solitary thing . . . I would have liked to stay at home by a roaring fire. Because we had to go to the hospital, it was still as good as it could get! (p. I-13). We had a positive hospital experience both times . . . . There was never once, that I can recall, a hint of homophobia or anything but utter respect, support, professionalism. (Ellen, p. II-18)

The process of disclosing as a lesbian family, as birth mother and as coparent, was an essential priority for this couple. Sharon’s work environment was a place that accepted and celebrated their family relationships. Ellen notes that those involved had an opportunity to get to know Sharon before she disclosed that her partner was expecting. “I don’t think it was there until you arrived. Everyone liked you so much that they had to make a choice—either to support you or not” (p. I-3).

Programs

Locally this couple found some personal support within the lesbian community at a lesbian moms’ group, but they noted that all of these mothers had children from heterosexual relationships. “We’ve been to a few seminars and stuff” (Ellen, p. I-21).

The 519 Church Street Community Centre in downtown Toronto provides organized programming for the lesbian community. There is a drop-in for lesbian parents from Monday to Friday (p. II-39) and there are other social options for same-sex families.

Policies

The hospital policy which encouraged family involvement during the labour and delivery process was perceived as inviting for this couple. Policies which offered inclusive access, for
example AI resources which openly offered service to lesbian and single women, were perceived as positive. Inviting informal policies were those that facilitated access to care through professional and institutional practices based on philosophies which promoted informed choice, facilitated disclosure, and maintained confidentiality.

**Politics**

The couple observed that recent legislation which amended laws to confer common-law status on them has been perceived as inviting, since same-sex couples receive same benefits as other couples.

The privileges that shaped this couple’s perceived status in the community have been an issue in their interactions. Ellen stresses that, “the only thing that could have been better is if we were rich, and I was a doctor” (p. II-23).

It is difficult to pinpoint just what support was readily available to this childbearing lesbian couple. Much depended on their willingness to disclose and risk—as well as their available networks of professional and personal resources. As well, their determination in making informed choices about how to find supportive individuals and create inviting environments likely influenced the amount of support available to them.

**Thematic Summary for Question 4**

The following themes were dominant throughout this section:

- Support perceived as inviting people, places, programs, processes, policies, and politics
- Coparent experiences
- Biological mothering experiences

Other themes described in less detail included:

- Determination
• Strategies
• Public and private availability of support
• Childbearing as a turning point in their lives
• Diversity of lesbian communities.

Inviting support was framed in terms of people, places, programs, policies, processes, and politics. It thus validated, celebrated, and offered safety for the participants. This support was described in various ways: advocacy, instrumental support, honest feedback, reassurance, and respect. Those who encouraged informed choice, and demonstrated nonjudgemental support for the couple’s decisions, searched on their behalf for information, and who facilitated access to choices which might otherwise have been unavailable, like epidural options, were perceived as positive. Positive interactions with people and institutions and processes were those which facilitated disclosure, maintained confidentiality when appropriate, and demonstrated an equal valuing of each mothering partner in their relationship. The participants valued those who respected their less stereotyped roles within families.

The couple received lesbian-positive support from a range of people: family members, lesbian women, mothers and nonmothers, heterosexual mothers, and friends, as well as health care providers. In all cases, the couple was out to those who provided support. Each mother indicated that she received tremendous support from her partner. Even their oldest child validated them as mothers in the way he differentiated them in his use of “momma” and “mommy.”

Places which were characterized by the above descriptors were deemed positive. However, the participants emphasized that the ways in which the diversity of lesbian parenting is both visible and organized within Toronto is publicly validating. The positive experiences within
both home and institutional birth settings fostered an optimism within them that influenced how future decisions would be made.

The process of becoming a lesbian family was inviting in the ways this was validated and celebrated in the above ways. However, the joy of sharing mothering experiences together while challenging traditional role stereotypes was positive in itself. Resources which were inclusive in an acknowledgment of diversity in many ways included AI donor services which offered options for cultural or racial variation.

Institutional policies perceived to be inviting to this couple included those which permitted access to the childbearing process in a way which respected both the biological and nonbiological mothers and their lesbian family as legitimate. AI policies and the hospital policy which encouraged family-centered care and informed choice in childbearing were inviting.

Inviting politics were those in which the power dynamics facilitated supportive care. As the couple noted with respect to disclosure and positive birth experiences, the power inherent in the couple’s professional status and other aspects of their situated privilege may have influenced the positive reaction from others to their disclosure in the workplace and hospital settings. As well, the status of the midwives within the hospital and reproductive health systems may have been factors in the couple’s interactions within the institutional birth setting.

Through their acceptance within the lesbian community, the couple had access to AI and other resources through lesbian-positive networks which offered them privileged information. In addition, with their feminist analysis of the power dynamics involved in their lives as lesbian women, the participants had a power to name the structural influences that shaped their childbearing experiences. Recent spousal legislation was perceived as affirming.

The couple’s determination to make the childbearing process inviting to both the
biological mother and coparent was evident through their extensive planning strategies. This was made possible because of the couple’s private access to support through the lesbian community and Toronto networks, as well as their extensive knowledge base of childbearing systems and professional contacts who were also part of a private access to information.

The theme which described childbearing as a turning point in the lives of the women was noted. It was childbearing which forced a decision for the couple to disclose as a lesbian family. A number of individuals and environments became supportive or continued to be perceived as positive within this context. As will be discussed in a later section, the process of childbearing itself was inviting in the ways in which the women individually and collectively derived meaning from their experiences.

The diversity of lesbian community was described as lesbian parents or lesbians without children who shared their perspectives and friendships, providing social support.

**Question 6: What support is not readily available?**

Although the participants found support in a variety of ways, they also faced disinviting messages from both individuals and environments. Even those interactions which included some forms of support were at times perceived to be mixed with irrelevant information or negativity. The participants identified barriers to accessing information in relation to people, places, processes, programs, policies, and politics.

**People**

Many well-intentioned individuals were unintentionally disinviting. Ellen described her network of friends:

I spend my time with other extremely privileged white, upper-middle-class, heterosexual women, which is fine on the one hand, and difficult in many other ways. They don’t have
a clue about the upward struggle we have in life. I find with these other moms, we all have children that bond, but there is a huge part of me and my family that is missing from those interactions. But I really find it hard to consider giving up those contacts because the pluses of that don’t outweigh the negatives. It’s hard to spend time with other moms who have so much privilege. They don’t have to fight for recognition of family and partner. They don’t have to struggle to adopt their children. People are continually asking questions. “How are your baby?” and “How’s Sharon’s pregnancy?” They don’t have any concept of the fact that these children are ours. So at times, I find it overwhelming, this sense of profound isolation and oppression that we have, and that although these women are extremely nice, . . . and positive parents, they’re not in any way, very conscious, I don’t think, or aware of our upward struggle, every day, that we’re surviving. (p. I-2) Ellen recognizes that her sensitivity to remarks can play a part in the interaction as well. People say, “Which one of you is his mother?” And we’ve struggled with the answer. Sometimes I say that I am not, that Sharon isn’t, but I know they’re asking which one of us pushed him out. It’s hard because sometimes people ask innocent questions. But it’s such a laden question for us about family identification, that it’s so easy for me to take it the wrong way. She didn’t mean any harm and neither did you, but society ostracizes us so much from our selves and our families. It’s easy to take things in my opinion a little harder, maybe than are meant. (p. II-15)

Again, it is the lack of awareness which is perceived as disinviting.

Even when individuals attempt to demonstrate that they are caring, they can be unintentionally disinviting by their exclusion of the coparent. Sharon notes that,

I came out to my family [in my] mid-20s, and initially they were great, but then this stuff
around homophobia came forward, which was a struggle, and in lots of ways, Ellen got the brunt of it, because there are a lot of stages that families go through. (p. I-4)

For these women partnering in childbearing this attitude has been especially noticeable with Sharon’s family during her pregnancy and delivery.

[My mother] sees herself as being supportive of me. Ellen does not believe my mother sees this pregnancy including Ellen. It is in the language my mother uses. For example, “Sharon, what are you going to name your baby?” She’s not feeling like this is actually anyone’s baby but mine, meaning mine and my mother’s. (Sharon, p. I-22)

As professionals in the health care field the participants have insight into health care providers’ frequent discomfort with sexual orientation issues. Much of their energy early in the pregnancy was devoted to circumventing the possibility of disinviting messages from providers. Sharon, a physician herself, stresses, “I’ve worked with the nurses and I know that most of them are reasonable human beings. But I don’t know how they would necessarily be when encountering two lesbians” (p. II-21).

They emphasize that childbearing women who are marginalized in other ways in addition to their same-sex orientation are likely at increased risk of receiving disinviting messages. “Well, God forbid that you’re a single lesbian having a baby, or that you’re a black lesbian having a baby! I mean, you don’t even want to go there!” (Ellen, p. II-23). In fact, they perceive that teenagers would be so focused on disclosure issues at that stage of their lives, that survival and day-to-day living would be the priority. They do not feel that many teens would be both comfortable with same-sex orientation and ready to consider a pregnancy—although admit that a number could be struggling with both concerns.

Having the power to choose care providers that the couple knew personally and
professionally were lesbian positive, but also would provide labour and birth support in the home setting, conferred a semblance of control over the labour and delivery process. However, a major factor in Sharon’s decision of when she would be willing to go to the hospital after 22 hours at home in labour was when her admission would coincide with the hospital shift change—in order to minimize the number of providers involved. After an exhausting period of labour with slow progress, she made a conscious decision that she would head to hospital despite the fact that the shift had not yet changed.

Both Sharon and Ellen are strong supporters of midwifery. However, they note that, “Not all midwives are lesbian positive . . . . It’s all circumstantial again” (p. II-22). With close ties to midwives as an educator, Ellen has had the opportunity to discover that many are conservative in their views on the family.

Sharon experienced a great deal of support in her workplace when she shared the news that she was part of a childbearing family. This was in contrast to her colleague, who’s a lesbian and wants to have kids, but knows as soon as she gets pregnant, she will be observed and judged by colleagues she works with at the hospital . . . . She’s trying to become more out, but as she becomes more out, she’s finding that people are more homophobic. (Sharon, p. I-2)

Although the participants attribute the vast majority of disinviting messages to homophobic stigma, the diversity of stances on childbearing within lesbian communities has contributed to feelings of isolation for these women within their own networks. As coparent to Etheridge and as an expectant mother, Sharon received contradictory messages from those in the lesbian community—although she has been active in this community for years.

There are people, [lesbian] colleagues, friends, acquaintances, that won’t even address
the fact that I am pregnant. They won’t even address [Etheridge] or talk about it. So, you know, . . . . Well, it does hurt. It feels, feels like you’re being isolated once again, excluded once again, and it has a double impact coming from the lesbian community. But there are so many differences in the community itself, that it would just make sense, that dynamic. (Sharon, p. I-22)

As the participants reflected on the support they received after the birth of their firstborn, they noted that the local lesbian community provided mixed support.

You were asking about the community. We had a great deal of support—the first week he was born—and that was it. Part of it is because he is a boy . . . . A male child has different meanings across the lesbian community. (Ellen, p. I-22; II notation)

Sharon qualified these comments:

We also haven’t been as involved in the community since he was born. We don’t have the opportunity. We don’t have a caregiver right now. So it’s both ways, but there is a group that feels very strongly that you are not a real lesbian if you have kids. It’s sort of like those women who don’t have children are not a real woman, or you’re not a real woman because you haven’t married, that sort of thing. That dynamic exists in this community for sure. (Sharon, p. I-22)

While this couple has connected with a local lesbian moms’ support group, they have been unable to find other lesbian moms who have birthed in a lesbian relationship in this city. “We’ve been to a few seminars and stuff where we’d hope to really take a lot away, yet the discussion always digressed into custody and access—having men in their children’s lives. They are mostly very separate issues” (Ellen, p. I-21).

Much of the difficulty for this couple is focused on the lack of recognition of the coparent
by family, friends, colleagues, as well as the larger community. Sharon relates,

I had dinner with a colleague who knows my partner’s a woman, but there’s absolutely no talk about my life, my holidays, my son, my partner. I was with another party. She’s heterosexual. A lot of talk amongst the two of them: their kids, their husband, their wives, so it’s just that no one says, “How’s your child?” They don’t see the child as yours. (p. I-2)

At another point in the interview Sharon reiterated: “Even one of Ellen’s greatest, truest, best friends doesn’t see me as this other parent . . . . She refers to me as Sharon, not Mom . . . and she’s an adoptive mother” (Sharon, p. I-33).

Struggles to find acceptance by their families of origin are ongoing. Ellen’s family, who were initially nonsupportive when she first disclosed to them in her late teens, has become accepting over time. On the other hand, Sharon notes that her family took two steps back with the birth of their second child.

This couple agrees that the birth of their second son was tremendous. However, their efforts to shape a positive experience were shattered by an incident with Sharon’s mother soon after the delivery. She took Ellen, the coparent, out into the hall and proceeded to lecture her.

Three hours after he was born, I [get] that whole . . . “It’s not normal for us to have children, and I need to respect their relationship, and I need to redefine.” If I were a man, she’d feel better because I would know what my role was and I would take a backseat. (Ellen, p. II-31)

Sharon notes that,

She didn’t feel excluded from my other two sibs’ births when they had their children, but she felt excluded with mine. And she didn’t feel excluded when Ellen had Etheridge. The
fact is, all that was about homophobia. She doesn’t see Ellen as a true valued partner! (p. II-31)

They described this as devastating—as “a black cloud which hung over them for days!” Ellen says,

We never got over it. The first day of his life was black . . . and it was hard. It was really hard, because it wasn’t like something we could go out and fix easily. I mean, these people had 5 years and this is what accumulated. (p. II-34)

In fact, they received similar disinviting messages from all of those in Sharon’s family postpartum: from bestowing of gifts on Sharon only, to cards that addressed her as first-time mother. Ellen stresses that, “there’s no recognition about the fact that she has had a newborn 2 years, and did the newborn thing 2 years ago, and the only thing Sharon hasn’t done is breastfeed” (II, p. 33). When Sharon’s whole family came to the hospital within a few hours after birth, the couple perceived this as disinviting, as if the family intentionally prevented them from celebrating this time as a couple—since they had never done this with previous births in that family.

Although Sharon states that her mother has a very positive relationship with her grandchildren, her mother’s major concern is that

there comes a time when they have to stop identifying with you, and start identifying with their father—otherwise, they might become gay, or might be meek, or they don’t get accepted by their peers—this sort of thing. She’s very concerned about when that process is going to happen, and who they’re going to identify with. (Sharon, p. II-32)

Sharon reiterates, “But it is also an example, though, of my family who’s been
exposed to us on a regular basis. Think of this this way: Even though they know something different, imagine what the rest of society thinks!” (p. II-33).

Processes

The process of considering pregnancy as an option within a lesbian relationship is influenced by strong societal sanctions against childbearing within a non-nuclear family structure. Ellen states:

I found that a lot of single lesbian friends of mine would say they would like to have kids, but no one ever has. And so in a way, I think that it comes from the fact that the barriers are so profound. A lot of friends say that “One year, one day, we’re going to have kids,” but are not able to say when and how, and don’t seem to be moving to that stage. (p. I-5)

The process of AI presented many issues for the couple. As the participants checked out possible sources of support for alternative insemination they encountered barriers to accessing the system that were specific to their lesbian status—those women assumed to be heterosexual would not face. Ellen notes,

We heard that with lesbian women . . .[this fertility clinic] would make you see a social worker, and they’d ask you who’s going to be the positive male role model in your child’s life, and what are you going to do if you have a boy—totally inappropriate and homophobic . . . . The majority of AI clinics in Ontario (17 out of 23) won’t serve heterosexual single women or lesbians. (Ellen, p. I-9-10)

Even resources that were considered lesbian positive were problematic at times. Ellen explains:

We were very interested in [this hospital clinic] because we had heard such positive feedback, so we called them. They sent us an information package and all the information
was on, “Now that you know you are infertile.” First of all, for most women, that is a hard thing to hear. But you would think that they would want to explore further before they drew that conclusion. Secondly, we did not know if we were fertile or infertile. We just didn’t have a male factor, which makes things a little more difficult, but not infertile. (Ellen, p. I-10)

Even this particular service which was considered lesbian positive required a physician referral, which could be disinviting to women whose access to lesbian-positive practitioners is limited. As well, this clinic was “exceedingly expensive” (Ellen, p. I-9). Since the AI system is not regulated, the costs per month for donor sperm might range from $500 to $1,300 per month on top of any fertility medications which could be required (which cost on average $1,000 per month).

The limited and variable information on donors was an issue for a couple for whom cultural selection was a priority. One clinic provided information limited to height and weight, while the clinic they chose offered donors that reflected racial diversity.

It took effort on this couple’s part to locate a practitioner who would support lesbian childbearing, even using contacts who themselves were part of the large lesbian community in Toronto. One lesbian-positive clinic offered two or three pages of anecdotal information which consisted of a few lines about feedback regarding individual physicians. A lesbian physician friend working in Toronto was unfamiliar with any resources that could assist lesbians who want to have children.

The process of adjustment to the changing roles within the family as the babies arrived presented the couple with difficulties. Sharon, especially, as coparent to their first child, identified the first 6 months postpartum as extremely stressful. “I didn’t seem to get the
instinctive stuff that Ellen was going through. For example, if Etheridge cried, I wouldn’t go immediately to him at all times” (p. 1-16). Ellen agrees that

*that* was a huge bone of contention between us. His every need was to be met as soon as possible. Sharon didn’t feel like that should happen, and yet I felt that was the most natural thing for me to do. But what was really hard was, I think, the whole layer of how you coparent with anyone regardless of gender. (p. 1-16)

Sharon speaks of the lack of information available for couples who are looking for guidance around this issue.

The hardest time for a heterosexual couple is during the first year postpartum. Most divorces, breakups happen . . . a lot of violence. There’s that body of literature, but it doesn’t speak to any of our issues, and there are only patriarchal role models. (Sharon, p. I-24)

**Programs**

The couple was unable to locate any local programs that incorporated the range of information and support which they found relevant for their childbearing. This would include preconceptual information as well as information on pregnancy, postpartum, and parenting. Neither the local lesbian community nor mainstream parenting resources available to childbearing women provided resources that met their needs.

Prenatal classes were perceived as disinviting. Ellen explained:

It is our understanding from colleagues, friends, and other health care professionals that prenatal classes [are] so unilaterally assumptive and focused on marriage, and male and female relationships, not to mention middle class, [that] even friends of ours who had been to prenatal either left for that reason, [or] highly recommended that we don’t go. (p.
Postpartum supports, those geared for mothers with newborns, that were visibly lesbian positive were not available. Parenting supports within the lesbian community were seen as more relevant for lesbian parents with school-age children.

The participants emphasized that although organizations and resources which focus on women's issues may be lesbian positive, this is not necessarily so. A number of those who direct programming may be disinviting in the homophobic and heterosexist messages they convey. As well, even resources managed at times by lesbian women may convey disinviting messages when family stereotypes are not challenged. They recognize that some individuals may not have the power to control curriculum or program directions, and this may play a part in the way these barriers continue. Sharon stressed that the lesbian community is well informed and, as a result, midwives would also be aware of these issues.

**Places**

Finding a care provider that provides the unconditional emotional support and acknowledgement of both women's needs throughout the pregnancy is important; however, maintaining a safe environment for the family after the baby is born is also an issue. Ellen notes that, "there's not a huge lesbian community here, because people tend to coagulate in centers, you know, where the possibilities are greater, and that is not here, I don't think" (p. II-23). This factor limits the resources available for families.

The inability to guarantee a lesbian-positive environment for their child influenced their decision for one mother to stay home with the baby. Sharon stresses that

We didn't really want to put him into a generic day care because we didn't think that he or his family would be validated at all. Friends of ours conceived a child similar to the
way we did, and when he goes to day care here in Hamilton, the day care provider is
telling him that he doesn’t have two moms, that it’s impossible. So he comes home and
tells his moms that they don’t exist in the same context that he knows them to exist.

(Sharon, p. I-1)

Policies

The participants identified several policies which were disinviting in the way they
prohibited access to lesbian women, treated lesbian clients in a different way from those
childbearing women who were assumed to be heterosexual, or did not openly commit their
nondiscriminatory policies to include same-sex orientation. As well, they identified that the lack
of clear policy which addresses sensitivity to disclosure provides opportunity for difficulties.

AI services which limited services to heterosexual couples posed questions about positive
male models to lesbian women and not heterosexual women. Organizations which omitted
sexual orientation from policy statements have been noted. Services which require physician
referrals and social worker consultations may present barriers.

The participants offered contradictory perspectives on documentation policies and
procedures. While Ellen insisted that consent is required for documentation or sharing of any
sensitive information in any health organization, Sharon noted that “the norm is to communicate
with or without permission on paper. So, in the patient’s chart it would say, ‘Lesbian woman, 23
years old’—in the consult” (p. II-pp. 48-9). Lesbian women who cannot control how information
that is shared with a provider will be used may be reluctant to disclose. This unpredictability
contributes to the perception of an unsafe institutional environment.

Politics

Although the participants applaud the recent gains in legal status for lesbian couples, they
note that the persistence of negative stereotyping of lesbian women continues to put them at risk for custody and access issues when there are children in the family. Sharon relates that,

The courts have been really horrible, especially in low-functioning families. The lawyers can be just horrible, just horrible. They can be just awful. People have lost custody over their kids just because she is lesbian. Husbands are concerned their partner is going to molest the child. (p. I-7)

Such practices continue despite evidence from well-respected psychological sources that children who are part of same-sex families are not at increased risk for harm. The women note that media images that focus on and sensationalize sexuality of gays and lesbians perpetuate these stereotypes. From the participants' perspective, funding and opportunities for promotion for lesbian-focused and family-focused Gay Pride celebrations are less available than those for the high-profile parade in Toronto (p. II-49).

Political acceptance of alternative care providers within traditional health care environments influences the possibility of lesbian positive advocacy. As Sharon indicates, even if a midwife is perceived as lesbian positive, and takes an advocacy stance for lesbian mothers, midwives themselves are not universally accepted by mainstream practitioners across Ontario. In her view, midwives have been legitimated as practitioners in centers like Hamilton, Toronto, and Kingston, but in other areas this is not necessarily the case.

In the couple's view, other alternative care providers, like doulas, who are involved in childbirth support and who may have a role to play in providing lesbian-positive advocacy for women, may also lack the status within some hospital or birthing settings to facilitate an inviting environment. The participants stress the difficulty this implies for lesbian women seeking an advocate in such a system of power inequity.
Thematic Summary for Question 5

Throughout their childbearing processes the participants encountered barriers to support. This theme and several others are described in detail under this section.

- Barriers to support perceived as disinviting messages from people, places, programs, processes, policies, and politics
- Biological mothering experiences
- Coparent experiences
- Childbearing as a turning point
- Diversity of lesbian communities
- Isolation

The participants found that barriers to locating support for their childbearing were widespread on both institutional and individual levels. Nonsupportive messages were perceived to be either intentionally or unintentionally disinviting. Frequent disinviting messages from family, friends, colleagues, and other lesbian women, along with institutional practices which excluded their childbearing, contributed to feelings of isolation within their kinship communities. At times messages from individuals or institutions appeared to be well intentioned, but their lack of sensitivity or lack of knowledge conveyed a disinviting message.

This isolation often stemmed from others' reluctance or refusal to publicly validate their lesbian childbearing identities and roles. This occurred when the biological mother was celebrated at the expense of the coparent. At times, lesbian women were assumed to have the same needs as heterosexual women, or were treated in a way that heterosexual women were not. Frequently their lesbian family existence was ignored altogether.

Exclusion related to identity was not confined to heterosexual contexts. In fact, the
participants sensed that as childbearing women, especially as mothers of male children, some lesbian women who were supportive of them within the lesbian community prior to childbearing would no longer offer support. It was as if their lesbian identities had been invalidated through childbearing.

The unpredictability of responses from individuals across communities, as well as the circumstantial support from professionals, institutions, and friends, hindered the couple’s confidence in locating support. The participants were aware of their sensitivity to verbal and nonverbal indicators within interactions which was based on the inconsistency of affirming and validating messages that they would receive. The lack of validation of their identities as lesbian women and a lesbian family was an important aspect in how these interactions were interpreted as uncaring.

In fact, the negative support from the family of origin as well as a number in the lesbian community, both of whom the couple sought as important sources of emotional encouragement, was a major consequence of their decision to bear a child and contributed to emotional turmoil even with the delights of childbearing.

- Public or private availability of support
- Strategies
- Determination

The couple’s decision-making regarding all aspects of planning for childbearing, from preconceptual to postpartum needs, was tempered by their perception of how resources offered support: how they provided safety and validation of their lesbian childbearing. The multiple ways in which they sought support reflected the determination they required to locate support given the numerous barriers.
Attempts to access information and support through public resources were often made after these routes were screened by feedback from their professional and lesbian contacts. Thus, these women used private points of access as important sites of information. However, the couple learned that even lesbian health care providers were not necessarily aware of resources for those choosing pregnancy.

The couple emphasized that the interaction of other social locations which contribute to marginalization intensifies the barriers for the diverse women who partner with another woman. The anticipation of homophobic reaction influences whether childbearing is seen as a viable choice for lesbian women, as well as whether disclosure is an available option when they seek safe environments in their workplaces, childbirth settings, and family contexts.

**Question 6: What support do they create themselves?**

In order to locate support that was meaningful to their experiences, these participants incorporated a range of strategies which facilitated this process. Their perceptions of available choices were shaped by their own lived realities and feedback from others. Options available were often interpreted in terms of whether collective experiences were inviting or disinviting.

As women who acknowledged a feminist analysis, they named their conscious understanding of how disinviting interactions were influenced by societal norms of heterosexism and homophobia. A feminist analysis and understanding of systemic power dynamics facilitated their ability to analyze the issues and informed their actions. The choices made by this couple included approaches which could both potentially minimize the impact of homophobic reaction on their childbearing process and precipitate increased risk of disinviting messages.

A primary decision, prompted by their first pregnancy, was to “face our own homophobia” (Sharon, p. I-3) by increased disclosure to others. With a priority on receiving
validation from others for their family, the couple addressed the need to be more than selectively open about their relationship. This commitment required immense courage and determination as Sharon disclosed to her workplace that her partner was expecting.

The decision to disclose was taken in terms of previous experiences of disclosing as individuals and as nonchildbearing couples—those inviting and disinviting messages received about being out to family, friends, and community. Ellen related that she was out since age 18 to her family—who had great difficulty with this. She described her process of disclosure:

But in terms of being out in the city that I was living, with my work and everything, I just got this great job where everybody seemed great and there were lots of other lesbians, so although I don’t think I ever made a conscious decision. I just ended up being me, and it felt so natural just to be me, and people were so much themselves. I don’t know. It just sort of naturally evolved for me. (p. 1-3)

Ellen attributed this positive atmosphere to the diversity of race, sexuality, and “levels” within her workplace.

Sharon, on the other hand, had disclosed only to a small group of friends within the lesbian community and her family. She notes that her family was initially supportive, but then reacted more negatively, projecting blame onto Ellen and refusing to acknowledge her status as Sharon’s partner in life. With these disinviting messages from those close to her, the decision to come out required great courage.

Sharon:

I wasn’t out, until a few years back. It was because Ellen was pregnant and I couldn’t just show up with a child one day. I had to come out. I didn’t want to deny my life with Ellen and Etheridge, so I did come out and it was fine. I didn’t think it wouldn’t be, but . . .
Ellen: "It was really my pregnancy that got kind of got you to a point of coming out."

Sharon:

We also feel very strongly about the fact that we couldn’t deny our kid to the world, so we have to be strong, Knowing he was coming, we just started making it 100%. By the time he arrived, we were pretty much 100% out and confident, not that we didn’t have our wavering. (p. I-3)

The process of being completely out as a childbearing couple influenced their decisions. A crucial link in supporting their stance that being out was integral to a healthy family was their choice of midwifery. Their familiarity with the midwifery philosophy, which they note is unobtrusive, demedicalizes the whole childbirth experience, and “gives more power in decision-making to clients than medicine essentially does” (Ellen, p. II-30), offered them increased control over their birth experiences. This included a choice in their planned location of birth:

Ellen explained that

The reason I wanted a home birth is because I didn’t want to deal with anyone else’s homophobia! So, it wasn’t like I was a heterosexual, middle-class, white woman. I don’t know what I would have decided. I probably would have gone to the hospital because it would have been fine. But, I didn’t want anybody to interfere, interject, and intervene, and bring anything nasty in that moment with my partner or my child. So I feel like the safest place was at home. (p. II-18)

Another inviting aspect of midwifery is the advocacy role that the participants interpret in terms of how this facilitates safety within a health care system that has historically been disinventing to lesbian women. Sharon, a birth mother, coparent, and physician, stressed that

We would still have had a midwife there with us to help us advocate . . . [even if either
one of us had been assessed as high risk] . . . I would be afraid to go into the health care system with a physician. (p. II-20)

Sharon noted that many lesbian women choose alternative care providers because of their perception of an unsafe traditional medical system. As midwives promote home birth as part of their philosophy of childbirth, they are considered alternative care providers within the reproductive health system. In fact, Sharon felt that their positive hospital experiences were not a reflection of a change in basic support for lesbian childbearing by health care providers or the community, but rather an indication of the respect for the midwife within their particular hospital community.

I think though, that lesbians having babies are in a bit of a different position than lesbians not having babies, in the sense of: they are usually middle class, they’re articulate, etc. They will probably seek out alternative routes of child birthing experiences (i.e., midwifery). So, when a midwife comes into the hospital, I think the staff reacts to the midwife, because they know that this is a progressive patient anyways—because midwifery is progressive. So they behave differently. And I think that might be why people are behaving differently, versus they’re changing their values about the fact about whether they believe lesbian and gays should have children. (Sharon, p. II-44)

Moreover, in the couple’s experience, a doula, who could also provide labour support and advocacy, would not be respected to the same extent because of the hierarchy of status within a hospital setting. Ellen states, “in fact, they probably would be treated terribly!” (p. II-21). She elaborates on their choice:

Probably if our family doctor [whom they perceived as supportive] did obstetrics, we may have gone with her, but for me the big reason for midwifery was really that I wanted
to know who was going to be there, and I wanted to be in control in advance, and not risk having the resident on call and the clerk and the two nursing students, involved—not knowing their level of homophobia. (p. I-12)

The couple’s interpretation of how a midwife facilitates a safe environment is “that what a midwife means [is] what you have is a professional advocate, and you also have someone who is a buffer” (Ellen, p. II-21). The continuity of care provided through the midwifery system counters much of the unknown in the hospital system.

However, their choice of a home birth was made in terms of safety in childbirth weighed with pain management. Ellen explained: “So by default that meant no pain management outside of natural management” (p. II-18). This became an issue, especially during the birth of their second child. Sharon had respected her partner’s call for a home birth with the first child, but with her experiences as a physician, she opted for a hospital birth where pain management in an epidural was available.

Inherent in planning for a safe birth is a choice of not just health providers but other personal supports. Sharon explained:

I think we also chose people in our life that would support us throughout our choices, would respect us as a family during the childbirthing experience. For example, I didn’t choose my mother to be with us during that time because of her ideas about the way things should be. (p. II-31)

Ellen, who perceived that she was being excluded by Sharon’s family, attempted to facilitate communication with Sharon’s mother by phoning her during the labour, even though Sharon was not in favour of this.

Throughout the childbearing process the participants demonstrated commitment to
support each other. This involved placing a priority on the visibility and decision-making power of both partners. Ellen notes that "our plan was that we would labour at home. If either one of us felt uncomfortable emotionally, physically, worried, whatever, we decided each had the prerogative to say we’re going [to the hospital]" (p. I-13).

Postpartum, the women consciously involved the coparent as much as possible. Ellen recalled that

I felt that Sharon did a lot of firsts with him that I didn’t do, and part of that was our way of presenting to the world our united relationship with our child. That was a huge part of it: to bring you [to Sharon] in a very physical, obvious public way. When we would go out in public, Sharon would most often be carrying him, and that was our way of just demonstrating that. (p. I-17)

However, with a lack of role models, their attempts to share the mothering contributed to conflict within their relationship, especially during the first 6 months postpartum. Sharon acknowledged this:

I think the way we got through it was we focused on what was best for Etheridge, and that seemed to help. Because in lots of ways we were both trying to do what is best for Etheridge, and so we tried to work through that rather than be caught up in "This is where you’re at" and "This is where I’m at." "This is what we both think." The relationship was solid. A break-up of the relationship would be much more likely if the couple was not well grounded. (p. I-24)

Another strategy was the couple’s conscious choice of language as it pertained to their childbearing lives. One of the ways in which this couple has elected to handle the process of family identification with their children was in the terms they chose for themselves. Ellen stated
that, “He knows me as ‘mommy’ and her [Sharon] as ‘momma’” (p. II-30). This naming issue has been important and was considered inviting to them as a couple,

because in public it affirms when Sharon is with him, her relationship to him, and the same with me. The only time it turns heads is when we’re both together and he calls both of us “mummy”—people don’t really address it. They’re just sort of confused. (Ellen, p. I-15)

As well, the couple’s choice to speak of AI as alternative insemination rather than the traditional artificial insemination was another strategy to normalize the birthing process for them. As they named their children it was also important to consider the implications of the names they chose. Ellen remarked that “one of the things about having really unique names is that our children don’t have that sort of baggage that everybody knows: you know a [Sally], so therefore they have a certain set of ideology and expectations about [Sally]” (p. II-9).

The couple chose androgynous names which honoured, in a symbolic way, cultural aspects of the women’s families. That they opted to use spelling which was nonphonetic, indicated the value they have placed on countering the accepted social norms and expectations while affirming their families of origin. The process of naming the children in which they chose names jointly was at odds with Sharon’s family’s expectations that the birth mother alone would take that responsibility. It represented yet another way that the family discounted the role of the coparent.

Initially, Ellen notes that she was enthusiastic about co-breastfeeding, but they made a conscious decision with their first child for the birth mother to breastfeed exclusively. So despite their commitment to sharing of primary caregiving, they felt this would meet the child’s needs for a particular biological connection with the birth mother. The high value they have placed on
breastfeeding for both the physical benefits and psychological comfort it provides has shaped their postpartum decisions. With Sharon nursing Lang, while Ellen is nursing Etheridge who is just 2, they feel this “allow[s] Etheridge to be cared for too as the baby that he still is” (p. II-16). However, as Ellen’s sole breastfeeding of Etheridge has had an impact on Sharon’s ability to soothe him or take full responsibility for nap and bedtime routines, the couple felt that their decision could change with this second child.

When these women sought information that could assist in their decision-making and understanding of childbearing for lesbian women, they turned to the literature. As well-educated and politically astute women, they first “read the Royal Commission document on reproductive technology in Canada [which] generated questions” (Sharon, p. I-8) for them. This highlighted a number of legal and ethical issues for them and shaped their decision to use an anonymous sperm donor in the artificial insemination process. In addition, as the couple experienced difficulties postpartum, Sharon did a search on postpartum conflict for lesbian women. She found the academic literature did not address this issue.

The couple’s perceived choices for postpartum support were made in a context of whether they would provide safety. Although they made a decision for Ellen to be home full time with the children, and have found this provides as positive an environment as possible for them, they felt that affirming day care supports were unavailable to them. Sharon remarked that “the lack of adequate day care removes that choice from us, and this forces a loss of income for our family” (p. I-1).

Preschool settings and children’s books have been chosen with the intention of providing less stereotyped family role models and less technologically focused educational opportunities. However, they have felt compelled to repeatedly read the same stories in which animals are
principal characters, because of the lack of safe alternatives in children’s books. Even the progressive nursery-school environments and preschool library programs reinforce nuclear family stereotypes and the central role of “father” in the family.

As has been previously discussed, the participants accessed information and support through their networks of potential childbearing supports found in Hamilton and Toronto: those in both the mainstream and lesbian communities. Because their exposure to other lesbian AI families has been limited, they have at times stressed the need to reach out to lesbian moms’ groups in Toronto, “especially when we are feeling particularly isolated. We sort of go through stages. A lot of it is energy” (Sharon, p. I-21). Ellen stressed that “we don’t want him to think he’s the only kid in the world who has two moms” (p. I-21). Although they view on-line resources as a social support, they felt that time and energy limits their ability to tap into that option.

It takes a real determination to focus on decision-making with the goal of creating inviting and supportive possibilities. However, this couple’s decision to have a child and the actions they chose in spite of their perceived limitations have had an enormous bearing on their lives.

**Thematic Summary for Question 6**

The following six themes prevail throughout the discussion of how the participants created support for their childbearing:

- **Determination**
- **Strategies**
- **Barriers** as perceived as disinviting people, places, processes, programs, policies, and politics
• Biological mothering experiences
• Coparenting experiences
• Support perceived as inviting people, places, processes, programs, policies, and politics

With a feminist analysis the participants had a cognitive understanding of the underlying societal power dynamics implicated in diversity and lesbian mothering. Having experienced on a daily basis the privileges of their situated experiences, as well as the homophobia and heterosexism inherent in many interactions, they also understood on an emotional level the courage they would require to counter the depth of negativity surrounding lesbian childbearing.

However, also having experienced positive and affirming environments and interactions, with their connections to many networks, as well as a strong commitment to each other, this couple also displayed a confidence in their actions. This optimism shaped their perceptions of available choices and influenced the conscious decisions they made to address barriers to locating relevant support for childbearing. They demonstrated determination and used great amounts of energy to carry out strategies in the face of ongoing disinviting messages from others: invisibility, exclusion, and assumptions by families, communities, friends, and institutions about their lives.

The strategies used through their biological mothering and coparenting processes included: choice of health care provider; choice of location of birth; facing their own homophobia by increased disclosure to others; naming of power dynamics; weighing of choices in light of risks of hospital birth and options for pain management; choice of personal prenatal, intranatal, and postpartum support systems; ensuring visibility of coparent; choice of language for family and processes, breastfeeding decisions; searching the literature for support; choice of day care options; and donor insemination; as well as choice of educational opportunities for their
children. Actions taken were facilitated by previously and ongoing inviting experiences with individuals, health care providers as advocates, and systems.

**Question 7: What impact on their lives did the decision to bear a child have?**

Childbearing is a major life experience for all women. As families adjust to the arrival of children, day-to-day priorities change focus. However, for this couple, childbearing has influenced a range of issues in their lives, many of them directly related to their identity as a lesbian couple.

For these women the impact of childbearing began preconceptually as their desire for a child in their relationship increased markedly with the onset of the AI process. Their vision of themselves as a lesbian couple with a child became more frequent. The vast majority of images upon which they based their expectations of childbearing were based on lesbian families in which a male had been involved at some stage.

However, it was the pregnancy itself which forced a decision around disclosure for the couple. Their commitment to authenticity and honesty in relationships did not permit exclusion of partner or child within their networks or larger community. In order to become more out in their lives, they risked negativity and potential repercussions in their workplace and community. In a contradictory way, as the participants sought safety in terms of validation of lesbian partner and child relationships, they risked unsafe interactions with disinviting homophobic reaction from others. Sharon’s desire to provide a safe and encouraging environment for her partner and child, as a coparent, motivated this step. Sharon noted, “so I did come out and it was fine. I didn’t think it would be” (p. I-3).

From the first disclosure during pregnancy, the women found inviting support which encouraged them in their decision to be out in all aspects of their lives. In many ways then,
childbearing provided an opportunity for these women to learn about themselves and their partners in a context very different from previous experiences.

There were implications for lesbian identity as they each took on the biological mother and coparent roles. With the birth of their first child Ellen explained how Sharon “took on that sort of other parent ‘father role’ which was unnatural” (p. II-16). At the same time, Ellen felt that she “gave up a lot that most heterosexual women take for granted because that’s the role women have” (p. II-16), as she consciously shared the baby’s firsts with her partner. Sharon herself recalls that she “didn’t understand her [Ellen’s perceived] loss” (p. II-16).

Sharon reflected on how her “ability to be very instrumental has helped her through a lot of anxiety around mothering, being the biological mother, for example” (p. II-13). She attributed this to being one of many children in a family. Trusting her own instincts about situations has given her more confidence in accepting the difficult periods with the baby. She has also found it easier to trust her partner’s instincts and skills which Ellen has developed, especially at times when she herself is feeling vulnerable or overwhelmed by the children.

Ellen remarked about how a friend recently expressed anxiety about her body deteriorating after pregnancy. In contrast, Ellen has internalized a stronger sense of resilience—“How much your body is extremely capable. My potential was actually profoundly greater than it was before. What I am able to endure, survive, and thrive in” (p. II-17).

Reflecting on the childbearing experiences during the dialogue with the researcher offered the participants an opportunity to reconstruct their interpretations of the process as they considered the impact of childbearing on themselves and their partners.

Ellen (to Sharon):

What did I learn about myself throughout your birth and pregnancy? I think it was so
awesome, and I mean “awe”—that only it was a miracle to watch. And so I think learned a lot about the sort of magic that comes with life, as opposed to, with me, when I had Etheridge, I was in so much pain, that I just suffered tremendously, and with you, it was like watching the most magical thing, and to be a part of it! So, I think, I was able to witness, I was able to experience, and be a part of something magical that I didn’t have with my own birth. So I actually now feel as if I have a complete sort of phenomenon inside of me—and birth and the creation of my family. Because it was magical when I had Etheridge, but it was not without suffering. It took them an hour to sew me up—it took forever! And that really took away from the magic . . . Whereas with Sharon, we got him right away.

Sharon: “You learned that the epidural was good (laughing).”

Ellen: “That was a big one. So, if we have another child, and I’m birthing it, I’m just going to sit myself right up there because I didn’t have that” (p. II-18).

As has been discussed, the first 6 months postpartum, and in fact the first year, were quite stressful for the couple. As they negotiated roles and shared in the mothering, they found that their assumptions about each other as women influenced their expectations within the relationship. With a lack of role models and feelings of loss of control and certainty in their lives, this time was in some ways a test of the relationship. They both felt that they had done so many things where they had problem-solved together that this provided a strong base for the relationship.

However, Ellen stressed that there are real joys to their lives as they parent together. “[It is] an absolutely wonderful dynamic” (p. I-18). They noted that their commitment to caring for the family, in a way which is not based on stereotypical roles, prompts questions when others
from more traditional relationships observe how easily they share tasks. Ellen remarked that at restaurants “we are both clearly involved in his care, his feeding, his cleaning equally, and people are just amazed that two women are doing so well” (p. I-15).

With the arrival of a second child and a reversal of biological/nonbiological roles for the couple for this child, they appear to have pinpointed the exclusive breastfeeding issue as one decision they would have changed. Their priority to breastfeed both children and encourage self-weaning has prompted a reevaluation of whether the coparent could contribute to the infant’s needs for comfort or nutrition by nursing at times. “It was a privilege that Sharon [as coparent to Etheridge] doesn’t share” (p. II-14) with his biological mother. They may consider this option when Sharon heads back to work after her maternity leave, although at this stage Sharon intends to continue nursing.

As they reflected on their lives with a second child just over 2 months old, the participants discussed whether their support systems had changed with the second child. Sharon explained that they have “a little bit more active social life, but I don’t think those [disinviting] sorts of issues have been addressed or have resolved themselves in certain situations” (p. II-38). In fact, they find themselves sensitive to the amount of time that the grandparents spend with their grandchildren. They wonder if the biological mother’s family interacts in a different way with the child she birthed compared to the child she coparented, and whether this differs from the attention that other grandchildren receive from them. The couple recognizes that there seems to be at times a “hyper-awareness” on their part as they look to the family for support, but they continue to make opportunities for their families to share in their childbearing even when the messages are less than supportive.

Throughout their childbearing, Sharon and Ellen strategized in order to avoid or
minimize the effect of others' homophobia on their births. Their own experiences and feedback from other lesbian women had made them wary of the health care system. However, having had two positive hospital births they note that their confidence in the possibilities of the system has increased—hence an optimism which had been missing. Ellen stressed how the two positive birth experiences demonstrated for her that “let[ting] go of a lot of circumstance and the outcome can actually be better” (p. II-18).

However, the mixed support from the families and a variety of community at times continues to take its toll. Whereas Sharon’s family of origin has been perceived as nonsupportive of Ellen, Ellen’s family has been inclusive of Sharon and the children. The lack of predictability at times is also difficult. Although Sharon is not hopeful that her family support will change markedly, Ellen remains optimistic, having experienced a change in her family over time.

The women speak of the tremendous time and energy they devote to making decisions that will offer more positive possibilities. Whether it is planning how to approach pain management for childbirth or considering how to handle family situations, this couple finds that much of their time is devoted to anticipating disinviting reaction. As well, they feel they are continually educating those around them about their lives, both other lesbian women and professionals.

In fact, at times they feel that they are now primarily identified by their parenting roles within the lesbian community. “They see us as these lesbians who have kids—they don’t see us as Ellen and Sharon anymore” (Ellen, p. II-38). Their connections with the lesbian community have focused more on parenting concerns since the arrival of their children, although they have sought out social outlets which include sports in which they are the only parents in the group of lesbians involved. This group is part of the Toronto lesbian community activities.
Certainly one effect resulting from the decision to have children is how this couple feels at times isolated from their local lesbian community: the lesbian parents who are part of this community cannot provide the specific support they require to parent or birth children because they did not go through the AI process; they birthed with a male partner, and all of the children are older. Those lesbian friends and acquaintances who take issue with the philosophy of lesbian childbearing exclude this couple in a way that questions whether they are authentic lesbian women if they choose to have children. At the same time, the couple described the incredible support they have received from other lesbian women who are also part of their local network. The diversity of lesbian women within the community and the range of support they choose to provide has influenced how this couple feels validated within the community as lesbian women and as a lesbian family.

With their ties to medical communities, alternative reproductive health practitioners, and academic environments, as well as the local lesbian community, this couple also has an awareness of how their own privileges may have influenced their access to support. They have become resources for other childbearing lesbian women birthing locally. As Ellen remarks, "If someone is brave enough to ask at the [women's bookstore], they would send them here" (p. I-25).

As parents, they have gained an awareness of larger community issues and importance of safety for their children. They emphasized that in comparison to pregnancy, parenting within a lesbian family relationship is very difficult. Sharon noted: "There's a lot of romanticism that goes into having a child, but then you have the child, and then what? There's a whole world. There's a whole life, and we're just discovering it!" (p. II-27).

They spoke of an increased awareness of potential safety concerns for their sons as they
consider the very real dangers of life as sons of lesbian moms. These experiences have alerted them to the difficulties that lie ahead as the children reach school age. “We have to make sure that we have mechanisms in place to counteract that. We have to talk to all our teachers beforehand” (Sharon, p. II-28). The couple describe the fear for their children’s physical and emotional safety as they anticipate how their choices as parents for locating safe environments, those which will accept and celebrate their family, must be priorities.

Ellen:

Pregnancy was hard. It was all hard, but I don’t think in any way it’s comparable to what’s ahead in raising two boys to not be “boys boys”—to be lesbian moms of two boys and to raise decent human beings. I mean, every parent must feel at the bottom of the hill, looking up. I think our hill is just higher.

Sharon:

Our hill’s higher because we don’t buy into the socialization, the role-stereotyping, and I think most parents can actually sit back and relax because they know the school system’s going to do the job that they also are going to do. But that’s because the school system, and the church system, and the after-school system is going to help them along. They don’t have the same sort of worries that we do . . . .

Ellen: “Do you know how much energy that takes? It’s like climbing Mt. Everest every other week! So-o much time and energy!” (p. II-28)

Although they noted that feminists may have similar concerns about raising sons in a society which is less than accepting of those who may reject societal stereotypes, and they note that the available “opportunities for kids even of heterosexual parents” (Sharon, p. II-28) are limited, they emphasized that these heterosexual women “are probably not as scared” (Sharon, p.
II-29) as they are about their sons’ futures.

They fully intend to be open with their sons about how they were conceived and will share available information about the donor with them. Because both biological mothers conceived using the same donor, their sons share family identities in a number of ways.

Childbearing influenced this couple’s lives in terms of their identity as lesbian women, their relationships with each other and with the community, as well as their perceptions of possibilities for the future.

**Thematic Summary for Question 7**

These findings, which present the impact of childbearing on these women’s lives, incorporate all themes which emerged from this research dialogue:

- Childbearing as a turning point
- Strategies
- Support perceived as inviting people, places, programs, processes, policies, and politics
- Barriers perceived as disinviting people, places, programs, processes, policies, and politics
- Future possibilities
- Biological mothering experiences
- Coparenting experiences
- Isolation
- Diversity of lesbian communities
- Public or private availability of support
- Determination

Childbearing prompted the couple to reflect on their lives. The couple’s priority on
authenticity in their relationships encouraged them to be 100% out as childbearing women. This decision to disclose has been a crucial component of their experience of childbearing.

As well, the meanings that they have attributed to childbearing and the learning that occurred during the childbearing process have contributed to inviting processes on several levels: with themselves, their partners, and others.

Upon reflection, these women have identified strengths in themselves and their partners which they feel are related to their childbearing experiences. These include descriptions of developing resilience, an ability to be instrumental, and increasing trust in self and others—all of which demonstrate enabling or empowering capacities.

Through inviting interactions with individuals and institutions from whom they anticipated homophobic reaction, especially with respect to the hospital delivery experiences, these women now perceive more choices for future childbearing. This increased optimism and trust is, however, contained within a specific context of care. This couple stresses that they will continue to make decisions with a goal of safety, and that this will define the circumstances in which they choose to deliver, although they recognize that letting go of circumstance can at times be inviting.

The participants consider their family lives a “wonderful dynamic” as they challenge role stereotypes and enjoy their mothering experiences. The impact of childbearing on their lives was most keenly felt as they negotiated and internalized role changes as biological mother and coparent related to mothering identities and family identity issues. Identity issues influenced relationships with each other, families, and larger community supports.

As raising children became central to their relationship, they felt they were primarily identified by their lesbian family status within the lesbian community. The quality of support that
they sought but often was not available to them through the heterosexual and lesbian communities contributed to frequent feelings of isolation from both communities within their home town. The visible lesbian community in Toronto offered an alternative to their situation. Their understanding of lesbian partnering experienced in different ways, as coparent and biological mother, has highlighted for them the need for supporting other women negotiating these changes within their relationships.

When these women moved past the immediate postpartum stage, their perspective on locating safety took on a new meaning. As expectant childbearing women, the couple continued to anticipate negative and disinviting messages in response to their lesbian status, but as lesbian parents, their commitment to open disclosure prompted a determination to continue to locate safety while risking unsafe situations. They came to the realization that safety issues in pregnancy and early postpartum are a small part of the larger picture of social systems in which their sons will bear the brunt of their lesbian family identity. The couple's determination to teach others within their lesbian and health communities takes incredible energy resources as they call up courage to disclose and plan for safety on an ongoing basis in the public sphere. By providing resources for other lesbian women locally, the participants also influence the ways in which lesbian women can access private access to support.

**Question 8: What inviting possibilities have they imagined for the future?**

Throughout this narrative, the participants identified their perceived educational needs, defined aspects of support and barriers to meeting these needs, and described what choices they have made in order to find support as childbearing lesbian women. As women who are parenting in a family structure which remains invisible in the public domain, yet which has such an impact on their lives as lesbian women and those of their families and friends, they feel that
communities have an obligation to address the needs of childbearing lesbian women.

This couple stresses that with their immense situated privilege, access to information and networks, and with a fair amount of personal support, they find huge difficulties with the current situation. Within the research context, we spent some time imagining possibilities which, short of an overhaul of the whole system, might contribute to providing support to expectant childbearing women in a public health context. These will be described in terms of invitational theory.

**People**

In this dialogue, the participants illustrated a number of issues that were particular to their perspectives of childbearing within their relationship and common to others’ experiences. They noted that there is diversity of childbearing lesbian women and differences within and between communities of women who partner with another woman. Recognizing that many women are closeted to institutions and individuals and do not have the option of disclosing is essential.

A fundamental issue is the need for education of practitioners: educators and health care providers throughout the community, including day care providers, preschool educators, and librarians. Their understanding of health care professionals, including midwives, is that they are not a homogenous group and a good percentage hold traditional views on the family. Those providers who communicate in a way that privileges heterosexual relationships and who assume that lesbian women have the same needs as other childbearing women are perceived as disinviting. This poses a barrier to open discussion of lesbian concerns within a childbearing context and limits the potential for disclosure. The ways in which people are marked as lesbian positive or noninviting have been previously discussed.

The role of professionals and others as advocates has been mentioned as invaluable, as they may facilitate how childbearing lesbian women negotiate their way through the system. The
value of out childbearing lesbian professionals and how this may impact on the interaction between clients and professionals is also relevant in terms of facilitating disclosure and access to support. Sharon notes that although her preference is to be out to those in her family practice, she takes into account how disclosure may affect the therapeutic relationship as the first priority.

Programs

The participants offered some ideas for addressing education for both practitioners and childbearing lesbian women themselves.

**Curriculum for professionals.** It is the couple’s understanding that midwives participate in sensitivity training, but that “any education they receive on lesbian issues is self-directed” (Ellen, p. II-50), so preparation of practitioners would vary. There is some concern about how much information would be discussed with relation to lesbian childbearing specifically in relation to any education in medical and nursing curriculum. They are not aware of a consistent educational component that provides any health care professionals with the tools they require to address this issue. Although their familiarity with community workers outside of the health care profession is limited, they emphasize that educational preparation for all those who work with families would facilitate lesbian-positive resources.

Education of prenatal instructors and others is recommended on a broad level: sensitivity training which confronts assumptions around childbearing that expectant women are heterosexual and/or have male partners. The use of “nonheterosexist language” (Sharon, p. II-42) is suggested. However, educators must have an opportunity to understand that this is not sufficient in order to be perceived as inviting.

Ellen suggests that curriculum for educators should include “a whole section on power: power in health care relationships, power within their intimate relationships” (p. II-42). This
would also address concerns around “working with women who are in abusive relationships or survivors of abuse” (Ellen, p. 42): issues which are relevant for women partnering with either males or females.

**Curriculum for prenatal education.** The couple notes that educational opportunities set up by lesbian parents specifically for lesbian childbearing women would likely be perceived as inviting (p. II-40). In fact, Sharon wonders whether lesbian couples will attend prenatal classes unless there are specific prenatal classes for lesbian women (p. II-42).

However, for a number of reasons, expectant women in a lesbian relationship may attend more traditional prenatal classes that are currently geared to heterosexual couplings. The participants recognize that many women are unable to disclose to institutions. This implies that any classes currently targeted to expectant women must take into account issues relevant to lesbian women and reflect this in the curriculum. Issues such as control and the reproductive health system which are relevant to lesbian childbearing women might also be those which warrant discussion for other women. Sharon stresses that in her view, “heterosexual women are in a much better position to cope, similar to white [individuals] being in a much better position than [those who are] black” (p. II-46).

The women offer a list of relevant issues specific to lesbian women which could be addressed, in addition to the generic topics such as nutrition and delivery, in inviting prenatal settings:

Homophobia with the healthcare system is an essential topic: how it is expressed, coping with it, and “how to negotiate your way in the hospital if you don’t have an advocate like a midwife or a public health nurse” (Sharon, p. II-43). “Access [issues] and barriers to access” (Sharon, p. II-46) are important.
Relationship issues are a major concern. These would include: expectations of each other as women, role modeling, "how we're socialized as women [to be the caregiver and how] that makes life different around parenting" (Ellen, pp. II-43-4). As well, issues around the role of the biological mother versus the role of the nonbiological mother or the other parent are important. "There's no template to go by . . . So it's high stress" (Sharon, p. II-44).

Another aspect is to "talk about honor[ing] your differences" (Ellen, p. II-44). They suggest that "some general education around respect, diversity, and differences" (Ellen, p. II-46) may be relevant. They note that although one class may not be enough to address the multiplicity of issues, it would be a start. "It's really easy since we're both women to think the same and feel the same about similar things. It's easy to fall into making those assumptions, only to find out there are differences" (Ellen, p. II-44). They also advise that discussion be tailored to the lesbian couple with a focus on "valu[ing] the role of good communication" (Sharon, p. II-44).

However, Ellen wondered whether spending time on diversity in a prenatal class setting in which pregnant women were expecting a focus on labour and delivery could be perceived as irrelevant. Sharon noted that gearing the focus of prenatal discussion to "what to expect" would necessitate addressing relationship concerns. Her perspective is that any dialogue around interactions within family or health care systems could prompt sharing of topics which include homophobia, advocacy, and support systems.

The participants emphasize that although all childbearing women have potential issues about family, "for lesbian couples it's particularly more loaded" (Sharon, p. II-44). A discussion of homophobia within one's family and the issues about childbearing may provoke an array of responses—supportive and not. Meaningful education would identify the range of family reactions and offer insight into coping strategies. "People need to be aware that things they have
worked 10 years on developing may change" (Sharon, II, p. 44).

Preparation for dealing with the great stress that comes with living as a family in a homophobic world is another concern. Providing local resources as well as those which have been developed in Toronto would be valuable. Facilitating a helping network with other moms through lesbian prenatal classes and/or a drop-in would offer support. Resources could be targeted to include lesbians with children, women partnering with another woman, and those who use AI: known and anonymous donors.

The couple agrees that many of the issues listed are relevant to education of both educators and lesbian childbearing women. They emphasize that altering prenatal curriculum without sufficient opportunity to address education for practitioners will not be perceived as inviting. However, they acknowledge how difficult it can be to find sufficient time for facilitating education for professionals. Ellen spoke of the limited time “in the system” for diversity workshops in her experiences with mass education (p. II-46).

Places

Organizations which are perceived to offer lesbian-positive childbearing information and support are inviting in many ways. In order for places to be inviting they need to make themselves more accessible. Access to information and support which takes into account geographical limitations, disclosure, situated privilege, and public and private availability of information has been noted. Other considerations are noted under people, processes, policies, and programs.

However, some specific points are noted here:

The participants stress that the lack of visible lesbian childbearing women in the city of Hamilton, which is “blue collar” and conservative politically, limits the perceived possibilities
for childbearing lesbian women. They note that in order to have success with a drop-in or other resource, it would entail increased numbers of “lesbian [women] having children or coming out” (Ellen & Sharon, p. II-39).

The benefit for the participants of working in inviting workplaces in which their same-sex orientation has been accepted may have implications for others who work in settings with childbearing women and who may have issues around disclosure.

The participants indicate that much of the available information on gay and lesbian issues focuses on AIDS—even at the Gay Pride information table. Providing resources that focus on the spectrum of same-sex family lives would be perceived as inviting.

This couple has young children, but is very aware of the need for educational and other institutions to address how they support families who have same-sex parents. “Imagine that if we could send our kids to a school that reinforces our more earth-centered, little less technology-driven, less socialized, less role-typed [values]?” (Ellen, p. II-28). Educational processes which validate lesbian families as they do other family structures would be inviting. The couple envisions this as a long-term process.

Processes

Some cities have a central focus for relevant information and support. The participants suggest that any process to facilitate programming must respect the ways in which the lesbian community has often developed its own resources. For example, in Toronto the large lesbian community has not had to use the public health system as they have their own resources (p. II-41). This may not be possible where the visible lesbian community is small in a large center, as the participants describe their city.
Informal networks of communication facilitate access to lesbian-positive services. For instance, the participants note that midwives would be well informed about local supports.

Public health units offer the bulk of prenatal education and are provincially mandated to ensure that education for expectant women and parents is available and accessible. The couple stressed that education which is relevant to childbearing lesbian women would need to be parent driven, coming from the lesbian community itself. They offered to look at the available prenatal curriculum in order to offer more input at a future time to assist with this process.

The participants suggested that building on any current lesbian-positive community resources could be seen as more inviting than having public health organizations take full responsibility for programming. However, incorporating education and support into existing inviting programs like *Healthy Babies, Healthy Children* could be perceived as a supportive component, given the barriers to disclosure.

"The public health department could communicate that to the public that there is something available that the lesbian community has put together . . . . That would be supported, certainly" (Sharon, p. II-41). They agreed that increased connections between midwifery and the health department regarding childbearing education could benefit the process. As Sharon stressed, "If there was a network, public health would be a great vehicle to communicate that because there is such a huge machine there. They disseminate information everywhere" (Sharon, p. II-41).

**Policies**

The couple noted that organizational policies often exclude sexual orientation. Having an antidiscrimination antioppression statement which explicitly includes sexual orientation [and is] publicly displayed . . . [e. g.,] in every elevator" (Ellen, p. II-47), is one step to affirm an
institution’s commitment to addressing diversity issues. As Ellen remarked, “I’m more inclined to take my service there” (p. II-47).

Ellen also felt that “setting up a really good complaints or concerns process that is accessible to people of different privilege, those of different language or whatever” is important (p. II-47). She noted that many organizations offer this service, but it is effectively inaccessible to the public when people often feel powerless to make a complaint and anticipate that individuals concerned may be homophobic.

The couple considered that an organization determined to facilitate access through policies and other avenues would benefit from a systematic assessment of their programs and policies. Ellen stated:

You would have to commit the institution to assessing all their documents, all their tools, interviewing assessment tools. If you could get representatives of various groups, race, colour, privilege, sexual orientation to actually look at some of their assessment interview tools, the very least they can say is they have done that process, and that says a lot to the public because word will spread. (p. II-47)

Providing a sensitive policy on documentation with respect to same-sex orientation would also be inviting. Sharon noted that even a policy statement which mandated the use of a generic term instead of “husband and wife” (p. II-47) would be considered supportive, along with other measures.

**Politics**

As the participants reflected upon alternative ways to facilitate education for expectant lesbian women, they considered how childbearing lesbian women who have historically been marginalized by mainstream organizations may connect with them for support. Development of
supportive community resources will take into account existing resources and networks. The couple stresses that resources which are perceived to be inviting for lesbian childbearing women should come from the lesbian parent communities. Moreover, mainstream organizations which offer childbearing education must acknowledge barriers to disclosure and adapt heterosexist resources and curriculum in order to be more inviting.

This research process in which participant perspectives can contribute to the development of lesbian-positive services for childbearing women was perceived as a form of caring. The participants remarked that through this process they shared intimate details of their lives with someone who "cared enough to ask" (p. II-49) about their lives.

They observed that further research is needed on conflict postpartum in lesbian relationships, and on how the numbers of single women presenting at fertility clinics is related to lesbian childbearing. "A good way to tap into that one might be to survey female family docs" (Sharon, p. II-24). Research which illustrates the diversity of experiences of lesbian women who parent will contribute to more informed and sensitive support.

**Thematic Summary for Question 8**

This question discussed some possibilities for future care as the participants and public health nurse researcher reflected together on the issues raised during this research dialogue. All 11 themes were relevant to this discussion:

- Biological mothering experiences
- Coparenting experiences
- Public and private availability of support
- Support perceived as inviting people, places, programs, processes, policies, and politics
- Barriers perceived as disinviting people, places, programs, processes, policies, and
politics

- Determination
- Isolation
- Strategies
- Childbearing as a turning point on their lives
- Diversity of lesbian communities
- Future possibilities

As the participants reflected upon how future educational opportunities could be facilitated for childbearing women, they addressed issues of content and process in terms of individual and organizational aspects of educational interactions. The couple used their everyday experiences in the childbearing and coparent roles, as well as the impact of childbearing on their particular lives, to offer their perspectives on what information could be useful in terms of developing relevant support. They described how people, places, programs, policies, processes, and politics might invite lesbian childbearing women.

Addressing the isolation that lesbian childbearing women experience, the diversity of lesbian childbearing women, and the communities that may offer them relevant links to support, necessitates an understanding of barriers to access and the issues that contribute to these. The participants acknowledged how their situated privilege offered them access to information and support, although this was available after considerable effort on the couple’s part. However, neither within their local lesbian community, nor in the publicly available parenting resources, was there support that met their needs for information for the preconceptual to postpartum periods. The choices made by this couple in light of their knowledge of networks and inviting providers of care, their access to private resources, and previous experiences of locating inviting
support, as well as their determination to live as an openly lesbian family offered them options that might not be available to other women.

They considered the ways in which lesbian women are seeking support and parenting in a political environment which excludes their presence and hinders the disclosure process. The perceived invisibility of lesbian childbearing women prevents women from connecting with each other for support, and lesbian communities or health care communities from acknowledging their needs. In order to counter the isolation that is often part of their lives, inviting processes would enable more childbearing lesbian women to be perceived to be birthing through an AI process, and encourage more lesbian women to be able to disclose as biological or nonbiological mothers. Thus, educational opportunities which facilitate disclosure and offer safe spaces for childbearing women to connect will offer more inviting possibilities.

With an understanding of the barriers to disclosure, the couple noted that although educational opportunities set up specifically for lesbian women would be preferable, they acknowledged that nonheterosexist resources for childbearing women would offer all childbearing women insight into the issues they face. From this couple’s perspective, changing curriculum alone or addressing programs in isolation may be ineffective.

Certainly from the participants’ experiences, childbearing was a turning point in their lives. It had both positive and negative consequences for their support networks in addition to other implications for their lives. They stress that women considering childbearing in a lesbian relationship need information on this, as well as strategies to address the daily issues they face. Hence, their perspective of inviting education relevant to expectant lesbian women was not confined to either the prenatal period or the labour and delivery process, but was comprehensive in content and approaches.
They offered curriculum suggestions for a range of educators involved in the community, as well as considerations for policy and program development. Education of providers of care is a priority for invitational care. The participants emphasize that the quality of interaction requires educators who can facilitate the development of environments which provide safety. This necessitates more than using nonheterosexist language and curriculum.

The participants emphasized how power relations are essential components of both the substance and method of educational practice and development. The political considerations of how to develop lesbian-positive resources within the communities necessitate an understanding of the historical factors involved in the relationships between mainstream and alternative systems of care. The couple noted that the public health networks offer a way to disseminate information in a way that could facilitate access to inviting programs developed by the lesbian community. As well, facilitation of networks which incorporate childbearing lesbian women and their advocates into public health space in a way that validates and celebrates lesbian families would be perceived as inviting through curriculum, policy, staff development, physical resources, research, and advocacy.

**Thematic and Theoretical Summary**

This narrative reflects the experiences shared by two white, middle-class, well-educated, lesbian childbearing women, as they make their way through life with their two sons, Etheridge and Lang. Through this research dialogue, Sharon and Ellen wove their stories of their everyday experiences of pregnancy, labour and delivery, and postpartum: their delights of childbearing, and commitment to shared parenting in the face of pervasive heterosexism, homophobic reaction, frustration, and isolation from others who could not provide them with the support they sought. As well, they spoke of the genuine caring they have found in many relationships with friends,
family, and health care providers. Theirs is a life informed by feminist perspectives: consciously addressing oppressive societal barriers and critically assessing options available to enhance their childbearing decisions.

As this couple described their educational needs for childbearing support, it became evident that relevant information, while important, was only one facet of education that would be meaningful to expectant lesbian women. This research dialogue addressed mechanisms for providing support for lesbian childbearing women: defining inviting support in terms of how it enables safety, validation, and celebration of individuals and identifying barriers to support in terms of disinviting interactions between individuals and institutions. Other issues that surfaced in relation to accessing support addressed the diversity of situated experiences within lesbian communities, disclosure concerns, the public or private availability of information, as well as the perceived safety of resources. Throughout the findings, the participants share their personal strategies to locate supportive environments for all phases of childbearing: from preconceptual to postpartum and parenting experiences.

The themes that emerged focused on issues of living day-to-day in relationships with self and others: childbearing and coparenting experiences, negotiating role identities and decision-making strategies, as well as the emotional and behavioural impacts of childbearing on their lives. These findings highlight the determination and energy required to cope with the negativity which often pervades relationships within this couple's environments.

The heart of the invitational perspective is just that: understanding processes of living in relation to others in ways that facilitate caring. The theoretical base upon which invitational theory rests is one which is comprised of theories which focus on perception, self-concept, caring, and democratic processes. It offers opportunities to address the quality of interactive
relationships by assessing people, places, processes, programs, policies, and politics.

However, invitational theory is also premised on an optimistic stance. It focuses on potential avenues for improving relationships with a goal of developing educational environments which convey respect and provide support that is meaningful to individuals from their particular perspectives. The final theme of future possibilities emerged through a process of reflection by the participants and me, with respect to considering what inviting support for childbearing lesbian women might look like and how it might be facilitated within a public health context.

The focus of the fifth chapter will be a theoretical interpretation of the thematic analysis of these study findings, using an invitational framework. In order to facilitate this discussion I will focus on the 6th P, politics, which addresses issues of power relations which are inherent in promoting invitational relationships. A variety of feminist perspectives which address relations of power will offer insight into an interpretation of this analysis.
CHAPTER FIVE: OVERVIEW, DISCUSSION, AND IMPLICATIONS

Overview of Chapter Five

The purpose of this research was to explore childbearing lesbian women's perceptions of their educational needs for support in order to facilitate the development of inviting community resources in a public health context. An ethnographic case study of one childbearing lesbian couple offered insight into these issues.

I will first describe how this final chapter is organized to interpret the study findings and then offer a summary of the research process as laid out in the previous chapters. The focal point of the chapter will be a conceptual framework for access which interprets the thematic analysis from Chapter Four in the context of the literature.

In order to interpret the findings of this study, I have focused on the political dimensions of educational practice by discussing how an analysis of power relations, informed mainly by feminist perspectives, extends an invitational analysis of access in educational interactions. The invitational framework systematically addresses five indicators of educational environments: people, places, programs, processes, and policies. In 1992, Dean Fink considered how a 6th P of politics could offer support to the framework, especially with regard to political savvy in educational settings. I will argue that the political component of invitational interactions is a key aspect of enabling educational opportunities, as power is implicated in the very possibilities inherent within individual and institutional interactions.

In this study, power is conceptualized as having repressive qualities and also, in its positive form, as producing knowledge through action (Corry, 1991). The diverse feminist approaches used in this analysis reflect my understanding of such concepts and have been chosen as an invitation to open space for reflecting on ways to link feminist theorizing and invitational
theory in a practical vein: how this can enrich educators’ understandings of promoting inviting community care for childbearing lesbian women.

Summary of Research Process

In this section I have summarized the study process from the preceding chapters. I have reviewed the study questions and described a context for the focus of this chapter: an interpretation of the research findings.

This study stemmed from my experiences as a public health nurse educator with an in-depth knowledge of sexual health and childbearing issues. Working from my position as a feminist public health nurse educator and mother who has a limited personal connection to lesbian childbearing, I desired a better understanding of how my own heterosexist assumptions have shaped my nursing practice, as well as those factors which have rendered lesbian childbearing invisible in public health contexts.

With an awareness of how the pervasive effects of heterosexism and homophobia have shaped societal norms, I sought insight into how these oppressive circumstances shaped childbearing lesbian women’s lives and their perceived choices to act under these conditions. As well, I was familiar with an invitational approach to systematically addressing educational environments with a view to facilitating inviting communities. The framing of the study questions reflects this focus on the 6 Ps of invitational theory: people, places, programs, policies, processes, and politics.

I wanted to explore the everyday situated lives of childbearing lesbian women and what they defined as educational needs for information and support. Given the conservative political climate, what public and private venues did they use to access relevant support? It was important
to discover their perceptions of how people, places, programs, policies, processes, and politics either facilitated or hindered access to supportive care. Based on the choices they perceived to be available to them, what actions did they take to create support? I also sought their interpretations of the impact of childbearing on their lives. Lastly, with a goal of facilitating an understanding of what changes might be perceived as inviting, I wanted to reflect with childbearing lesbian women about how they might imagine some possibilities for the future.

A review of literature in Chapter Two examined a wide range of issues which contributed to my understanding of childbearing lesbian issues. Seven areas of interest were identified. The sources used for a review of the literature, along with a discussion of historical perspectives, contextualized the ways in which discourses around reproductive and lesbian issues have changed over time. Historical, cultural, sociopolitical, and professional developments were documented. An articulation of perspective offered a detailed discussion of invitational theory and feminist theoretical contributions related to individual, institutional, and community interactions in order to frame the political aspects of educational environments for childbearing lesbian women. As well, issues of power relations were noted in four other specific areas of literature reviewed: homophobia and heterosexism, lesbian health research, lesbian health concerns, and lesbian parenting.

In Chapter Three, I described the feminist methodology which informed this ethnographic case study research process and the underlying assumptions about knowledge claims with respect to this approach. I noted how reflexivity, the social action focus, and other issues of power relations are congruent with doing with invitational processes. As well, I demonstrate how these factors shaped the purpose of the study, the choices throughout the
ethnographic process, the ways in which the findings have been reported, the data analyzed, and the interpretations of the findings documented.

In Chapter Four, I set out the narrative findings of this case study of one lesbian couple as they related their perspectives of educational issues relevant to expectant lesbian women. The stories shared by these two women portray the lives of mothers highly committed to creating supportive environments for their family. However, they face ongoing struggles within their communities as they seek environments which will validate and celebrate their situated lives by offering them the information and support they desire.

In this next section I will offer an interpretation of data presented in the preceding chapter and the themes which emerged from an analysis of the findings in the context of the theoretical literature. I will frame this discussion using a conceptual framework which extends the analysis of findings by linking the themes to theoretical understandings of relations of power implicated in access to support. This will provide support for addressing the political implications as they facilitate or hinder access to inviting educational environments.

For ease of reading I will introduce the conceptual structure and present it in three sections, with subheadings to clarify distinct areas of discussion. In Section One I will address the four interactive components of access which emerged from the thematic findings: perceived safety of resources, disclosure status, situated privilege, and public and private availability of support. In the second section, I will describe the consequences of lack of access to comprehensive support by highlighting the effects of heteronormative strategies of alienation, repression, omission, and stigmatization (Onken, 1998) on childbearing lesbian women and their communities. The third section offers implications for educational research and practice by
systematically presenting educational possibilities using an invitational framework. These are based on the reflective work of the research dialogue with the participants as it relates to effecting inviting educational environments for childbearing lesbian women in a public health context. A final summary of this chapter follows.

**Introduction to the Conceptual Framework**

In order to structure an interpretation of the extensive narrative findings of the prenatal and postnatal interviews and eleven themes presented in Chapter Four, while maintaining close connections to the voices of the participants, I have formulated a substantive theory (Kirby & McKenna, 1989) which remains close to the data. This conceptual framework emerged from the thematic analysis of the study findings as I interpreted these in relation to the theoretical literature. The 11 themes identified in the analysis of findings included:

- Coparent experiences
- Biological childbearing experiences
- Isolation
- Determination
- Support perceived as inviting interactions (using the 6 Ps)
- Barriers to support perceived as disinviting interactions (using the 6 Ps)
- Childbearing as a turning point
- Diversity of lesbian communities
- Public or private availability of support
- Strategies
- Future inviting possibilities
The original study goal was to facilitate access to inviting education for childbearing lesbian women. A common element in the literature presented in the second chapter was the complex relations of power which underscore the historical, cultural, and social dynamics of educational environments for lesbian women, and hence inform the context through which access to inviting childbearing support occurs. Using access as an overall organizing concept, I was able to group the 11 themes into broader concepts and systematically link them in way that created a three-part structure.

The first section incorporated several themes into four concepts or factors which interact to contribute to access. The second section offered insight into the effects of lack of access to support, and the third focused on imagining changes for the future. Such a framework, grounded in the narrative, integrated the thematic findings and theory in a way that “describe[d] and explain[ed] the research focus” (Kirby & McKenna, 1989. p. 137.).

Because of the priority I have placed in this study on participant perspectives, I have consciously linked particular points raised by the couple into this analysis. Although this has consequently lengthened this document substantially, I feel that such a focus on nuances enriches the understandings available through such an ethnographic process.

In each of the following subsections, I will briefly introduce and integrate into the discussion diverse feminist theoretical perspectives which address relations of power as they contribute to invitational interactions. This will facilitate an analysis of access which foregrounds the political dynamics inherent in enabling inviting support for childbearing lesbian women.
Section One: Four Interactive Components of Access

Introduction

I will first clarify the four interactive components of access and then discuss each factor under a subheading in detail as it relates to the literature. These four concepts: perceived safety, disclosure status, situated privilege, and public and private availability of support, emerged from the findings as I grouped themes which explained how the couple found the information and connections relevant to their childbearing. At any moment, the support available to the participants was not contingent on only one aspect, but all of these variables, and this established their interrelationships. Interactive components of access were a reflection of how thematic categories overlapped.

Each of the four components of access confers a potential privilege related to dominant social norms which conveys a specific authority denoting how lesbian childbearing women are perceived in relation to others. This influences access to support. The ways in which individuals anticipate, perceive, or experience the consequences of disclosure or nondisclosure, perceive safety within resources, locate public or private points of access to support, and encounter the consequences of their situated privilege conferred or denied, vary at any time with the historically, socially, and culturally specific context.

As well, these components interact, as access is contingent on several variables related to socially mediated power relations which influence whether support is available. In one institutional, individual, or community context, open disclosure as a lesbian childbearing woman may offer access to relevant information and support, whereas in other circumstances disclosure may expose barriers to care. The decision to disclose fully within a specific context may hinge
on a perception of safety within an environment, a perception that will vary with situated location and previous collective or individual experiences with similar environments. Public and private points of access to support may vary depending on situated privilege, information disclosed, as well as perceived safety of information or support offered.

**Perceived Safety**

The first component, perceived safety of resources, has been a recurring element throughout this study. As it has been defined through an analysis of the findings, safety is synonymous with inviting support: environments that validate and celebrate the diversity of lesbian mother experiences and which offer optimal physical and emotional care.

Throughout this study, the research participants placed a priority on issues of safety as they sought support for their childbearing. In their view, a favourable outcome for childbearing was that in which interactions were inviting processes: those that conveyed caring and respect for their lives as childbearing lesbian women, while disinviting relationships posed barriers to care.

Issues related to locating relevant childbearing information in supportive environments will be described as they relate to everyday experiences and the larger social context. I will link the impact of dominant discourses on childbearing lesbian women to their experiences of isolation, support, identities, and perceived choices to act. The roles of social location and intentionality as they contribute to inviting encounters will be considered.

Daily encounters with individuals and institutions offer understandings of the impact of power relations on childbearing lesbian women’s lives (Abbey & O’Reilly, 1998; Epstein, 1999a; Kirby & McKenna, 1989; Sawicki, 1991; Stevens, 1992, 1998). Women’s ways of knowing (Belenky et al., 1986), and the ways in which women understand themselves in relation
to their social context, stress the interconnectedness among identities, power, and knowledge (Epstein, 1999).

Understanding how knowledge claims related to childbearing are marginalized or privileged within specific contexts is facilitated by a discussion of power relations. Knowledge is informed by unconscious and conscious social influences: discursive processes through which knowledge and power are intertwined (Abbey & O'Reilly, 1998; Shogan, 1999). Discussions of power relations through Foucauldian discursive processes have become a key notion for feminist theorists in terms of how “social constraints, or in Foucault’s terms power, circulate in and through the production of discourses in societies” (Shogan, p. 3). The content of dominant discourses and the authority ascribed to the speaker of their subject matter reflect power differentials which are located in specific social, cultural, and historical contexts (Kemp & Squires, 1997; Shogan, 1999).

Circulating discourses produce power, reproduce dominant power relations, and permeate our ways of perceiving and interpreting messages through normative boundaries of behaviour (Shogan, 1999). In this way, these dominant narratives (Freedman & Combs, 1996) regulate social behaviour and shape everyday interactions and ways of knowing ourselves. The structuring of patriarchal power into social hierarchies and institutions (Eichler, 1997; Epstein, 1996b; Rich, 1980) informs and shapes heteronormative (Goldman, 1996) boundaries. An awareness of the pervasive nature of heterosexism, and the means by which heteronormativity is structured so that neither is likely to be perceived at the conscious level (Martindale, 1993; Onken, 1998), is crucial to this discussion.

Ways of knowing which are based on binary thought patterns and which form the basis of
language, dominant philosophies, and social patterns have been addressed by Abbey and O’Reilly (1998), Davies (1992), Kemp and Squires (1997), MacLeod (1992), and many other feminists. The hierarchical and oppositional nature of these dualistic forms shape hegemonic discourses which contribute to the ways in which difference is conceptualized as *other* in relation to an assumed reference point: often the white, middle-class, able-bodied, heterosexual male (Mullett, 1995; Nelson, 1996) in a Eurocentric context (Shroff, 1997). Mullett emphasizes that exclusionary practices are those which result when the implicit norm is left unexamined. Once acknowledged and stated, the consequences of marginalization and strategies for inclusion can be explored (Dei, 1999; Mullett).

This is not to say that individuals who are positioned as white, middle-class, able-bodied, heterosexual males intentionally or consciously practise in exclusionary ways. Certainly this study has been premised on the need to examine my own heterosexism as an educator working from a named social location. An essential theme throughout this discussion will be understanding how societal privilege ascribed to locations of dominance is unconsciously perpetuated through discursive representations of everyday language, thought, and institutions in ways that enable the ongoing marginalization of childbearing lesbian women by both females and males situated in diverse social locations.

Lesbian women who connect with each other through childbearing at times may share similar struggles to locate information. Although individuals may share marginalization as lesbian childbearing women, their experiences of oppression will vary according to Dei (1999) because of the ways these experiences have been structured in relation to their particular contexts. Historical and temporal contexts and social location (Kemp & Squires, 1997; Mandell,
1998) shape how difference is experienced.

Invitational theory (Purkey & Novak, 1996) explains that our self-concepts are always shifting in relation to different life experiences; however, the role of positionality must be identified and named in this process. Individuals situated in a position marginalized by gender, race, class (Roberts, 1996), sexuality, or other locations will interpret their worlds in a different way from those who are privileged through their dominant social locations.

Kelly (1955) uses personal construct theory to explain how information is processed into constructs which are ways of viewing the world. Existing information, on conscious and unconscious levels, is structured according to previous experiences within a specific historical, social, and cultural context. Dominant discourses which privilege certain beliefs, values, and knowledges are unconsciously internalized and form a framework upon which to construe embodied experiences in relation to the features of the normative social world. This structure enhances the predictability of interactions within the environment. Responses to events are based on existing constructs of the world. Conflict between experienced and predicted encounters with the world produces cognitive dissonance, which offers opportunities to modify existing constructs. Kelly uses the concept of cognitive dissonance to indicate gaps between existing constructions of the world and current life experiences.

Disparity between an individual’s understandings of self in relation to the world are not solely from a cognitive perspective, but include those which are affective and behavioural in nature. In addition to cognitive dissonance, marginalization shapes pervasive feelings of oppression which may be overwhelming. Dewey (1933) uses the term “felt difficulty” to represent the experiential discord within interactions informed by the biological or physical,
social, and historical dimensions of particular environments in relation to oneself. Tensions between individuals’ worldviews and those of the larger social and institutional environments may contribute to significant emotional upheaval and affect perceived options for action. The interconnections between cognitive, emotional, and behavioural aspects of situated lives demand an emphasis on the (w)holistic nature of embodied experiences which create knowledge and contribute to ways of understanding (Abbey & O’Reilly, 1998; Seigfried, 1992).

By foregrounding an individual’s social location, those who experience marginalization in relation to social norms would experience ongoing “felt difficulty” as everyday encounters with language, institutions, and others, positioned in different ways are also shaped by power relations. These oppressive ways of knowing and being are related to the subordination of selves or knowledge to those with authoritative privilege within a specific context.

Normative assumptions implicit in existing language and social discourses contribute to disenfranchisement on emotional, cognitive, and behavioural levels for those not represented by dominant interests. For instance, when statements are made using the universal “we,” there are assumptions about the characteristics of “we” that are often at odds with the lived experiences of those supposedly included. When the vast majority of writings on lesbian women do not address racial or ethic diversity, the assumption is that white lesbian women are privileged in relation to nonwhite (de la tierra, 1996; Kanneh, 1998).

Thus, lesbian women who have construed identities as lesbians and women are, through daily experiences, also constituting subject positions which contribute to how they see themselves as women in relation to men, their same-sex preference in relation to opposite-sex preference, their same-sex preference as females in relation to males with same-sex preference,
and so on with respect to race, class, ability, etc.—all within a specific historical, cultural, social, and geographic context. The particular social location of a lesbian woman will influence how she incorporates discourses on lesbian childbearing into her self-concept, and hence how she perceives potential environments with respect to safety.

Lesbian motherhood is considered contentious and queered (Comeau, 1999) through public discourses. It is “perceived as contradictory: both resisting and accommodating the institution of motherhood” (Lewin as cited in Epstein, 1996a, p. 61) which is based on an assumption that the patriarchal standards of the nuclear family form the socially desirable reference point. Gabb (1999) pinpoints the “unnatural status—[the] disruption of the reproductive narrative—that lesbian parents pose such a threat to society” (p.15). According to the normative discourses in which motherhood and sexuality are separate spheres, lesbian motherhood sexualizes parenthood (Comeau, 1999; DiLapi, 1989; Epstein, 1996a; Gabb, 1999). Dominant discourses of lesbians and lesbian motherhood which perpetuate negative stereotypes affect how lesbian women see themselves and others in relation to the world and their perceived options.

In contrast, Abbey and O'Reilly (1998) emphasize the importance of “recogniz[ing] biases and omissions in the maternal discourse” (p. 16) in order to frame lesbian motherhood as potentially transformative in its creative meanings. Since lesbian mothers negotiate a contradictory motherhood, as women who both resist its conventional scripts while reaping the intrinsic benefits, their opportunities to develop new family structures are potentially transgressive (Epstein, 1996a).

Choosing to mother or parent as a lesbian woman has diverse meanings for the women
involved (Epstein, 1996a); however whether motherhood is considered an available life choice for lesbian mothers is related to the messages women perceive. Ellen’s initial understanding of motherhood was that it was available as a choice exclusively for heterosexual pairings. As a teen coming to terms with her lesbian identity, heterosexist discourses established that her childbearing option was closed.

As lesbian women anticipate motherhood they grapple with how their identities as lesbian women will shift (Clunis & Green, 1995). Childless women who partner with another woman encounter ongoing discrimination in individual and institutional contexts (Stevens, 1992). Locating support to validate same-sex orientation is a process that varies considerably across kinship and community networks and contributes to feelings of isolation (Clunis & Green, 1995; DeMarco & Simkin, 1996; O’Hanlan, 1998; Stevens, 1992; Vida, 1996).

Ellen noted that for a number of lesbian friends who had hoped to become mothers, the perceived barriers to achieving motherhood are overwhelming. When lesbian women are already experiencing isolation and exclusion in relation to their sexual orientation, they may encounter a plethora of concerns as they consider childbearing: the invisibility of lesbian families, the unpredictability of support networks, and the negativity of dominant discourses. Lesbian women may encounter too great a gap between how they predict their life will change with childbearing and the way they currently construe themselves in relation to their world, which for many is already unwelcoming on many levels. Discourses on lesbian childbearing contribute to the possibilities they can imagine with respect to self-identity.

Understanding one’s own positionings and examining one’s own experiences of both oppression and struggles could be part of this process. A key premise of invitational theory is
related to promoting positive self-regard (Purkey & Novak, 1996). For individuals to feel supported by others, they must feel able, valuable, and self-directing: they must first become inviting with themselves (Novak, 1992). Opportunities for honest self-evaluation and reflection are useful in determining priorities and strategies for dealing with oppressive realities as childbearing lesbian women.

The couple identified the need to face their own homophobia as a primary strategy in addressing childbearing issues in their lives. With an awareness of the effects of internalized homophobia and pervasive heterosexism in their lives, they chose to risk disinviting experiences by disclosing as a lesbian childbearing couple early in their pregnancy. For them, safety included authenticity and honesty in interpersonal relationships, and public validation of each member of the family. Confirmation and validation which affirm and celebrate the uniqueness of every individual are essential aspects of inviting relationships (Noddings, 1984; Purkey & Novak, 1996).

The ability to claim self-identity as a lesbian to oneself or others is a crucial element in developing the self-concept. How we perceive experiences and make sense of them from a self-concept perspective will be in relation to learning that has occurred previously. According to self-construct theory (Kelly, 1955), lesbian women who seek affirmation for childbearing in atmospheres which are fraught with disinviting heterosexist discourses around childbearing may experience cognitive dissonance as they attempt to authentically construe their identities to self and others. Stereotypes which distort their lived realities and demean caring relationships may be at odds with the many joys and range of embodied emotional experiences of lesbian parenthood. Ellen describes their lives as they parent together as "an absolutely wonderful dynamic" (p. 1-
Abbey and Reilly (1998), instead of focusing on the dilemmas which are posed by conflicting aspects of self, celebrate the multiple complexities which constitute subjectivities and which challenge normative boundaries. "At any given moment several given selves will be complementary and conflicted" (p. 14). It is the gaps, the contradictions, and tensions which offer opportunities for exploring understandings of self in relation to rigid social categories and cultural prescriptions (Shogan, 1999).

Invitational processes through self-construct theory (Kelly, 1955) focus on the meanings of experiences for individuals derived through self-reflection. The process of childbearing itself can be construed as power in action in terms of the opportunity it presents for enabling knowledge production. As childbearing women consider the implications of decisions made in specific contexts, as well as contemplate the emotions and behaviours experienced subjectively through childbearing, they integrate embodied experiences into their self-concepts. Childbearing emerged as a turning point in the participants' lives as they claimed identities as lesbian mothers and consciously reflected on the meanings of the childbearing process for themselves, each other, and others in their lives.

These women used phrases indicative of empowerment through enhanced self-esteem and self-efficacy (Labonte, 1990). These included: "learning to trust my [partner's and] my instincts," "gaining increased [physical and emotional] potential", "resilience", and "experiencing the magical birth and creation of my family." This couple was favoured with caring friends and family, they located supportive caregivers, and found the institutional providers of care inviting as well. For these women, despite the frequent feelings of isolation, the
process of childbearing was enabling: the supportive environments and commitment to their relationship facilitated increased confidence in themselves, their partners, and institutional providers. In fact, for this couple, the positive hospital environment opened access to birthing strategies which had previously been considered less available to them. The two inviting birth experiences prompted a consideration of hospital and home environments for future childbearing, with options of epidural or other interventions which are restricted to institutional settings. The meanings attributed to learning during the childbearing process and the increased perceived possibilities for actions are congruent with invitational theory's priority on a hopeful and optimistic stance.

However, the participants did stress that their inviting experiences were conditional on midwifery or other inviting advocacy within the hospital environment. The circumstantial nature of these supportive institutional interactions is what requires such energy, foresight, and determination to anticipate and shape environments which offer, but still cannot guarantee, safety. Invitational theory (Purkey & Novak, 1996) recognizes that inconsistency, unreliability, or uncertainty within interactions contributes to environments which are either unintentionally inviting or unintentionally disinviting, depending on whether the messages received are those which incorporate respect, optimism, and trust or suspicion, contempt, and pessimism.

Purkey and Novak (1996) have differentiated between intentional and unintentional invitations. They stress that intentionality “suggests a purposive act intended to benefit the recipient” (p. 53). There is a conscious component which is inherent in this process of intentionality which Purkey and Schmidt (1996) have illustrated as a polarity or duality: intentional/unintentional. The optimal stance results in intentionally inviting encounters. Actions
are goal directed with a purpose of offering invitations to others which convey genuine respect, validation, and unconditional acceptance of others.

For this lesbian childbearing couple, support was described in various ways, from instrumental support, honest feedback, and informed choice to advocacy and legislation. For families with children, instrumental support in the form of child care is inviting. Lesbian friends assisted with child care during labour, and participated in the delivery celebrations with the couple and caregivers. There is often an even greater reliance on a network of lesbian friends in order to deal with the demands of parenting within the lesbian relationship (Boston Women's Health Book Collective, 1992; Clunis & Green, 1995).

Sharon noted that their choice of support systems for the birth did not include family members, but lesbian-positive midwives and friends who could also advocate for them. Several siblings were, however, present in early labour. Lesbian women often have friends from their lesbian community with them during childbirth and a strong intrapartal formal support system (Kenney and Tash, 1992). The strategy of choosing these birth teams may reflect feminist political priorities which also facilitate family adjustment and acceptance by the larger community (Kellogg, 1998). Certainly the couple's perspective on childbearing as lesbian women was informed by feminist analysis as they thoughtfully considered their options for locating support.

The participants found their midwives intentionally inviting in their respectful stances, ongoing advocacy, and encouragement of their choices and abilities, congruent with consistently inviting verbal messages. The principles involved in inviting interactions which incorporate intentional stances of optimism, trust, and respect (Purkey & Novak, 1996) have implications for both childbearing lesbian women and those they encounter. Receptivity to communication of
messages is conveyed on verbal and nonverbal levels. Practice is shaped by experience and receptivity in interactions. Noddings (1984) stresses that consistency in messages sent helps to build trust and perceptions of caring.

Within their own relationship, the couple found that at times they experienced conflict in interactions because of assumptions that they had about each other as women and mothers. Dominant patriarchal discourses shaped their expectations of postpartum and their abilities to care for each other with the arrival of a child and the shift in family roles. Their commitment to a relationship based on open communication helped overcome misunderstandings exacerbated by lack of role models for lesbian mothering. As well, their priority on sharing all aspects of mothering was reflected in their flexibility in roles and enabling visibility of both the biological and coparent. The couple’s actions to maintain an environment which was supportive and safe for each partner incorporated Nodding’s (1984) four components of caring which include: validation, dialogue, practice, and modeling.

Prevailing discourses on lesbian childbearing also affect the content and process levels of health and educational interactions for lesbian women who seek support. Power is implicated in the positionality of both those seeking support and those who determine what and how education will occur. Inviting support is that which not only offers relevant information, but conveys caring in other ways. Previous inviting or disinviting experiences with environments will shape whether they are construed as caring. What information is included and how information is represented visually, through text, and discussion symbolize relations of power within the educational interaction. As Stevens (1998) emphasizes, providers’ assumptions and discriminatory attitudes are communicated in their behaviour in both overt and subtle ways (p. 83).

When defining what information and support can be deemed important for educational
settings, invitational theory (Purkey & Novak, 1996) offers explanations through perceptual self-concept theory. Kelly’s personal construct theory (1955) stresses how information is organized into concepts or constructs based on how it relates to the existing structure of information. Relevance of content and experience determine how new concepts are interpreted in relation to familiar previous encounters.

Educational content that is perceived to enhance or match personal experiences and is consistent with lived realities may be considered inviting. For the participants, an understanding of everyday struggles conveyed empathy. Demonstrating sensitivity to health topics with lesbian issues in mind is considered important. Health care providers are considered gay positive and supportive when they do not assume heterosexuality. Although use of supportive language by providers indicates a possible comfort level with lesbian issues (Regan, 1981), Sharon noted that a shift of perspective is required to be inviting. In order to provide the respect that is sought in a lesbian supportive provider, health care providers must reflect on their knowledge base of same-sex issues and awareness of communication strategies (Lehmann et al., 1998; Robertson, 1992; Trippet & Bain, 1992).

Because language is considered to indicate “acts of power” (McLaren, 1995, p. 110), sensitivity is essential when using terms for childbearing women who partner with another woman. The participants consistently used “lesbian” to describe themselves or those in their community. While Arnup (1998), Epstein (1993), Pepper (1999) and Comeau (1999) describe lesbian parenting concerns, Chandler (1999) and Gabb (1999) specifically refer to queer mothering with respect to same-sex childbearing partnerships. O’Hanlan (1998) has noted that general assumptions cannot be made, as the preferred words may vary with political affiliation, “outness,” and age (p. 8). The use of gender-neutral language and establishing terms acceptable
to clients is important.

A crucial aspect of interactions with health care providers is the provider’s response to disclosure of lesbian status. Negative reactions and less than optimal care have affected so many lesbians’ experiences with disclosure that many avoid this completely and providers remain unaware of their role in the interaction (Lehmann et al., 1998; O’Hanlan, 1998; Robertson, 1992; Stevens, 1992, 1998; Trippet & Bain, 1992). The couple carefully strategized to locate lesbian-positive AI providers and health care professionals. According to Zeidenstein (1990), disclosure to a provider rarely produces a reaction that celebrates lesbian status. That all providers in the participants’ hospital birth settings contributed to labours and deliveries which facilitated and celebrated their lesbian childbearing family was unexpected for the women, based on previous institutional encounters.

At the same time as this couple devoted time and energy to locating supportive caregivers and networks, Ellen noted that she also learned that “letting go of circumstance” is possible. On the one hand, she and her partner attributed their inviting experiences to deliberate strategies they chose to minimize homophobia, and did not perceive that there was more public support for lesbian childbearing than previously. Yet, in the face of identifying the circumstantial nature of their supportive experiences, she contradictorily concluded that taking risks is alright—that inviting encounters are still possible. This appears to be a reflection of the magnitude of support for childbearing the couple perceived in an institutional context and provides evidence of how inviting experiences are valued, especially when such support cannot be predicted on the basis of previous encounters. These institutional interactions could be considered unintentionally inviting with respect to their unreliable nature; however, the participants’ chosen providers of care were
perceived to be intentionally inviting. From a self-construct perspective, the cognitive dissonance produced through these experiences and meaning attributed to them shaped more hopeful and optimistic constructs related to childbearing within institutional settings.

Perceptual and self-construct theory offer valuable insight into the concept of tunnel vision (Kelly, 1955) which contributes to sensitivity on the part of many lesbian women as they constantly scan their environment for negativity based on frequent previous experiences. Both Sharon and Ellen recognized that they were quite alert to any hint of negativity within interactions based on previous experiences, and that this influenced their interpretation of encounters. The selection of information processed within the phenomenal field is such that it conforms with existing constructs. Information is construed in a way that increases the predictability of future interactions. As well, tendencies towards maintaining constancy in structure allow for cognitive dissonance when perceptions are at odds with previous experiences. At times the couple wondered whether they perceived disinviting messages when none were intended.

A recurring theme of isolation emerged throughout the narrative as the women experienced childbearing. These participants illustrated how society alienated them from themselves as well as from others. The concept of enforced heterosexuality developed by Adrienne Rich (1980) offers insight into the “power-over” of patriarchy that permeates many feminist discourses. She has shown how heterosexuality is enforced and woven into dominant social values which direct all social institutions. The essence of the threat of lesbian women to patriarchal power is that the emotional and/or physical bonds between women serve women’s needs without requiring male legitimation or sanction. As such, women’s issues and perspectives are valued in their own right (Eliason et al., 1992).
Sharon noted that there were often only patriarchal models available for them. Dominant patriarchal values influence the support that lesbian women may find from both males and females situated in diverse social locations. When women who self-identify as heterosexual unquestioningly adopt norms based on patriarchal stereotypes which recognize women only in relation to men, the cost to women is alienation from each other and an enforced dependence on males. Homophobia and heterosexism are pervasive social and cultural proscriptions which inhibit open disclosure of sexual orientation, and hence prevent lesbian women from connecting with each other for support. As well, these patriarchal influences which render lesbian women invisible also stigmatize same-sex issues, and thus hinder potential support by both males and nonlesbian identified females.

Onken (1998) explains that such stigmatization conferred by powerful norms which promote sexism and patriarchy contributes to perceptions of lesbian women as “failed women, failed heterosexuals” (p. 18). He conceptualizes the maintenance of widespread normative and values which inhibit the celebration of same-sex orientation through moral exclusion and other strategies as direct and indirect forms of socially sanctioned violence, knowingly and unknowingly perpetuated by individuals and institutions. As a consequence, lesbian women struggle to claim their identities and are isolated from themselves and others. The study findings which equate safety with both physical and emotional well-being are congruent with such arguments (Stevens, 1992, 1998).

Negative discourses which distort lesbian relationships mark lesbian women as child molestors by focusing exclusively on the unnaturalness of their sexuality (Gentry, 1992; Stevens, 1992). These messages are perpetuated by media sensationalization that excludes the diversity of
positive lived experiences. The couple found that prior to childbearing they constantly battled such misconceptions as virtually the only information available for family members to understand their lesbian relationship was sexualized.

Discourses regarding lesbian childbearing are superimposed on the above processes. In fact, lesbian mothers face custody battles which are frequently premised on such concerns (Arnup, 1998). Childbearing women who partner with another woman may be at increased risk of social isolation as such environments limit others’ understanding of lesbian families and inhibit disclosure of those who parent in same-sex relationships (Coalition for Lesbian and Gay Rights in Ontario, 1997). The couple reiterated how they spend enormous amounts of time teaching others about their family.

Issues of social location related to race, ethnicity, and ability will also interact with these processes (Shroff, 1997). Marginalization by race and class, as well as other systems of oppression, contribute to how couples locate support. This will be further discussed under disclosure status and situated privilege.

Childbearing lesbian women may feel isolated from other lesbian women, from their partners, and from the larger community. According to the findings, lack of empathy was a key element in how the study participants perceived a lack of connection with others. Invitational theory’s (Purkey & Novak, 1996) focus on the centrality of empathy to the invitational experience is related to how interactions can be perceived as caring. As Goleman (1995) states, “for all rapport, the root of caring, stems from emotional attunement from the capacity for empathy” (p. 96).

For the participants, some of these family or other supports provided mixed support at
times. While these well-intentioned individuals contributed to daily social experiences with playmates and family gatherings, they offered nonjudgemental social support. However, the participants noted that often issues crucial to their own lives were quite different and invisible in the interactions, despite their commonalities with others based on motherhood, sexual orientation, or kinship. This included interaction with heterosexual mothers who did not appear conscious or aware of the depth of their daily struggles as mothers. Families of origin who continue to discount the coparent of the child born in a lesbian relationship, by gestures which exclusively celebrate birth mothers or ignore their focus on shared decision-making and care, alienate these mothers.

Isolation is also experienced in terms of how lesbian women may feel alienated from communities of other mothers: those who identify as heterosexual, those lesbian mothers who have partnered with a male partner, as well their own mothers, grandmothers of their children. Although the couple derived some support through a local lesbian mothers’ group, all had partnered with a male and the recurring issues of custody and visitation were irrelevant to the participants’ lives. Concrete information or networks for AI were invisible in this context. Connecting with the large numbers of openly AI mothers in Toronto offered an important support that was unavailable locally.

For this couple, childbearing underscored how the depth of others’ lack of understanding of their lesbian family relationship was an ongoing contributor to lack of support in their lives, especially from those whose support they valued highly. This was an important learning experience for the participants. Jordan and Deluty (1998) refer to the importance of the family-of-origin’s support for lesbian women, but do not address how this is influenced by childbearing.
Other sources note how variable kinship support may be when lesbian women bear children (Comeau, 1999; Epstein, 1993, 1996b). Even if potential grandparents have accepted the same-sex relationship to some degree, the news that the coupling is producing a child, by whatever means, adoption or birthing, brings no guarantees of support for the couple (Asten, 1997; Clunis & Green, 1995; Nelson, 1996). In fact, according to these sources, disclosure of same-sex orientation to potential grandparents is often avoided if there is a risk of perceived negativity. However, as noted, this couple did not consider this an option for their family.

With the birth of their second child, the couple, who had carefully planned to minimize homophobic encounters, faced the postpartum exclusion of Ellen, the coparent, as Sharon’s mother openly lectured her about “taking a secondary place” in the family from that point. As well, Sharon’s family celebrated her biological childbearing as if it were her first mothering experience. So despite this peak birth experience, the first week postpartum was coloured by the knowledge that 5 years of becoming familiar with their lesbian relationship and childbearing was insufficient for validation by this family-of-origin on their terms as equitable partners and mothers in this family. This rejection of the coparent weighed heavily on their perceptions of themselves as a lesbian family, with a view to redefining traditional notions of “family” (Comeau, 1999; Epstein, 1996b). According to Epstein (1993), there may be an ongoing struggle for recognition of the legitimacy of the nonbiological parent by the extended family.

Although Sharon explained that her family’s initial reaction to the news that she was in a same-sex relationship with Ellen was positive, this changed markedly with time. In fact, she is not optimistic that it will improve. At times the participants appeared to sense that the other family members’ comments directed toward their priorities to name their child jointly and have
the coparent take a back seat to the grandmother’s role with the new baby were actually intentionally disinviting as they purposely sought to contribute to potential conflict by shifting the power balance within the couple’s relationship. Purkey and Novak (1996) have addressed how the demeaning messages that are purposely sent in intentionally disinviting interactions may be a reflection of prejudice. As has been mentioned, this discrimination based on same-sex status continues to be socially sanctioned. Certainly Ellen’s family is highly involved and supportive, although a number of them live a few hours away, as indicated by their presence during Sharon’s labour and the couple’s vacation with these grandparents only a few months postpartum after the second birth. The variable support which families can offer is influenced by the preponderance of heterosexual couples and exclusive support for them. This will be further discussed under public and private availability of information.

Friends, both lesbian and nonlesbian identified, may become lesbian families’ primary extended family when families of origin cannot provide support (Epstein, 1996b; Nelson, 1996). Kenney and Tash (1992) emphasize the effort needed to find acceptance in both groups. The couple counts as their closest friends other lesbian women or couples, although they state that they have the support of friends in opposite-sex relationships as well. In fact, important feedback related to prenatal classes came from friends whom the participants described as a progressive heterosexual couple. Friends’ acceptance of lesbian childbearing is conveyed through an understanding of how issues of language and content of resources are relevant to their lives.

At the same time as this couple receives support through friendships with other lesbian women locally, they have found that within their local lesbian community this support is conditional upon several factors. The quality of support would be enhanced by the availability of other out AI mothers who are not visible in the community, although other lesbian parents with
older children are. Some lesbian women are uncomfortable with the notion of lesbian childbearing or raising sons (Rich, 1976). Claiming motherhood as a lesbian woman within this community does not guarantee support, although a number of inviting lesbian women are part of the couple’s lives. This will be discussed further under situated privilege.

With their background as health professionals, this couple was well aware of providers’ various comfort levels with same-sex issues and made this a high priority. In contrast to other stories of lesbian women’s search for supportive childbearing providers, this couple was already familiar with an inviting family physician and midwives. Pepper (1999) cautions childbearing lesbian women who are involved in locating AI services and childbirth professionals that homophobic providers exist, however suggests that alternative supportive providers are available. Nelson (1996) indicates that the search for supportive professionals for childbearing can be dehumanizing emotionally as well as physically. Repeated pelvic examinations may be carried out in the process of having assessment appointments with prospective providers. She describes lesbian women’s experiences with physicians who have openly criticized them for considering childbearing. The quality of physical or emotional care available from such providers is compromised by open disclosure (Stevens, 1992). Yet, financial, geographic or health circumstances may preclude open choice of professionals and services.

Sharon, a physician herself, empathized with her partner who desired a home birth, saying that it would be unsafe to be under the care of a physician in a childbearing context. Both women would have opted for midwifery support if they had been referred for high-risk medical care: choosing midwifery in addition to physician care. During each woman’s pregnancy, a high-risk provider was involved for a short time. The participants attributed the supportive care in part to their midwife’s involvement in the referral process. Kenney and Tash (1992) have noted that
issues of control related to labour and delivery increase the perceived vulnerability of lesbian women who are already anticipating limited support in institutional contexts. For these women, advocacy through midwifery care enabled inviting environments. As it happened, the participants felt well supported by their family physician, midwives, and the reproductive endocrinologist who was involved in the AI process, each of whom they chose based on their inviting stance. As well, however, they also received inviting support from the specific nursing and medical caregivers who, in conjunction with their midwives, offered care at their deliveries, although they were not aware of who would be scheduled at that time.

Institutional practices throughout the community contribute to fears and negative health experiences and are avoided if possible (Boston Women’s Health Book Collective, 1992; Canadian AIDS Society, 1992; Coalition for Lesbian and Gay Rights in Ontario, 1997; O’Hanlan, 1998; Ramsay, 1994; Simkin, 1997; Stevens, 1992; White & Martinez, 1997). This couple was aware of such humiliating experiences with institutions and individual providers through their personal experiences and shared networks.

When seeking AI resources, the couple noted that many agencies openly excluded single or lesbian women from care, and another institution, reported to be lesbian supportive, sent a letter which conveyed an assumption that the women were infertile. The participants indicated that the invisibility of lesbian women in antidiscrimination statements, the limited complaints processes, and lack of guidelines on documentation or policy on the use of sensitive language for partners within institutional settings are disinventing. However, this couple did find the family visitation policy in their local hospital inclusive. The outright exclusion from services (Coalition for Lesbian and Gay Rights in Ontario, 1997; Stevens, 1992) and lack of sensitivity to issues of
confidentiality or discrimination further stigmatize childbearing lesbian women and invalidate their needs, marking such resources as unsafe.

A key element in assessing institutional environments for safety is how they encourage conditions that encourage disclosure and how they support out employees (Coalition for Lesbian and Gay Rights in Ontario, 1997; Stevens, 1992). Although Sharon discovered that she has received great support in her workplace as a physician in the community, she feels that her work setting is progressive. An important factor for Sharon in disclosing to patients in her practice is how it will influence the therapeutic relationship. Purkey and Novak (1996) stress how inviting interactions take into account the consequences of sharing of information, with the needs of the client paramount.

In contrast to Sharon's experience, the couple described a medical colleague who has encountered judgement and homophobic reaction in her hospital working environment as she attempted to locate support for disclosing as a lesbian woman. This woman would like to have children, but is perceiving tremendous barriers as a nonchildbearing lesbian woman. Institutional environments which avoid addressing homophobia or heterosexism within the workplace exhibit disinviting characteristics. Purkey and Novak (1996) have described consistently and/or consciously nonrespectful settings as “lethal” (Course materials, EDUC 5P43, January, 1997) and the Ontario Human Rights Code (Coalition for Lesbian and Gay Rights in Ontario, 1997) uses the term “poisoned environment” (p. 123).

The importance of having health providers that are lesbian positive and/or openly disclosed has consequences for how attuned they may be for identifying and understanding relevant issues for childbearing lesbian women, in addition to offering affirmative role models
for others in their visibility. This includes offering childbearing as an option for single or lesbian women. O’Hanlan (1998) indicates that for significant numbers of lesbian women childbearing is relevant to their current lives or future plans. However, a lesbian physician, a colleague of the participants, was not aware of resources for childbearing lesbian women when Ellen turned to her for assistance. She did search on their behalf for information and offered relevant and inviting information. The lack of awareness regarding childbearing by health providers or even those in the lesbian community reflects the widespread impact of discourses of invisibility and heterosexism.

Even when lesbians have “come out,” the provider’s lack of understanding of parenting options for lesbians may preclude a discussion of preconceptual health and related relationship stresses in planning a pregnancy (Gentry, 1992; Olesker & Walsh, 1984). Shroff (1997) notes that choosing which partner will be the biological mother can contribute to relationship conflict. For this couple, the partners’ career issues and financial benefits of medical residency facilitated the couple’s decision as to who would bear their first child.

Relationship issues are a crucial issue for women identifying same-sex orientation, whether closeted or out. Providers are perceived as encouraging when they express concern regarding support networks (O’Hanlan, 1998; Ramsay, 1994; Stevens, 1992; Zeidenstein, 1990). The couple found their reproductive endocrinologist, midwives, obstetrician, and nursing staff inclusive of the coparent and son. Acknowledgement of partners and children is perceived to validate childbearing identities. However, Sharon expressed disappointment at how, at times, as both an out biological mother and coparent, these aspects of her life are ignored when other families are the topic of conversation in social settings.

Although relationship issues are major issues of concern for all childbearing women
whatever their disclosure status (Boston Women’s Health Book Collective, 1992; DeMarco & Simkin, 1996; O’Hanlan, 1998; Vida, 1996; Waitkevicz, 1996), childbearing adds other dimensions which may not be anticipated (Clunis & Green, 1995; Comeau, 1999; Dundas, 1999; Epstein, 1996a, 1996b, 1999; Nelson, 1996).

Sharon notes that with the tremendous relationship difficulties they experienced during the first year after their first son was born, and especially the first 6 months postpartum as coparent, she could locate nothing that spoke to the relationship concerns in the literature. She specifically mentioned the violence related to postpartum that is well documented for heterosexual couples, but stresses that only patriarchal models are available for guidance. Susan Dundas (1999), writing as a child and infant psychiatrist and biological and nonbiological lesbian mother, offered insight into the lack of information available. “As a child psychiatrist, I spoke about parenting to people all the time, but nothing I read or observed in my training taught me how to behave or explained what I was feeling” (p. 38). Given the ongoing negotiation of roles, issues of locating supportive networks, and the pressures dealing with infant care, postpartum relationships for lesbian women may prompt relationship crises. These anecdotes imply that issues for childbearing lesbian women related to perceived safety of resources may be disinviting in the scarcity of relevant information, even through professional or academic routes.

Although violence in lesbian relationships is beginning to be acknowledged (Boston Women’s Health Book Collective, 1992; DeMarco & Simkin, 1996; O’Hanlan, 1998; Vida, 1996; Waitkevicz, 1996), there is little documentation which addresses conflict in childbearing lesbian women’s lives. Of all of the literature that I read in the course of this study process related to childbearing lesbian women’s experiences, only one, Boggis (1996), referred to an abusive postpartum relationship. In this case, it was sparked or intensified by breastfeeding
issues which Epstein (1993; 1996b) has identified as a potential stressor in childbearing lesbian women's lives. This will be further discussed in the section on situated privilege.

In addition to patriarchal models for medical care, the participants emphasized that they encounter consistent depictions of family in educational settings for their son which exclusively perpetuate nuclear family stereotypes. The couple perceives this focus on the necessity of father as frightening and unsafe, as it subordinates the value of both the biological mother and coparent and their abilities to parent, as well as ignores the diversity of family structures which exist (Epstein, 1996a). They note this occurs in day care environments and progressive preschool settings. The lack of support for raising their children in safe environments which validate their family plays an important role in the decisions they make with respect to nurturing their children. Epstein (1999) and Comeau (1999) address how increasing encounters with community institutions for lesbian families as the children grow necessitate constant decision-making with respect to enabling supportive environments for their children.

As these participants interact within their partnership and with the larger community, they identify supportive information and networks in a variety of ways. In the process, they negotiate altered identities and deal with inclusion and exclusion based on their childbearing status as lesbian women. Although they locate support, they also identify many barriers to care. Disinviting individuals and institutions which discourage disclosure through heterosexist assumptions exclusively support dominant stereotypes of the family and other discourses which invalidate their embodied experiences and contribute to maintaining the status quo. In this way, they are complicit with dominant sociocultural strategies which promote isolation and feelings of oppression. These issues may influence what strategies lesbian mothers use in order to gain
access to support.

The performative aspects (Shogan, 1999) of power through action have important implications for childbearing and the power relations that are created and encountered through the experience: actions taken become survival strategies. This concept will be discussed in the following section on disclosure status.

**Disclosure Status**

The second factor identified through the thematic analysis which contributes to potential access to support, disclosure status, refers to the sharing of information about social location with others. In this study, disclosure referred primarily to sexual orientation status; however it also incorporated other aspects of social location including cultural, professional, coparenting and biological mothering, ethnic, and other identities. For lesbian women this decision to be totally invisible, selectively or completely out in relation to sexual orientation, motherhood or other identities is often dependent on the perceived safety of the environment: frequently when there are signs of inviting messages, but also when safety is threatened. Thus issues of perceived safety or barriers to support and strategies are also relevant to this concept of disclosure status.

Invitational theory’s focus on relationships that promote trust is based on a premise that inviting interactions involve sharing of authentic issues of self with significant others within appropriate contexts. For childbearing lesbian women, disclosure of information related to social location will take into account how each aspect of the self-concept, the many subject positions that constitute the self, are understood in a particular context.

Environments which encourage honest disclosure and genuine communication between individuals are considered optimal for educational exchanges (Purkey & Novak, 1996). Widely
disclosing lesbian orientation has been linked to healthy personality and positive mental health in terms of reduced anxiety, greater positive affectivity, and greater self-esteem (Jordan & Deluty, 1998). It might be surmised that disclosure of lesbian motherhood could be construed as an important factor in accessing relevant support which might facilitate achievement of educational needs while promoting caring processes which facilitate positive health indicators.

However, the findings of this study suggest that many women may not disclose as lesbian childbearing women. As women highly involved in the local lesbian community in their city of over 400,000 people, this couple knows of only one other couple who has delivered through AI in this city, in addition to a small group of lesbian mothers whose heterosexual partnerships produced children. As the participants noted, a number of local lesbian women interested in childbearing through AI have been referred to them, but only one has contacted them for information. Several other couples are involved in the AI process but have not yet become pregnant. To their knowledge, all of these women are closeted or out in very limited contexts.

In Canada it is estimated that there are thousands of lesbian women who have become parents through AI and many more who became parents through heterosexual partnerings (Arnup, 1998). Of the parents in same-sex relationships surveyed across all regions of Ontario for CLGRO’s (1997) report, 70% were “generally open about their sexual orientation [but] . . . almost all had to hide the fact they were parenting with a same-sex partner” (p. 85). The previous discussion highlighted safety in relation to accessing resources. It is worth considering the dynamics of disclosure as they pertain to access for childbearing support.

What information is disclosed, how information is represented to others, and the reasons to choose disclosure in a specific way are conditional on context, and as an important component
of this, perceived safety. Epstein (1999) notes that there is a discourse of disclosure: perceived safety is an element of the complex issues involved. Stevens (1992) explains that

The degree of lesbians' openness about themselves is guided by the contingencies of particular interactions. In each context they must imaginatively construct the anticipated response of others while balancing personal vulnerability and available resources in an attempt to avoid social rejection, humiliation, restriction, or attack. (p. 111)

As demonstrated in the participants' narrative, the daily lived experiences of lesbian women may be described in terms of their outness or vigilance regarding social interactions in which homophobic reaction may be anticipated (Gentry, 1992; O'Hanlan, 1998; Stevens, 1992). The "narrative structure of the closet" (p. 12) is described by Sedgwick (as cited in Armstrong, 1996) as one in which the public has the power to name the space in which affection can be displayed or concealed.

Information shared with others verbally or nonverbally is contingent on how individuals experience and understand themselves in relation to their environments. Purkey (1992) explains that the self-concept, "what an individual believes to be true about his or her personal existence, . . . enables the individual to assume a particular role or stance" (p. 17). The self-concept (Purkey) or subjectivities in process (Abbey & O'Reilly, 1998; Shogan, 1999) are informed by relations of power. Understanding bodies as sites of knowledge production (Abbey & O'Reilly) and resistance (Bordo, 1998; Gabb, 1999; Meekosha, 1998; Shogan, 1999) contribute to the complex ways in which women negotiate their multiple representations of childbearing to self and others. Ways of understanding embodied experiences incorporate knowledge, feelings, and possibilities for actions. The "felt difficulties" (Dewey, 1933), which represent disparities
between the ways we know and value ourselves in relation to how we know the world and what it values, influence disclosure.

For these study participants, lesbian motherhood’s virtual invisibility in public discourses until just recently has contributed to misconceptions or disapproval which shape their everyday encounters. Negative messages maintain the subordinate status of lesbian childbearing women within larger society through stereotyping and myths which promote their invisibility and exclusion from institutional supports. These messages are internalized and also contribute to self-talk or internal dialogue (Purkey & Novak, 1996) which shapes the self-concept. Internalized homophobia, as well as discourses of lesbian motherhood, contribute to the ways in which childbearing lesbian women construe their identities.

Normative assumptions inherent in discourses shape perceived actions. MacLeod (1992) stresses that “women’s struggle is limited by the constraints of existing social discourse” (p. 554): the strategies available to childbearing lesbian women are related to their perceived choices given the dominant cultural narratives (Freedman & Combs, 1996) which shape their ways of knowing and being. However, the feminist focus not just on oppression, but on how women overcome barriers in their lives, necessitates an emphasis on how power is produced through action (Shogan, 1999).

Within the everyday lives of childbearing women, there are ongoing opportunities to disclose or withhold specific information at any time based on the perceived consequences of this action. Sawicki (1991) interprets Foucault’s (1978) theory of power relations in which everyday experiences, at the microlevel of society, incorporate opportunities for resistance (p. 23). “The practical implication of his model is that resistance must be carried out in local
struggles against the many forms of power exercised at the everyday level of social relations” (Sawicki, p. 23).

Factors which contribute to how women perform as childbearing lesbian women are those related to issues of how they identify same-sex orientation to themselves and to others, as well as the relations of power which are inscribed in language. Feminist strategies specifically address power relations in relationships as well as in representational forms with a focus on language (Abbey & O’Reilly, 1998; Kemp & Squires, 1997).

Two aspects of sexual orientation relate to behaviour and claimed identity (Bass & Kaufman, 1996). Partnerships with women may be reflected in a verbal declaration as lesbian, bisexual, or queer, or other term denoting same-sex orientation. The participants self-identified as lesbian throughout the dialogues and referred exclusively to lesbian communities rather than those deemed queer or bisexual.

The claiming of a specific identity for self may depend on the acceptance of a perceived fit within the boundaries of a specific category as delimited by dominant social norms. The nondichotomous nature of sexual orientation (McLaren, 1995; Onken, 1998), heterogeneity in sexual practices, as well as fluidity of sexual identities over a lifetime contribute to how identities are claimed. Ellen surmised that many women who are currently childbearing in heterosexual relationships, either single or partnered, may self-realize as lesbian women in the future, given the number of women who identify as lesbian in midlife.

The intersection and fluidity of identities (Kemp & Squires, 1997) contribute to discussions of claiming a primary identity, for instance one in which racial identity may be considered over sexual orientation. By imposing a primary identity, divisions among potentially
interactive and supportive groups are enforced and structured to act in opposition instead of with others who are also oppressed (Lorde, 1996). In the United States, the dominance of visibly white gay and lesbian identities have marginalized by race others who claim a same-sex orientation (B. Smith, 1996). As well, the instability of categories of “Black” (Kanneh, 1998) or “woman of colour” points to the misunderstandings and assumptions made on the basis of nationality, cultural, racial, and social affiliations (Kanneh, 1998). Ways of knowing informed by religion, class, politics may all be subjugated to racial identity with sweeping generalizations made on the basis of “Blackness” (Kanneh, 1998, p. 95).” These will influence how race, ability, ethnicity, and sexual orientation are disclosed.

The complexity of identity issues highlighted by possibilities of disclosure affects what meanings are intended by claiming or rejecting a specific identity, as well as underscoring the contradictory aspects of identities which force or enable shifting alliances with specific groups for political purposes (Kanneh, 1998; Lorde, 1996; B. Smith, 1996). In this respect social constraints may have enabling outcomes as women find commonality of oppressive experiences through identification with groups on the basis of sexual orientation, race, or other situated locations (Shogan, 1999). The reclaiming of lesbian or queer as empowering identities of pride have offered potential political weight through collective strategies for social change (Lorde, 1996; Goldman, 1996). However, as the complexity of difference is acknowledged, there is never universality of experience in relation to the category or group (de la tierra, 1996; Goldman, 1996; Kanneh, 1998; Kemp & Squires, 1997; B. Smith, 1996).

In addition to issues of social location which denote sexual orientation, race, or other identities are those which offer a claim to motherhood status. For the participants, primary
aspects of their identity were tied to their roles as biological or nonbiological mothers. As has been noted, dominant understandings of motherhood assume a heterosexual partnership; however, biological motherhood may also be privileged over nonbiological mothering (Abbey & O’Reilly, 1998). Asten (1997) notes that not all women who partner with a lesbian mother claim a mothering status; however those that do may find themselves seeking ongoing validation in a role that is often invisible to others (Comeau, 1999).

The lack of language available for childbearing women who partner with another woman may be related to lack of societal validation for the nonbiological mother. Comeau (1999) has stressed that coparents often contend with language that is negating. She cites Muzio’s (1993) concern that the use of non-biological or non-birth mother “contributes to public and private discourses” (p. 56) which focus on inadequacy.

As well, there may be a conflation between the terms “mother” and “parent,” an assumption that the words are interchangeable, when in fact they may have very specific meanings for those that use them (Eichler, 1997; Epstein, 1996a). Eichler (1997) notes that the use of the generic “parent” masks the gender bias of division of labour which females as mothers undertake in families. The participants chose to use the terms, “coparent” and “biological mother,” and “nonbiological mother,” descriptors of mothering roles which are frequently used in the childbearing literature (Asten, 1997; Clunis & Green, 1995; Comeau, 1999; Epstein, 1996a; Nelson, 1996).

“Coparent” may signify the cooperative nature of the division of labour within a lesbian couple. This focus is reflected in the couple’s encouragement for their son to call them “momma” and “mommy,” both of which name mother in a way that represents equitable sharing
of mothering roles. A variety of naming strategies are used within families (Asten, 1997; Epstein, 1996; Nelson, 1996). The decision regarding children’s surname is often contentious in lesbian couples (Epstein, 1996b; Shroff, 1997), although these participants did not allude to an issue here.

Representations of dominant or counter discourses (Abbey & O’Reilly, 1998) which interrupt powerful norms are also produced through language. The creative use of language available for women to describe their lives can reflect issues of power and validation. For the participants, strategies of language and naming were important in disclosure of cultural identities. The pseudonyms chosen by this couple for themselves and their sons reflect images of popular lesbian culture as well as issues of lesbian motherhood. “Sharon” is the first name of a well-known woman whose custody dispute over her children in a lesbian relationship was a landmark case for lesbian mothers. “Ellen” represents a lesbian woman whose television series was sensationalized by her disclosure of her lesbian status to her parents (Arnup, 1998). Their sons’ first names, “Lang,” and “Etheridge,” are the surnames of two lesbian vocalists, k.d. lang and Melissa Etheridge, who refuse to make an issue of their lesbianism (Armstrong, 1996).

Because of the couple’s desire to protect most identifying information within this study, their actual choice of names for their sons cannot be disclosed. However, for these women, the naming process offered them an opportunity to honour their cultural and family heritage through language. Although the women self-identified as “white” when describing their social location early in the interviews, they later revealed that one of the mothers had some native background. Disclosure of this aspect of identity was expressed by naming one son after a renowned historical figure, a rebel in his culture. Use of the coparent’s father’s name visibly celebrated the women’s
partnering and a supportive male presence in their family. Their use of nontraditional, less role-typed names and spelling which defies accepted phonetic customs offer other ways to subvert the normative order. Naming for this couple represented an important strategy of empowerment which supported holistic nature of ways of knowing and being.

Another conscious choice of language which the participants used was “alternative insemination.” This term is found often in the feminist literature (Asten, 1997; Comeau, 1999; Dundas, 1999; Epstein, 1993, 1996a; Nelson, 1996; Pepper, 1999) as it counters the technological implications of artificial insemination. Other ways to denote this process of reflecting the importance of language as signifying meanings of power: “Alternative fertilization (http://tor-pw1.netcom.ca/~lnaylor/baby/donor.html, 1999),” and donor insemination (Boggis, 1996) may be used for either artificial or alternative insemination as preferred terms to avoid the subordinating meanings of alternative, as well as references to the male in the process. One lesbian couple on the internet names this process “baby dancing” (http://tor-pw1.attcanada.ca/~lnaylor/baby.html, 2000).

Jacquelyne Luce (1999) indicates that “the anthropology of assisted reproduction, [in contrast to the anthropology of reproduction], moves inwards examining the ways in which the developments, utilization, naturalization and normalization of new reproductive technologies constitute and make sense of new narratives of conception” (p. 1). The meanings attributed to assisted reproductive processes by the women involved may be reflected in the language used to provide opportunities to counter dominant narratives in a way that offers relative safety.

Openly claiming lesbian motherhood status within a specific environment requires an assessment of the cost and benefits of doing so at any one time. Daily encounters with curious
onlookers as well as well-meaning acquaintances necessitate frequent clarifications and education (Comeau, 1999; Epstein, 1999). As Ellen noted, questions asked about the paternity of their children and the particulars of a partner’s pregnancy often bear assumptions about their mothering relationships. The opportunities chosen and language used to describe their lives are a function of the perceived choices to act. As well, the participants noted that they are sensitive to comments, and this plays a part in how interactions proceed.

What information is chosen or withheld for disclosure may be that which enables privilege. The timing of this disclosure may be relevant. Ellen recalls her internal dialogue as she reflects on responses to questions at the grocery store: “Do I have the energy to deal with this right now? Do I not have the energy? Do I have the confidence? Am I willing to face their homophobia and hatred?” (p. I-2). Stanley (1992) addresses how an individual’s internal dialogue may contain strategies [for coping] . . . and can be used to alter one’s emotional state or behaviour” (p. 227). In this case, Ellen shares the frequent everyday decision-making which is focused on the potential consequences of disclosure within interactions and her own resources for dealing with them. Stevens (1992) has remarked on how being constantly tuned in this way can exact enormous energy from lesbian women as they seek safety. The determination which underlies the couple’s commitment to disclosure is weighed with available energy resources and perceptions of safety.

As well, timing of disclosure may be relevant in terms of how the couple locates information themselves. In this study context, the participants had achieved pregnancy through AI before widely sharing the news of their childbearing with others. With their local professional connections to reproductive health, the need for confidentiality and anonymity was important for
this couple in the preconceptual period.

Although Jordan and Deluty's (1998) study of the psychological adjustment of lesbian women did not address issues of childbearing in lesbian women, it did examine the degree of disclosure to family, gay and lesbian friends, straight friends, and co-workers, and found that the greater the disclosure, the higher the level of social support. However, disclosure for childbearing lesbian women may offer supportive interactions for reasons which vary with the context.

Sharon and Ellen perceived the acceptance of their news of childbearing as a lesbian couple by Sharon's peer group and Sharon's workplace in relation to two factors: acceptance according to group norms and professional relationships. Ellen thought that because other couples in Sharon's medical residency group were expecting, albeit in heterosexual relationships, the commonality of pregnancy normalized their experience. In the workplace, Sharon wondered whether her hierarchical privilege as a physician contributed to the acceptance, and Ellen thought perhaps acceptance was facilitated because she was well liked before they discovered her lesbian partnership. In this latter case, the couple attributed inviting experiences of disclosure to Sharon's situated privilege which may have enhanced the perceived safety of the environments.

Certainly the decision to disclose to providers or others depends on not only the anticipated response during the interaction, but a concern for how that information will be used. Sharon and Ellen remark that their midwife used sensitivity in relaying information to other medical providers. However, although they agreed that consent is needed for written disclosure, Sharon remarked that in practice, for example in consultation processes, such information may be shared in ways that the client is not fully aware of the extent of disclosure of this information
to others. Confidentiality is an important concern for lesbians, especially regarding medical records. Providers can respect lesbian clients’ wishes regarding how information will be shared, verbally or written (Gentry, 1992; Harvey et al., 1989; Jones, 1988; Johnson, 1981; Kenney & Tash, 1992; Lucas, 1992; Zeidenstein, 1990), or if it is to be shared at all (Lucas, 1992). In this context, disclosure with respect to both emotional and physical safety is tied to lesbian women’s desire for protection of information which could potentially be used to their detriment (Coalition for Lesbian and Gay Rights in Ontario, 1997).

The participants’ decision to disclose during pregnancy was congruent with proudly validating each member of the family. Full disclosure as a childbearing lesbian woman or couple may be considered a way of subverting heteronormative discourses (Epstein, 1996a). In order to counter the invisibility and silence which contain and restrict childbearing lesbian women, several sources note that full disclosure is necessary. Terry Boggis (1996) states that “it is impossible to remain closeted as a parent and not communicate to your child that you are ashamed to be gay” (p. 56). Open disclosure of lesbian identity in a childbearing context may be perceived to have political implications. Polikoff (as cited in Epstein, 1996b) maintains that “lesbian mothering is only radical if lesbians do not deny their lesbianism in the process of being mothers. Lesbian mothers should be clearly visible as mothers and as lesbians” (p. 112).

Epstein (1999), however, addresses the risks of disclosure especially for childbearing lesbians of colour. She notes that sexual identity cannot be privileged over other aspects of social location. Safety issues within larger cultural contexts are part of the multiple aspects of situated lives which must be respected in judging how an individual can participate in political strategies. Unpredictability of response to disclosure may include stigmatization and harassment as well as
pose professional risks (Coalition for Lesbian and Gay Rights in Ontario, 1997), as described
with respect to the earlier anecdote about Sharon’s medical colleague who was attempting to
disclose in her professional life. The complexity of issues related to disclosure involves more
than the closet (Epstein, 1999; Stevens, 1998).

The couple noted that opportunities for disclosure in everyday life are so numerous, that
enormous energy is devoted to assessing whether effort will be made to clarify family roles as
well as considering how to respond to potential questions. The ongoing determination to educate
others is described as a common experience for lesbian moms who disclose (Comeau, 1999). As
Epstein (1999) and Boggis (1996) note, the opportunities continue and increase in number as the
children grow older. Sharon and Ellen both have anticipated the work that will be part of creating
safe spaces for their children in their social and institutional environments. From their
perspective, pregnancy and birth, although difficult, represent only a small reflection of their
work as mothers. They expect to spend time disclosing their lesbian family with their sons’
educators in order to facilitate this process (Epstein, 1996b, 1999). They do qualify, however,
how their perceived choices for residing in safe environments precludes a move to a rural area,
based on their concerns for the safety of their sons as members of a lesbian family who wish to
live openly.

Childbearing lesbian women’s actions, given the daily lived realities of their oppression,
are important reflections of the intersection of power, knowledge, and identities. Behaviours can
be construed as having performative aspects (Gabb, 1999; Shogan, 1999) and may be interpreted
as contradictory in the ways in which they are at once both complicit and resist dominant
discourses. If power is effected in enabling ways through action, then conscious decisions made
to defy or push defined boundaries of prevailing discourses will potentially subvert and
transgress the scripted meanings for motherhood. Given the insidious ways in which powerful
discourses frame our perceptions of realities, actions taken on an unconscious level may serve
the purpose of maintaining the status quo or dominant realities. The couple’s actions informed by
thoughtful reflection and feminist consciousness of structured oppression offered opportunities to
claim strategies of resistance.

Meekosha (1998) describes how individuals enact behaviours which are circumscribed by
power in ways that such control and choice appear to be within the individual’s grasp. However,
the choices which are made actually contribute to maintaining dominant discourses: self-
regulation is a form of social control. This is a reflection of hierarchical relations of power as
well as more diffuse forms of power conceptualized by Foucault: self-surveillance (Meekosha,
1998). In a political environment that does not encourage disclosure, coming out is often a
process of struggle in which lesbian women may be acutely aware of normative boundaries
proscribed for childbearing as well as lesbian identities, and how they are perceived within
communities of lesbian women as well as by other mothers. This may involve dressing and
behaving in ways that either support visible stereotypes of lesbians or avoidance of these,
depending on the intended reaction (Pottie, 1996).

There are implications for both disclosure and the ways in which childbearing lesbian
women may perform in order to gain acceptance in public spaces (Gabb, 1999). In Ellen’s view,
the sensationalization of lesbian and gay sexuality in the Pride celebrations contributes to
discourses which distort lesbians' realities. These provide their families of origin with very
narrow visual representations of lesbian and gay lives. Although the Pride festivals include a
family-oriented and lesbian parade, its low-key approach is denied visibility in relation to the flamboyant costuming of the larger parade. At the same time, she recognizes that the increased acceptance of Pride celebrations affirms a gradual acceptance of same-sex issues in public spaces. Such performative strategies of self-conscious and voluntary parodies (Martindale, 1998) are both enabling and constraining in their effects on diverse lesbian women’s lives.

The vigilance (Stevens, 1992) described as part of the lives of many lesbian women both contributes to maintaining the “discourse of the closet” as depicted by Sedgwick, as well as a survival strategy for locating safe spaces—in search of empowerment. Despite a strong commitment to openness regarding their lesbian childbearing status, at times in fact, open disclosure was not totally possible for the participants until their first son was born. Perceived safety has been the priority for this couple. Until then, they emphasized that occasionally someone who had more power could cause them to waver. With the birth, however, they are 100% out. For this couple, such decisions, which disrupt normative discourses by giving voice and visibility to their family, are made consciously.

The ongoing processes of disclosure, in their complexity, influence what support is available for childbearing lesbian women. The intent to opt for selective or full disclosure in a specific context may at the same time resist or contribute to existing dominant discourses. Issues of support, identity, isolation, and perceived strategies are relevant to access in terms of disclosure status as well as perceived safety. The following section focuses on situated privilege as an important component of access.

**Situated Privilege**

Situated privilege is the third component of access. It is the societal privilege ascribed by
others to a social location which is claimed or assumed: that of sexual orientation, race, class, ethnicity, gender, ability, professional authority, or other positions. It may be based on visible markers, verbal disclosure, or affiliations with specific communities. Another aspect of situated privilege is how it confers access to geographic, financial, or other resources. Strategies chosen by individuals as they seek support, including what information is disclosed, contribute to the societal privilege available to them.

Whereas disclosure of social location which is not visibly evident is related to decisions for the most part under the control of the individual, given the oppressive circumstances which shape these actions, situated privilege is based on the social positions attributed to an individual by others' perceptions within a specific context. Relations of power through strategies of social control not only facilitate or impair the perceived safety of resources which contribute to disclosure status, but stratify social support based on perceived social location.

For lesbian childbearing women such privilege is related to mothering roles through biological childbearing or coparenting experiences and acceptance by lesbian communities, given the diversity within lesbian communities. For the participants, childbearing was a turning point in terms of the altered privilege they could locate as openly lesbian women within their communities.

The hierarchical privilege within a social or cultural context may offer access to support based on perceived level of deservedness (Labonte, 1990) or acceptance by individuals, institution, or community (Jordan & Deluty, 1998). Thus the particular privileges conferred on individuals by others in positions of dominance within a community offer differential support on the basis of a particular claimed, validated, or assumed social location.
In addition, an individual may desire acceptance or support by an individual who does not necessarily represent a specific dominant social location, but rather a valued connection, as in support by kinship. Childbearing lesbian women may strategize in order to locate support and acceptance by a specific group or community, given the differential privilege based on socially perceived social location.

The previous discussion on disclosure has highlighted the contentious nature of naming a specific social location and the assumptions and slippage inherent in categorical thinking (Kanneh, 1998; Kemp & Squires, 1997). As well, the interactive effects of multiple and possibly contradictory subject positions offer the possibility that privilege may be conferred by virtue of one aspect of identity and excluded by another. There are complexities involved in attempting to frame an analysis of access using language and categories which may appear to contribute to generalizations when the intent is to clarify and gain insight into the power dynamics which create conditions of support.

With an awareness of the complexities of social location, I will focus on how the couple participants were situated in this study: as they self-identified during the research dialogue. I will interpret the support they perceived to be available in light of their situated privilege in terms of issues of identity, support, isolation, and perceived strategies. As has been previously discussed, the educational support desired for the childbearing lesbian couple in this study has been defined in terms of informational resources and social connections which are perceived to be inviting on both content and process levels.

The couple described themselves as highly privileged in terms of social status and knowledge related to childbearing: white, English-speaking, middle-class, lesbian mothers. They
were simultaneously coparent and biological mothers within this relationship and each had professional and personal affiliations with the local reproductive health community, midwives, physicians, and nurses, and the hospital in which they gave birth. In addition, they had been highly involved in the local lesbian community for a number of years, both as nonchildbearing women and mothers. They were well educated, financially well off, geographically close to the local lesbian community as well as within an hour of Toronto’s resources. The women described themselves as having a feminist analysis, and this too contributed to Ellen’s comment that they had overwhelming privilege.

As women who each had professional and high educational status within the local community, as well as personal connections to each of these mainstream and midwifery reproductive health systems, this couple was afforded a social privilege based on their status in terms of potential informational and network support. For lesbian women, preconceptual decision-making (Clunis & Green, 1995; Epstein, 1999; Nelson, 1996) requires an understanding of the implications of all aspects of pregnancy and parenting, as well as the institutional processes they might encounter.

The couple’s desire to locate information preconceptually, without widely sharing their lesbian childbearing, limited their access to support for reasons of confidentiality. They were able to tap into academic and community resources, and could use academic library resources like The Royal Commission Document on New Reproductive Technologies (RCNRT; 1993) without divulging personal information. As women well versed in sociological analysis, such theoretical resources which discussed ethical and social policy implications provided them with material which contributed to their informed choice in childbearing. Having had access to this information described above over a number of years, the support available to this couple possibly
shaped their perceived options for childbearing well before they officially sought information.

Their social status offered them professional access to information about local AI and fertility clinics, as well as familiarity with women-centered philosophies about childbearing and technological options. Personal knowledge of caregivers within the system, as well as their philosophies regarding lesbian childbearing, facilitated their choice of health care providers. Having worked within the community and the hospital within which they birthed, they were familiar with the advantages and disadvantages of specific institutional policies, programs, and processes with respect to lesbian childbearing. Communication with potential community contacts was facilitated as English-speaking women of the dominant culture.

However, despite this immense privilege, the participants encountered barriers to care. The couple did not perceive that lesbian childbearing was celebrated by health or educational environments locally, reflected by the limited availability of openly lesbian-positive resources. Sloan and Gustavsson (1998) remark that inviting providers of care in the United States may be reluctant to promote services openly as feminist and lesbian/gay positive, for fear of losing funding. How this applies to resources throughout Ontario, with a conservative political environment, is unknown. Although midwifery offered them safe care, the couple’s preference for obtaining preconceptual care in Toronto offered the confidentiality they desired at that stage of their childbearing, and this was a primary consideration in locating support.

DiLapi (1989) has demonstrated how patriarchal influences determine the provision of support for motherhood by social institutions. DiLapi’s “motherhood hierarchy” privileges those who are heterosexual and in traditional nuclear family relationships over single or same-sex mothers. Nelson (1995) extends this analysis to include class and race in which a mother’s
emotional and physical proximity to a white, middle-class male determines the social support available to her. As DiLapi has noted, single mothers are marginalized, but by virtue of their assumed male partnering are more visible and accorded more parenting resources than openly lesbian mothers (Nelson, 1996). Privilege in terms of resources and emotional support to rightfully claim motherhood are conferred on single mothers, depending of course on their relationship to the dominant culture in other ways (e.g., age, race). However, single or partnered lesbian mothers in diverse social locations are often excluded from consistent and institutional support relevant to their needs.

There are implications for disclosure: issues of how a particular social location is claimed by an individual, and others’ assumptions regarding a perceived social location. The performative aspects of disclosure offer insight into how individuals may disclose in order to meet their needs. In order to locate support or gain acceptance, childbearing lesbian women may perform in ways that approximate social norms. Strategies such as disclosure may be those which enable them to meet their needs for support. As has been mentioned, issues of safety, as well as other identities of social location, will shape what information will be disclosed in a specific context.

The participants noted that many single mothers who partner with another woman have achieved motherhood through AI. Families headed by single women are numerous and increasing over time, and this is how lesbian mothers are often identified: by marital status, not necessarily by sexual orientation (Zeidenstein, 1990). In some lesbian childbearing partnerships, one mother is out much more than another, and the biological mother is perceived to be a single mother (Nelson, 1996).
Differential access to resources for lesbian and/or single childbearing women across social locations may include AI and general health information. AI clinics which reserve services explicitly for heterosexual couplings may be less likely to hinder access to resources if there is an assumption of heterosexuality in the partnership. However, in health care encounters for a woman who has disclosed as lesbian or who is assumed to be heterosexual and single, preventive education often excludes discussion of reproductive options other than birth control (Buenting, 1992). According to dominant discourses, planned motherhood is a privilege of heterosexual couples.

Families formed by lesbian mothers may be considered a form of resistance to the nuclear family stereotypes (Comeau, 1999; Eichler, 1997; Epstein, 1996a, 1996b) that are embedded in public discourses about mothering practices. The ways in which childbearing lesbian women choose role identities and behaviours that approximate or defy traditional gender role behaviours (Driver, 1996; Epstein, 1999; Gabb, 1999) contribute to their potential acceptance by others.

Clunis and Green (1995) note that a male identified with a family will be assumed to be the father. The couple described one couple who are raising children together for whom this relationship appears to be a nuclear family; however, the mother is lesbian and birthed two children through the AI process, and the male partner is gay. They lead separate lives, but will be perceived as a heterosexual couple and reap the benefits of heterosexual privilege, even with selective disclosure.

Because same-sex orientation crosses all socioeconomic levels, ethnic, and cultural groups, abled and differently abled, women may be primarily identified by providers in a context other than that of sexual orientation (Boston Women’s Health Book Collective, 1992; Stevens,
1998; White & Martinez, 1997). For instance, the study participants identified themselves as white lesbian women, while acknowledging that one had some native background. Given the racial privilege within a dominantly white society, white women are often perceived by others, including health professionals, in a way that other women members of racial minorities may not be (D. E. Roberts, 1996). Stevens (1998) described the responses to disclosure of lesbian identity by one African American lesbian woman to her male health care provider not confined to homophobic reaction, but “tied to experiences of racism in which Black women’s reproductive options are judged and monitored” (p. 85).

Claiming a status as white, and visibly appearing “white,” offer the benefits of “white privilege.” In most contexts, the participants are assumed to be part of the dominant racial class and are treated accordingly. Although their priority on addressing their cultural heritage was an important aspect of their childbearing strategies, they were not regarded through a lens of race and assumptions that Stevens (1998) has noted were often based on superficial clues about women of colour’s appearance or language. Assumptions made on the basis of visible childbearing regarding the mother’s sexual orientation are more complex when couples are women of colour (Comeau, 1999).

Assumptions of lesbianism, ethnicity, or other social location based on disclosure, stereotypes, or visible markers may contribute to support that either facilitates or hinders relevant care. There may be an assumption of homogeneity of same-sex identity position which negates the realities of variability of same-sex orientation over a lifetime, as well as the continuum of same-sex attraction, which have been noted elsewhere. Despite the few openly lesbian childbearing women in their community, the participants are aware that self-identification as
lesbian may come later in life for many women who have partnered with a male.

Communication with women that is based on an assumed and consistent sexual orientation may be disinviting, especially if the interaction conveys stereotypical and homophobic messages. The couple noted that when lesbian childbearing women were interviewed at one AI clinic, they encountered questions that were homophobic in content and were treated differently than heterosexual women. When lesbian status was not stated, the information provided assumed heterosexuality. A number of available resources, even those that were inviting in other ways, conveyed heterosexist or homophobic messages based on assumed or claimed sexual orientation.

As well, in preschool settings with their son, the participants encountered resources and programming that exclusively validated traditional families and roles which supported normative discourses of the nuclear family. Although these activities on the part of preschool educators in two different settings may be unintentionally disinviting, the couple perceived educators’ and other mothers’ lack of concern about this omission of positive female role models or alternatives to stereotypical families important indicators of privilege within the larger community. The lack of child care options which affirmed lesbian positive models forced their decision for one mother to assume full-time care of their son. The lack of resources which visibly represent nontraditional women or lesbian families sends strong messages of subordination based on same-sex parenting within the larger community.

With respect to mothering roles, the coparent and biological mother each encounter issues of support (Asten, 1997; Comeau, 1999; Epstein, 1996b; Nelson, 1996) based on claimed or assumed roles. Certainly when lesbian women take on a role of biological mother or coparent,
their mothering identities will be influenced by how they see themselves in these roles, but also how they are validated by others. Organizations and the individuals who represent dominant interests can validate or invalidate a claim to authority or social location through dis/inviting interactions which exclude or include, negate or support (Epstein, 1996b, 1999).

Thus, a crucial aspect of identifying as coparent or biological mother is determined by how individual lesbian women are perceived and judged by others whose values and attitudes are influenced by discursive ways of knowing. In addition to internalizing dominant public discourses which may disavow lesbian mothering themselves, lesbian mothers contend with issues of affirmation and validation by others as they learn to value their own motherhood authority.

Nelson (1996) describes a privilege conferred by childbearing which she calls an authority based on the culture of motherhood: the one consistent legitimate power and knowledge that women have been permitted. She describes this with respect to both biological and coparent identities, given the impact of widespread heterosexist assumptions and their invisibility. It is evident from the findings that for some lesbian women, biological motherhood may be insufficient to claim this authority. Such incidents occurred for Sharon, some of whose colleagues and lesbian acquaintances never acknowledged her pregnancy or life as a coparent to Etheridge.

Exclusion from discourses which celebrate motherhood within specific contexts and lack of acknowledgement of the diversity of motherhood experiences prohibit access to motherhood authority in a way that is often exacerbated for coparents. Disclosure and visible participation in mothering roles are potentially important indicators of whether childbearing lesbian women will
be validated as lesbian mothers by others who might otherwise assume heterosexual partnerings (Asten, 1997; Comeau, 1999; Dundas, 1999; Epstein, 1996b; Nelson, 1996). The participants referred to the ongoing explanations that they often felt were in order to clarify questions that assumed stereotypical roles, in addition to the strategies they used to present as a partnering couple.

Ellen, the biological mother of the couple’s toddler, found herself ignored and excluded as a coparent by Sharon’s family with the birth of their second child. In this case, the family disputed her coparent status and invalidated their partnership by celebrating this birth as Sharon’s first motherhood experience. Despite the couple’s determination to partner equitably, their relationship and motherhood authority were delegitimized by the family’s actions.

The language used by others to acknowledge and describe their mothering roles may signify support to the mothers. Disclosure of lesbian motherhood by claiming a name as a mother is insufficient. The coparent, who can potentially be visibly validated through such naming practices, may especially be sensitive to this, as Sharon indicated when a close friend used her name, “Sharon,” rather than “Mommy,” as she did for Ellen. The language used by their children for each mother may affirm mothering status in the family, although some couples worry that children may indicate a preference in this way (Epstein, 1996b; Nelson, 1996). Etheridge’s use of “Mommy” and “Momma” for each of the mothers in this relationship signified a validation of their mothering roles and was a defining moment for the couple. McCandlish (1992) as cited by Comeau (1999) reported that without any defined goal and social role, the [nonbiological mother] was wholly dependent on the child’s response and the biological mother’s expectations to give [her] a place in the family” (p. 52).
The participants encountered supportive environments as well. Sharon, coparent during the first pregnancy, experienced inviting encounters in her workplace as she disclosed that Ellen was expecting. She remarked on how good this felt, especially since she was uncertain of the reaction to this disclosure. Consistent validation of the coparent role is perceived as intentionally inviting, as it supports the nonbiological mother’s claim to motherhood.

Coparents, by virtue of their often invisible, nonbiological role, risk lack of affirmation by others whether or not they disclose (Comeau, 1999; Epstein, 1996a, 1996b), although Nelson (1996) explains that it is the work of motherhood, not necessarily the birth experience, that forms the basis upon which mothers are granted this authority by others. However, it is this affirmation, contingent on others’ acceptance, which underlies the power relations inherent in this process. In order to ensure that Sharon, as coparent, would visibly be involved in the infant care, Ellen found herself giving up activities which she felt biological mothers take for granted, a script she perceived as part of the privilege of biological motherhood. She perceived this process as a loss, but was committed to involving Sharon as equitably as possible, so she made this a priority. At the time, Sharon did not understand what Ellen gave up. Aldrich (1994), in her study of “stepfamilies,” indicates that birth mothers must surrender their sole authority over children and partners must establish identities as parents in order for partners to achieve parenthood. The participants identified this sharing as a priority for their relationship, yet it entailed disrupting the dominant maternal narrative for this to happen.

Comeau (1999) remarks that, in her study, several couples did not anticipate how difficult the sharing of roles or changes in the relationship would be with the arrival of a baby. In fact, in their particular lesbian and gay parenting support group, the topic was avoided. Whenever it was
discussed, a couple relationship dissolved. Although there is overlap with opposite-sex and same-sex relationships concerns (Clunis & Green, 1995; Simkin, 1997), societal attention on the visible biological mother during pregnancy and the arrival of the baby often precipitate jealousy (Epstein, 1993) which is layered through issues of role identifications. The lack of understanding of such struggles by lesbian childbearing women or their potential supports underestimates the power of normative discourses to enforce assumptions based on stereotypical roles and biological motherhood authority.

Having role models to offer support is a privilege that is less likely to be available for childbearing lesbian women. For Sharon and Ellen, their visions of families with children were all based on partnerships in which a male had been involved. In Comeau’s (1999) study, couples each had a “role model” family, a set of close friends who provided a mentoring role. However, each of these mentoring couples broke up after they had children. Comeau stresses the often unacknowledged obstacles to sharing lesbian motherhood. These experiences resonate with the tremendous stresses experienced by the couple during the first year, and especially voiced by Sharon, coparent to their first child.

Situated as both a biological and nonbiological mother, the participants each had an opportunity to view how others regarded them in different roles. However, the privilege available to them in each role varied not just by others’ interpretations of that role, but also by the privilege that a particular mother perceived to be available to her in that role. Sharon expressed the view that, for her, there were definite differences between experiencing motherhood as a biological mother and a coparent. She attributed a biological basis which offered instinctual cues for mothering their second son, whom she was breastfeeding. In
comparison, as coparent to their first son she sensed a qualitative difference in responsibility and attachment. Notions of motherhood as primarily a biological role versus a social role with a focus on the uniqueness of the biological mothering aspects of the relationship may be formed prior to childbearing or afterwards—with the breastfeeding experience possibly playing a significant role (Epstein 1996a). From this perspective, the support required for lesbian partners to mother in an equitable fashion requires determination to overcome this asymmetry (Comeau, 1999).

In other studies, mothers who have birthed in each role attributed any biological differences to breastfeeding, or differences in the two roles to variations in parenting styles or time spent with the child (Nelson, 1996). However, Comeau’s (1999) mothers describe the difference in experience as drastic. For them, the biological experience was more intense and physical, whereas with coparenting the process of bonding was slower and dependent on cues from the child and the biological mother’s expectations—which contributed to an anxiety in this role. Some of the women who were simultaneously coparent and biological mother in Epstein’s (1996a, 1996b) study appeared flexible in working arrangements to allow each mother to be primary caregiver and primary breadwinner over time, or to balance the intensity of the breastfeeding link to the child by having the nonbiological mother stay home after a few months.

Ellen, on the other hand, within this research dialogue, did not focus on issues in her role as a coparent with the second child, except with respect to how others perceived her. This is congruent with Comeau’s (1999) description of how the experience of biological mothering with the first child modified the adjustment to mothering as a coparent and biological mother simultaneously with the birth of their second.
Except for breastfeeding, the couple speaks of how flexible and equitable their mothering roles are in terms of sharing family tasks. The literature suggests that lesbian mothers often receive more support from their cohabiting partners in child care and household duties than other couples, straight or gay (Clunis & Green, 1995; DiLapi, 1989; Patterson, 1997). This challenges stereotypical notions of economic and gender imbalance in families (Epstein, 1996a, 1996b) and is a privilege that partners potentially offer each other in their lesbian relationship.

Breastfeeding strategies for the first son were the one decision the participants would have changed in hindsight. The couple’s perception that linking the biological bond of breastfeeding to the biological mother in an exclusive way would facilitate a specific role identity to the infant was a major source of distress for the couple. As Ellen noted, this time-consuming privilege of nurturing or care was not available to Sharon, the coparent, and essentially excluded her from participating in afternoon and evening rituals of reassurance with Etheridge because he would not nurse from her. The participants identified long-term breastfeeding as a privilege that was available to them because of their economic advantage and choices made regarding day care. The narrative does not allude to whether Sharon ever interpreted this as rejection by her son, but nevertheless, this issue hindered their goal of equitable sharing of child care.

According to Rachel Epstein (1993), “breast feeding was seen as the time when the difference between the biological and non-biological mother can be most marked” (p. 20). Although Epstein (1993) and Simkin (1997) note how both partners’ involvement in the process may contribute to difficulties, in the participants’ case, the couple initially reserved breastfeeding for Ellen, the biological mother. When they tried to initiate the coparent’s involvement after she began lactating as biological mother to their second son, Etheridge refused her involvement.
Terry Boggis (1996) explains how, in her relationship, breastfeeding issues became a major factor in partner conflict when plans to have the coparent bottle feed fell through when the baby refused the bottle. Although information related to lesbian childbearing often notes the high commitment of partners to breastfeeding (Clunis & Green, 1995; Harvey et al., 1989; Kenney & Tash, 1992), in my experience as a childbirth educator, virtually no lay or professional breastfeeding resources explicitly address lesbian couples’ concerns unless they are specifically geared to lesbian childbearing (Clunis & Green, 1995; Pepper, 1999).

As lesbian women who had been very active in the local lesbian community, the variable support from the community was a source of grief, and experienced during pregnancy as well as postpartum. As Sharon stated, “it feels like . . . you’re being excluded once again” (p. I-22). With the unconditional validation as lesbian women within that community prior to childbearing and the affirming connections that offered, exclusion through childbearing conferred a message of subordination or invalidation as a lesbian woman. Participation in the larger lesbian community is seen as evidence of acceptance and declaration of lesbian identity (Clunis & Green, 1995; Morris, 1996; Vida, 1996). Although the couple noted that with young children they could not participate in the community’s activities as they had previously, and perceived that this may have played a role in their limited support, they were aware that this was not the only issue.

The participants noted that pregnancy through AI is relatively new in their lesbian community. However, pregnancy can be deemed an affirmation of a couple’s relationship (Nelson, 1996) in a way that is celebrated within the lesbian community. On the other hand, the increased heterosexual affiliations by childbearing women within the community may be seen as
political threats to solidarity (Kenney & Tash, 1992). For some lesbian women, appearances of stable partnerships which include children may appear to approach heterosexual normative family forms and privilege coupled, and apparently monogamous, lesbian women further marginalizing the others (Martindale, 1998). Rachel Epstein (1996a), however, indicates that lesbian women must create family structures that meet their needs as well as those of their children, without being judged in relation to how these structures meet norms of political correctness or nuclear family boundaries.

As well, Ellen noted that a male child has different meanings across the lesbian community. Political stances which resist patriarchal influences may affect some community members’ comfort with supporting women who are raising males. In fact, sex selection is an issue discussed in AI resources (Clunis & Green, 1995; Pepper, 1999).

At times the women encountered contradictory privilege in terms of support based on others’ perceptions of their social location. According to MacLeod (1992), “women [who] are [both] part of the dominant and subordinate subculture” (p. 554) may be offered privilege through accommodation of normative values as they are perceived to identify with the dominant group. In hospital, the couple’s professional status as physician and educator would likely guarantee respect based on social prestige, while their same-sex status on its own would confer unpredictable care. Affiliation with midwifery mediated their access to support. For this couple, high situated privilege may have tempered opposition to their same-sex status. However, the limited support offered to the couple’s lesbian friend who was a physician indicated the complexity of affiliations and contexts which may contribute to lived experiences.

Yet, within their local lesbian community varying stances on childbearing influenced the
support perceived to be available for AI mothering. For this couple, their positions as lesbian women involved in childbearing through AI or raising sons placed them on the margins of those in the lesbian community who claimed “authentic” lesbian status—although this varied considerably over the community. The social context determines how issues of dominance and marginalization play out.

As well, social privilege legitimates certain knowledge, for example that acquired as a professional (Oakley, 1986). The various subject positions which reflect professional status and mother--coparent and biological mother--simultaneously offer contradictory understandings of issues. These differing subject positions are at the same time subjugated and privileged in relation to binary hierarchies (e.g., male/female) and social context. Complex role identities: the disparity between normative roles and lived experiences (Jakobsen, 1998), which individuals negotiate constantly, are sites of struggle and empowerment.

For Sharon, a physician, coparent with their first son, biological mother with their second son, the knowledge available to her as a professional increased her anxiety at times as she dealt with her newborn’s crying jags. Her professional self anticipated the many serious medical problems that could account for the crying spells. However, over time, and with her partner’s support, she learned to value her inner motherhood authority, which offered her a perspective that was less available earlier.

The patriarchal influence on the authority ascribed to reproductive health professionals has been addressed by Katherine Arnup (1994). She questions how both the historical and political factors related to the medicalization of reproduction and the professionalization of motherhood have at times contributed to wrestling mothering authority based on childbearing
women's own knowledge and experiences from women themselves. Such discourses shape the authority vested in others to validate or in other ways empower women based on mothering roles. Sharon found herself increasingly confident in her partner's experience with their older child, valuing her skills as a mother.

Hierarchies of power in terms of professional leverage within institutions, and power as ascribed by others through situated privilege, offer important contributions to understanding access and safety issues in educational interactions. For these study participants, choosing a midwife to advocate for them was an essential aspect of locating safety within an institution. In fact, the participants' explanations of their hospital experiences described a discourse which equated progressiveness with clients who choose midwifery. This was also tied to assumptions that these clients would likely be middle class and educated. Their explanation of positive hospital experiences was linked to their assumed privilege as clients of midwives, as well as the other aspects like, professional status.

The couple perceived that lesbian women marginalized by class or race, or who were perceived to be single, would be at increased risk of disinviting childbearing experiences. This is relevant considering that Ford (1993) and Shroff (1997) focus on how midwifery has prioritized equity issues in caring for marginalized childbearing women. A recent (1996) survey by Erin Connell (as cited in Shroff, 1997) has indicated that in fact, since acquiring the status of regulated professionals, and offering free services, midwives in Ontario have cared for proportionately more white, middle/upper class, heterosexual, able-bodied women than those whose access to traditional health care is limited. These issues will be addressed further in the following section on public and private availability of support.
However, according to the participants’ perspectives, as clients of midwives, they perceived that there was an assumption of progressiveness in their choice of midwifery and thus attributed some privilege to this association. The hospital staff might be prepared to be tolerant for this reason, in the couple’s view. Institutional hierarchies and affiliations contributed to the participants’ access to inviting care, as the couple noted that in this urban center the midwives were perceived to have high professional status within the hospital. Whether this assumption or privilege would hold true for those associated with midwives in other cities in which the couple identified they had lower professional status is uncertain.

The difficulties of offering professional or personal support for childbearing lesbian women based on assumptions or visible markers have been described. This has enormous implications for interactions which must convey sensitivity to information shared, choice of language, phrasing of questions, and nonverbal behaviours. Stevens (1998) explains that educators and providers are often unaware of their part in forging boundaries of socially acceptable behaviour. They may be unintentionally disinviting, but the consequences are such that marginalized clients are often acting in ways that do not meet their own needs, but “are actually simply behaving according to providers’ expectations in order to get the service they need with a minimum of friction” (p. 92).

It is evident that the disparity between claimed and assumed or invalidated social location or identity is an important factor in accessing both emotional and material support. Lack of validation for a disclosed identity or social location contributes to isolation of self and from the larger community from whom acceptance is desired. For the participants, this was especially relevant with respect to coparent identities and biological mothering identities, upon which the
couple placed great importance. However, individuals associated with kinship and friendship from both heterosexual and lesbian communities at times denied them the claim to identify as mothers as they desired.

In effect, as lesbian childbearing women name and claim their mothering identities, there is a displacement of power to others who represent dominant social groups (Royal Commission on New Reproductive Technologies, 1993) or dominant cultural reference points: those who assert the authority to validate lesbian motherhood. With such dynamics, couples often experience alienation from themselves and others. Despite the support offered to them across communities, the conditional or unpredictable support provided by their own claimed lesbian community, as well as individuals and institutions representing the dominant social order, impaired their abilities to openly claim identities as lesbians and mothers simultaneously.

Dorothy Roberts (1998) takes issue with the perception that “individual women are defined by the way that others treat us, rather than by a more complex process that includes each woman’s creation of herself from various parts of her experience” (p. 123). In this case, it is not that individual women are wholly defined by the way that others treat them, but the social context does contribute to emotional turmoil and feelings of oppression in terms of what aspects of their lives are validated or ignored or rejected. It also affects their perceived choices to resist these social norms or to push the boundaries—and this may depend on the perceived support or consequences for doing so. There are implications for creating their own support which is unavailable to them within their local communities because of their positions as lesbian childbearing women. The availability of support through public and private points of access will be explored.
Public and Private Availability of Resources

The fourth component of access addresses public or private availability of comprehensive childbearing information and support. In this section I will briefly offer some factors which influence how public and private arenas have been delineated within this discussion, and the historical and social factors which inform them with respect to lesbian motherhood. Several ways in which relations of power have been addressed from feminist perspectives will be noted as they shape the strategies in which childbearing lesbian women seek support. I will also tie the narrative findings to this discussion as they offer insight into the particular and concrete struggles that shaped the participants’ perceived options for care.

The previous three sections of the conceptual framework have discussed the links between access to information and situated privilege, disclosure, and perceived safety. Themes which emerged from an analysis of the findings relevant to this section are those strategies chosen to locate support and which address the ease with which support is located for their mothering experiences. Because biological and nonbiological lesbian mothers continually negotiate safety issues, determination, energy, and courage are required to locate relevant care in public and private arenas.

Public places and spaces have traditionally been those that comprise domains outside of the domestic spheres of home and family (Gatens-Robinson, 1999). However, defining discrete public and private spheres with respect to women’s complex situated lives (Gatens-Robinson; Kemp & Squires, 1997) gives rise to struggles which mirror those which surface with feminist deconstructions of other dichotomies. In this discussion I will use Dewey’s (as cited by Gatens-Robinson) definition of private interactions as “those interactions between people that have no
significant effects on those outside that particular interaction” (p. 172). The particular social context determines whether there are implications for others beyond such an interaction, such that the public/private boundaries are constantly shifting. In keeping with the previous discussion which recognizes a postmodern view that individuals are constituted by multiple subject positions, Dewey in this discussion of democratic processes identified a number of publics based on subject positions in which social privilege varies with the context and is at times contradictory. The ways in which the participants experienced such conflicting privilege has been described.

Nancy Fraser (as cited by Gatens-Robinson, 1999) depicts the “public sphere as an arena of discursive interaction among citizens that is distinct from both the state and the market” (p. 172). The previous discussion has identified a number of dominant narratives which are recognized by social institutions and dictate their functioning with respect to lesbian mothers and others marginalized within public spaces. Foucault’s conceptualization of power relations (Sawicki, 1991) can facilitate such an analysis with respect to access to support for childbearing lesbian women. His concept of “biopower” as defined by Gordon (1991) is useful as it connects forms of power over subjects within populations with respect to how “sexual and reproductive conduct interconnect with issues of [political] policy and power” (pp. 4-5). The ways in which institutional control of reproductive processes restricts access to support, and hence the possibilities available to lesbian mothers, is described.

A discussion of power which is understood only as something that can be possessed, which is repressive, centralized, and operating from a top-down model (Sawicki, 1991) shapes an analysis of access that might focus exclusively on patriarchal institutions as they intersect with other hierarchies of binary oppressions of race, sexuality, and so on. I have underscored that
these processes are compelling and pervasive dynamics which constitute individuals and institutions. Throughout this analysis of findings, patriarchal narratives have been identified by the participants as an important factor in their understanding of access.

A discussion of access to public health support for lesbian mothers must link notions of public spaces to the state when the political context determines discretionary programming and institutional funding. I have highlighted how dominant discourses of motherhood and heteronormativity based on the nuclear family are legitimized by institutions through provision of resources (DiLapi, 1989; Eichler, 1997) and in this process relegate others to marginalized status. Public institutions by their very nature confer social and cultural hierarchies and boundaries within the social order and in doing so legitimate established ways of knowing and being which are based on how difference is recognized (Canadian AIDS Society, 1992; Mehuron, 1997; and many others).

In addition to such considerations, Sawicki’s (1991) interpretation of Foucault also focuses on an understanding of power relations and discourses which are obscured with an exclusive attention to institutional power-over relationships. Conceptualizing power relations as exercised at the individual level through action highlights the disciplinary aspects of power as it shapes freedoms to act through the possibilities perceived to be available to individuals. Sawicki addresses the potential for resistance with respect to biopower as it affects understandings of motherhood and reproductive technologies.

This approach also identifies discourses of the body, family, kinship, sexuality, and others in which power relations are more diffuse (Meekosha, 1998; Sawicki, 1991). These discourses also interact with dominant narratives of gender, race, and others to contribute to ongoing processes of gendering and racialization as the meanings ascribed to such locations shift
with varying social and historical context (Flax, 1993). Such understandings contribute to the ways in which embodied childbearing experiences are interpreted with respect to knowledge claims. As well, there are implications for the strategies named by the participants, which included support by affiliation with kin and communities which were not directly defined through dominant patriarchal hierarchies.

The ways in which the participants created their own support at times appeared to resist, be complicit with, and accommodate dominant meanings of lesbian motherhood. Such dynamics have been identified throughout this paper and have been interpreted in terms of how such strategies effected knowledge production and enabling community connections. In this section I will interpret how the resources located through public and private points of access reflected meanings of lesbian motherhood which were perceived as safe, and were thus inviting for this couple.

I will briefly discuss some historical and social factors related to power that have shaped how current conceptualizations of motherhood and sexuality relate to the public domain. Divisions between public and private spheres which have been differentiated by gender have been shaped by historical, economic, social, and cultural relations of power (Eichler, 1997; Kemp & Squires, 1997; Mandell, 1998; M. O’Brien, 1981). Mary O’Brien has argued that patriarchal control of reproduction through dominant public norms reflects an appropriation of matters related to sexuality and procreation from the private realm and family. This issue is relevant to lesbian mothering which bridges dominant meanings of motherhood and sexuality, each of which has at times been relegated to the private sphere, yet which are subject to control by public institutions.

Arnup (1994) offered insight into how reproductive health practitioners assumed
professional authority to provide education on motherhood and parenting in public health spaces from the early 20th century. In her analysis she noted the moral implications of these public health practices which supported patriarchal ideologies and the medicalization of motherhood. Historical movements which saw childbearing institutionalized and medicalized as it moved from the home into the public sphere reflect similar philosophies (Royal Commission, 1993; Shroff, 1997). Midwifery, as it became officially recognized in Ontario through professionalization, has been balancing its women-focused philosophies with concerns that midwives have been coopted by the very institutions that led to its demise in earlier days (Shroff).

In addition to the cultural domination, stereotyping, and sexual objectification (Morgan, 1993) experienced by lesbian women, lesbian mothers face reproductive institutions which enable the perpetuation of dominant patriarchal discourses which often structure childbirthing practices (Boston Women’s Health Book Collective, 1992), and which interact with race (Nestel, 1994), ethnicity, and other hierarchies (Shroff, 1997). Throughout these periods, diverse individuals and groups, lay and professional, across cultures resisted such practices and offered counter discourses to the dominant narratives which enabled such movements as “natural childbirth” (Sawicki, 1991). Such discourses shape the available meanings of motherhood which vary with historical and cultural contexts and shifting subject positions.

Foucault (1978) described the ways in which sexuality became increasingly publicly regulated through religious, medical, and governmental institutions beginning in the 18th century, as normative boundaries were specified, classified, and pathologized. According to Jakobsen (1998), current discourses related to sexuality in the public sphere are influenced by conservative political and religious-based attitudes in which “nonsanctioned [queer images] and
public displays of any sexuality are thought to degrade the moral fiber of the individual and society as a whole” (p. 189). In this view, motherhood, which is reserved for heterosexuality but is nonsexual (DiLapi, 1989; Epstein, 1996a), is incompatible with same-sex visibility in public spaces. Childbearing is framed in terms of medical processes of surveillance and other forms of social regulation (Royal Commission, 1993; Sharpe, 1997), including self-surveillance. For lesbian mothers institutional support is often layered through similar processes with respect to sexuality.

Conceptualizations of lesbian motherhood as queer and/or potentially enabling are increasing in some media and community contexts. How these visions of childbearing mothers are represented in public spaces is related to historical and social contexts which have shaped dominant meanings of motherhood, as well as discourses of professionalism, surveillance, nuclear family, and others mentioned above, as well as democratic practice.

If, as Iris Young (cited by Leck, 1995) has noted, “the primary meaning of public is what is open and accessible” (p. 190), provision for diverse expressions and experiences within society would be represented by institutions. However, as Fraser has noted, the liberal model which conceptualizes public as a unified space, which brackets difference, and in which all participants are deemed equal reflects a lack of understanding of invisible, marginalized groups. Such discourses enable discretionary provision of support based on the authority ascribed to professionals and institutions to determine how difference is conceptualized within public spaces. Nondominant discourses are unavailable for consideration in official public spaces because they are invisible, in Nancy Fraser’s words, “subaltern publics” (as cited in Gatens-Robinson, 1999, p. 176). According to such analyses, democratic processes cannot be the cooperative inquiries that Dewey referred to unless the discourse of democracy which regulates
public interests recognizes the plurality of publics and takes into account how dominance and subordination are structured in the social context (Gatens-Robinson).

As childbearing lesbian women identify educational needs for information and support, they are, in effect, looking for experiences which enable knowledge production and caring processes in ways that validate and celebrate their lives. Information sought and gained in the process will have implications for how particular spaces are marked as safe for lesbian women. As such, they affect childbearing lesbian women’s perceived benefits to disclose or withhold information about their situated lives, and thus the ways in which they perceive themselves as valued, others as trustworthy, and their communities as supportive.

The findings of this study indicate that information and supportive networks for these childbearing lesbian women were not consistently and openly available in public institutions locally. This couple sought comprehensive care that addressed their preconceptual, intranatal, postpartum, and parenting needs in a way that offered them optimal emotional and physical care. For the participants, access to such safe and relevant support was greatly facilitated by their situated privilege, which included personal, professional, and political networks. Access through private points may require a specific relational privilege through kinship or professional knowledge, for example. As professional women accessing care for childbearing, this couple’s public and private roles shifted and overlapped. However, their encounters with institutional providers of care were considered public interactions.

**Preconception.** The importance of the preconceptual period in framing whether or how lesbian women will create their families has been described (Epstein, 1996a; Nelson, 1996). This couple began their official search for information by reading an academic report on new
reproductive technologies, which is publicly available in university libraries, however likely accessible to them because of their professional knowledge. Their knowledge of available fertility clinics for AI locally was information available in public domains, but they depended on feedback about these sites through professional (medical and midwifery affiliations) and lesbian-positive networks. This included a progressive heterosexual couple that provided them with feedback about prenatal classes. Another potential source of information in the public domain was local community centers which potentially offer a range of information on women’s issues and health care. The couple did not perceive that these consistently offered the inviting care they sought with respect to lesbian childbearing.

The preconceptual period is one which Sawicki (1991) has addressed with respect to how women understand dominant reproductive narratives in light of the emergence of reproductive technologies. Although she cites a number of feminist arguments which decry the dehumanizing and patriarchal potential of such processes, Sawicki emphasizes that lesbian women disrupt such hegemonic discourses through their demands for access to childbearing. Foucault’s concept of the discourses and practices of biopower are relevant to this discussion. Sawicki defines this as “the process through which women’s bodies [are] controlled through a set of discourses and practices governing both the individual’s body and the health, education, and welfare of the population” (p. 67). Some of the historical and social influences which have contributed to the limited public access to childbearing for women who partner with a woman, whether or not lesbian status is openly disclosed, have been noted.

For lesbian women whose designs on childbearing have been shaped by social narratives of motherhood and other discourses, access to the reproductive technologies of AI and/or
infertility is often limited by their marital/disclosure status or other social location, and potentially limited by financial access. When such practices are legitimated by reproductive institutions, public discourses are linked to both the state and the market. Private, for-profit AI and assisted reproduction agencies operate to fill the gap for women whose access to public institutions is either denied or deemed disinviting. However, institutional resources for AI in fertility clinics or health providers’ offices are provincially funded and consistently accessible for heterosexual partners in a way that was limited for lesbian women.

The participants’ decision-making about childbearing was likely shaped by interactions with midwifery providers and other professionals, lesbian friends with and without children, and public discourses around childbearing, as well as ethical deliberations related to issues raised by the Royal Commission document. Given the limited openly available preconceptual support for single or lesbian women in reproductive institutions and the implications of childbearing on their lives, the information available for informed decision-making is thus restricted markedly.

Acceptance as a member of a particular lesbian community may offer supportive information and networks. However, disclosure as lesbian or partnering with another woman is required to participate and locate support within lesbian communities (Jordan & Deluty, 1998). This is related to perceptions that participation in the larger lesbian community is seen as evidence of acceptance and declaration of lesbian identity (Clunis & Green, 1995; Jordan & Deluty, 1998; Morris, 1996; Vida, 1996). Prevalent homophobic norms in many communities create the need for safe community spaces. Such “closed communities” (anonymous personal communication, September 6, 1999) may limit general access to lesbian positive providers of care. However, the couples’ remarks which note that midwives are often well-informed of
lesbian-positive resources indicate that provider access to lesbian community information and support may also be a function of the communities’ perceptions of those who represent and advocate in inviting ways.

During the preconceptual time period, this couple required access to information that could facilitate informed decision-making which did not require disclosure as lesbian women and which was available in ways that protected confidentiality or anonymity. However, because of their many personal and professional connections locally, and because they had only selectively disclosed as a lesbian couple, this was not available locally through their personal or professional networks. Given the lesbian-positive providers and midwifery networks that are connected to the Toronto lesbian mother community, the local midwifery care providers would likely have offered an important access point for the couple preconceptually if confidentiality had not been an issue for them. Within the participants’ local lesbian community, information and network support for AI was limited, since all lesbian mothers had birthed in male partnerships.

The couple found that disclosure of same-sex mothering status facilitated their access to supportive health care providers for AI, pregnancy, delivery, and postpartum, as well as AI resources; however, they depended on personal and professional connections to determine whether these were inviting. Such AI resources offered access to lesbian women, provided sufficient information for decision-making, and included racially diverse AI donors through processes that explicitly conveyed support for both the biological and nonbiological mothers.

**Prenatal.** The participants perceived that public prenatal classes were disinviting as they were geared to normative relationships, and felt that lesbian women would not generally attend traditional couple classes for this reason. This couple’s knowledge level as professionals in
reproductive health also contributed to a decision not to attend formal prenatal classes, although they had different understandings of just what information was addressed in the prenatal class setting.

Certainly as the research dialogue progressed, we reflected in this research context on which issues they perceived to be relevant to childbearing lesbian women. It became apparent that they would have connected with such inviting opportunities despite their professional knowledge base. This is congruent with Clunis and Green (1995) and Enkin et al. (1991), who emphasize that the goal of birth preparation classes is to give the pregnant couple confidence and knowledge. The relevance of information and potential for enabling connections or experiences are the keys here.

Despite the participants’ initial assessment that expectant lesbian women would not attend publicly offered prenatal classes, my experience, through discussions with public health prenatal educators in the course of undertaking this study, indicated that on several occasions expectant women had disclosed to the instructor and class that they were in same-sex relationships. In other studies, few of the lesbian women in prenatal classes disclosed within the class or with the instructors (Harvey et al., 1989; Olesker & Walsh, 1984). As such, they “were perceived and accepted as single mothers” (Kenney & Tash, 1992; Olesker & Walsh, 1984). Clunis and Green (1995) have noted that the comfort level of the instructor plays a large part in how lesbian women feel invited. Nelson’s (1996) couples received enthusiastic support from other couples and the instructor. However, other sources maintain this is not always the case (J. Clipsham, personal communication, February 23, 2000; J. Luce, personal communication, August 11, 1999).
Certainly, home birth prenatal classes and private classes may offer information and provide support that is perceived to be inviting to lesbian women; however as the couple has noted, the tone of the group and flexibility of curriculum may depend on the educator (Clunis & Green, 1995). How other issues of culture and privilege are addressed within these settings will also shape how inviting they can be.

Another approach to offering care which the participants deemed preferable was to offer comprehensive support through lesbian-only classes and resources. However, separating resources such that lesbian mothers’ issues are exclusively dealt with in separate ways promotes invisibility and contributes to the lack of relevance of their struggles to the larger community. As well, this ignores the complex influences of disclosure, situated privilege, and perceptions of safety as they relate to access to support. Disclosure issues have been described in terms of perceived safety of environments. As Ellen noted, it is apparent that many lesbian women remain closeted to institutions because they are uneasy.

Moreover, the invisibility of the nonbiological mother in class settings has been noted to be a difficult issue for lesbian couples because some, but not all, concerns that fathers have are also relevant to the coparent. The coparent issue presents difficulty for couples who attend classes which separate male and female parents for discussion (Dundas, 1999; Nelson, 1996). There are implications for sensitivity to representations of mothers and language used by educator both verbally and in audio-visual and printed resources (DeMarco & Simkin, 1996) and educational strategies which explicitly address all expectant parents’ needs.

Public health institutions provide resources as one strategy for enabling power and self-determination within communities (Labonte, 1990). However, Eichler (1997) indicates that social policy and related resources for families are geared to definitions of family based on
structure, not function. This privileges families which mirror nuclear family structures but ignores others, including same-sex family structures. In fact, she notes that the “virulent homophobia . . . poisons the atmosphere for children and adults living in such families” (p. 16). This societal devaluing renders these families invisible and disenfranchises those which provide the same caring functions (Epstein, 1996b). As Sharon and Ellen noted, legislative changes which have recognized spousal rights are inviting, but the vast majority of social programming from preschool education to prenatal classes assume heterosexual relationships and emphasize the father’s role in family structures. DiLapi’s (1989) hierarchy of motherhood has described the provisional public support available to mothers who appear to be in heterosexually married relationships and situated in dominant social locations (Nelson, 1996).

Yet the findings indicated that for this childbearing lesbian couple, the meanings attributed to childbearing in their lives enabled growth of self, partnerships, and enriched understandings of their identities as lesbian women and as mothers. Discourses which frame lesbian motherhood as potentially empowering and transgressive offer understandings of situated experiences that facilitate freedom (Sawicki, 1991) garnered from understanding the complexity of situated experiences, the gaps between the ascribed social roles and identities that distort and are at odds with the lived realities of their lives. Such discourses are socially marginalized and reflected in individual and institutional practices in public spaces which create barriers to care.

However, the ways in which such discourses are taken up by institutions reflect the potential level of care that will be offered. As noted earlier, institutions that reflect levels of tolerance or acceptance of lesbian women are not deemed inviting. One such assumption is that childbearing lesbian women have similar needs for education as those in heterosexual
relationships. Although there are overlaps, this assumption indicates a lack of knowledge of lesbian women’s struggles. This concern shapes the possible integration of relevant information into existing structures geared to childbearing women. The study participants have identified a number of issues that are unique to lesbian childbearing women from the preconception stage on.

Even lesbian women themselves may not understand the implications of such struggles. Pepper (1999), a lesbian mother herself, in her recent book geared to address pregnancy and lesbians, declared that the assumptions regarding two women attending prenatal classes aren’t important: whether the couple is assumed to be a same-sex couple partnering or a heterosexually identified single mother with a support person, all attendees share similar goals to learn about their own birth experience. However, couples who remain closeted and are perceived as single may experience isolation through “discomfort along with denial of self” (Kenney & Tash, 1992). Environments which offer access to information or support in a way that passing as heterosexual or single is not only accepted, but celebrated in a way that lesbian childbearing is not, will be perceived as unsafe and uncaring.

Another potential public resource for childbearing lesbian women is professionals who are visibly out with respect to same-sex orientation. Thus, another area of access to public support is in the workplace. Certainly Sharon noted that she was able to disclose as coparent during the first pregnancy, and both her peer group (those she worked with as a medical resident) and those with whom she worked were offered inviting support. CLGRO (1997) and Stevens (1992) have stressed how public affirmation of lesbian women within health care institutions offers important support for the clients who access their services.

**Labour and delivery.** The participants did experience two inviting births as openly
lesbian childbearing women within a local hospital; however they attributed this to their situated privilege as reproductive professionals situated in dominant social locations, personal networks of support, and ongoing determination to strategize in order to minimize homophobic interactions. The lack of explicit commitment to providing support for biological and nonbiological mothers and their families within institutional settings for this couple: people, places, processes, programs, policies, or politics, and previous experiences of homophobic reaction within health care marked hospitals as unsafe. Although their particular births were inviting, the circumstantial nature of the institutional care required lesbian-positive midwife advocacy as an important factor in the positive outcomes.

Private support in terms of kinship relations and acquaintances has been noted to be important in many lesbian women’s lives because of the variable acceptance of same-sex orientation by families of origin. This couple chose friends who were nonchildbearing lesbians friends to provide child care and personal support during the labour and birth. Despite one grandmother’s perception that she was providing support for her daughter’s pregnancy, her lack of understanding of the coparent role precluded involvement during the delivery. In fact, her appearance and insensitivity immediately postdelivery provided the one deeply disinviting experience of the couple’s birth.

There is evidence to indicate that support systems which are traditionally available to parents in a heterosexual relationship, like grandparents and community parenting groups, may not be available for lesbian parents (Clunis & Green, 1995; Epstein, 1993; Kenney & Tash, 1992; Nelson, 1996). Grandparents and other potentially supportive families may have difficulties providing support, yet issues related to same-sex parenting are not generally included in public resources for all parents. This again reflects assumptions regarding lesbian mothers’
needs for support and minimizes the effect of dominant discourses on the families and communities who potentially provide care.

For the participants, choice of midwifery and home birth represented maternal narratives which offered potentially empowering childbearing experiences regardless of their sexual identity. Planning for a possible hospital birth which offered technology and options not available at home required a weighing of cost and benefits of their care. Longstanding disinviting responses between individuals and their environments may affect the ways individuals anticipate responses within their worlds. Even if environments contain supportive features, individual interpretations may be tuned to receiving information which confirms that their world lacks support. If particular organizations or settings have been construed as disinviting, based on either previous experiences or feedback from others, lesbian women may prefer other venues for support.

The couple described prenatal classes and specific hospitals which were perceived to be homophobic and disinviting in their approaches. Clunis and Green (1995) and Trippet and Bain (1993) have indicated that hospitals tend to be slow moving in their acceptance of lesbian couples as legitimate families, and the nonpregnant parent may not be accepted fully. Avoiding the hospital environment may be a priority for lesbian childbearing. The participants identified the home birth option as a crucial component of controlling potential exposure to homophobic reaction in their deliveries.

The couple’s access to midwifery care was an important factor in locating support once pregnancy was a reality. Their personal connections to local midwifery and reproductive health institutions precluded access during the preconceptual period. Midwifery services in Ontario may offer lesbian women access to supportive maternity care (DeMarco & Simkin, 1996; Ford, 1993;
Shroff, 1997; Van Wagner, 1988) and are publicly available. Midwives estimate that they provide care to a small number of lesbian women each year in the local Hamilton area (K. Kaufman, personal communication, August 22, 2000) and as well in Toronto (midwives, personal communication, September 13, 2000).

That the couple was aware that the midwifery philosophy offered inviting conditions of continuity of care, increased power through decision-making, and deemphasis on technology (Shroff, 1997), but that the comfort level of individual midwives with lesbian families varied markedly, was disconcerting. Although the couple indicated that not all midwives are lesbian positive in their experience, they do feel that the midwifery education does facilitate sensitivity to diversity in a way that other reproductive professional programs may not. These women had access to personal networks which ensured lesbian-positive midwives; however, they realize that not all women do. As well, the participants noted that institutional environments differ in how midwives are accepted within reproductive health hierarchies, so their power to advocate and control homophobic behaviour for their clients might be limited.

However, if a woman is considered to be in a high-risk category during pregnancy, she may have limitations imposed on her choice of provider or place of birth (Kenny & Tash, 1992; Neilans, 1992; Van Wagner, 1988; Zeidenstein, 1990). This couple stressed that they would access midwifery care even if referred to high-risk providers because of the advocacy stance midwives provide. A main focus of the participants’ childbearing experience has been strategizing in order to minimize homophobic reaction. In order to access a health care system they perceive as unsafe, they emphasized the need for providers who could advocate for them.

They specifically noted that a midwife, public health nurse, or family physician might
provide this role. However, the couple stressed that inviting support from professionals is circumstantial. Their positive birth experiences were not interpreted as shift in support for childbearing lesbian women in society, but instead a reaction to, and indicating a respect for, their particular midwives. The couple perceived a mediating effect of the midwife on the interaction. Shroff (1997) described the role of “the midwife as a cultural interpreter in a heterosexist hospital” setting (p. 288).

Certainly several issues emerged from this study which highlight how the participants found support in their midwives. They noted that the midwives provided a buffer and advocacy role, which was in part attributed to their perceived status in the hospital setting, a status and respect which the participants did not feel that a doula would be proferred. The continuity of care and nonjudgemental approach might have been achieved with a doula whom they could have screened and hired to accompany them. However, as regulated professionals, midwives also had access to an authority within the system which permitted them access to documentation, medical decision-making (referral to high-risk care), and use of physical skills and control over the institutional environment which could have markedly altered the childbearing experience for these women.

The power inherent in this professional model of midwifery care comes at risk of alienating those supporters of midwifery for whom regulation is a form of cooptation, as midwives are perceived to be medicalized themselves in the process (Shroff, 1997), or that which seeks approval from the patriarchal medical institutions that undermined their practice (Neilans, 1992). This is a whole other area for discussion, but is relevant in discourses around midwifery itself, how it is variously perceived as alternative, woman-centered, subordinate, and
empowering by both professionals and expectant women across a variety of cultures and classes who could potentially access its services (Neilans, 1992; Shroff, 1997).

However, in Ontario, current funding for reproductive caregivers and the limited numbers of midwives available for women across cultures and regions contribute to barriers to equitable access for such advocacy. The participants had personal connections to their midwives, as well as financial privilege, which ensured their access to inviting midwifery support: high situated privilege. This is not the case for all expectant lesbian women. Shroff (1997) cites Pat Israel, a long-time advocate for disabled women, with respect to access: “Because of funding rules, women are only allowed to be under a midwife’s care or a doctor’s care” (p. 89). She noted that provincial funding for labour support coaches in conjunction with physicians has been considered an alternative measure, since doulas are not consistently available or publicly funded. Midwives’ professional privilege offered another aspect of advocacy in a hospital setting that might be less available with a doula. If lesbian-positive, women-centered care were consistently available in reproductive institutional settings, such advocacy might not be deemed the priority these women identified for reasons of safety. However, current political arrangements privilege financially advantaged, childbearing lesbian women for access to such support.

As the participants discovered, there are many supports for lesbian motherhood in the Toronto lesbian community. These include preconceptual classes, prenatal classes, parenting support which is geared to diversity of financial access, families which encompass a range of sexual orientations, and which are supported by midwives and other reproductive health professionals (519 Church Street Community Centre, personal communication, Sept. 4, 1999). Although lesbian-sensitive resources may be protected to some extent from public scrutiny, in
Toronto, the large openly lesbian and gay organizations which support childbearing, and diversity of same-sex families, offer visibility in public spaces which is quite different from other geographic areas. Suburban areas around Toronto or in other regions in Ontario may have few openly lesbian-positive resources for lesbian mothers (E. Hampson, personal communication, May 26, 2000). Such private networks are influenced by the need to offer and maintain safety. As the participants discovered, even lesbian-identified professionals who are affiliated with the Toronto lesbian community may not be aware of lesbian childbearing resources. The variable stances related to lesbian childbearing within and across lesbian communities have been noted.

Several sources in the literature mentioned how lesbian or women’s networks offer informal listings and networks of “out” lesbian physicians and counsellors (Boston Women’s Health Book Collective, 1992; Clunis & Green, 1995; DeMarco & Simkin, 1996; White & Martinez, 1997). The couple describes women’s centers as important points of information. However, locally, the couple is now considered the main resource for AI information. In Toronto this information is available through the lesbian community; however, as one lesbian-identified educator noted, she has no qualms about having her name on a listing in Toronto, although she recently felt that her safety might be compromised to disclose in a small town location well outside of Toronto (anonymous, personal communication, March, 2000). This is significant given the recommendation in CLGRO's (1997) report that "service-providers who are affirming of lesbian[s] . . . must list themselves as such in referral, community, and other directories" (p. 35).

It can be seen that the public/private divisions are not discrete with respect to choice of provider and the level of public availability of information within the lesbian communities. The
couple specifically attended a community preschool program which they assumed would offer nonstereotypical educational opportunities because the provider was lesbian, information obtained through their private network. However, they discovered that the information provided focused exclusively on nuclear families—a position they perceived as excluding, disininviting, and unsafe.

Postpartum and parenting. Midwifery care provided health care during the postpartum period. However, parenting supports which addressed issues relevant to the couples' needs with infants, preschool, or young children were not located locally in public spaces or within their private networks. A lesbian mothers' group within the local lesbian community offered insight into the needs of mothers with older children or custody disputes with male partners. Major concerns for the participants related to coparenting, breastfeeding, and role adjustment; however all parent supports in the vicinity were geared to heterosexual partnerings and were not perceived as relevant to their particular needs.

The couple states that a number of heterosexual mothers with children are supportive, as are a number of lesbian friends with whom they socialize. Jordan and Deluty (1998) indicate that widespread disclosure to lesbian and heterosexual acquaintances likely offers more reliable support than disclosure to family-of-origin. The group of local lesbian mothers with children from heterosexual partnerships has provided the couple with insight into issues which are becoming more relevant as their children become involved in the community. However, the unconditional support that the participants perceived to be available through their affiliations with the lesbian community prior to disclosure of childbearing is not available.

The participants stressed that all social institutions, including legal, educational, social,
and health, provide potentially inviting care. However, dominant narratives which shape stereotypical notions of the family exclude and invalidate other expressions of mothering, including the diversity of lesbian mother structures.

The internet straddles both public and private domains. However, in its offering of potentially confidential or anonymous information and support through lesbian-positive resources and networking, on-line supports provide a potential venue for inviting support. The quality of support through this route may be limited, however. As Nawratil (1999) notes in her assessment of on-line learning, there are barriers to communication which have not all been addressed in the enthusiasm to praise on-line strategies for interaction. These may include issues related to inclusion and equitable participation (p. 89), especially with respect to sexual minorities. The participants had not accessed on-line resources although Sharon considered it to be a type of support. Perhaps visibility and voice that the couple sought are interpreted in different ways through on-line interactions.

Access to on-line resources is an issue related to situated privilege of financial, geographic, and educational status, as well as perceived safety of information shared. The rich variety of chat rooms and networks with information and participants representing diverse geographic locations indicates the potential for on-line strategies to provide support. Rachel Pepper (1999), a lesbian woman well connected in the San Francisco lesbian community, noted that her great isolation from others in her community sparked by her decision to bear a child was overcome through on-line supports.

The study findings suggest that the quality of care available for childbearing lesbian women who seek information for childbearing is related to public and private points of access to
information and that these depend on disclosure status, situated privilege, and perceived safety of resources. Power relations shape how each of these facilitates or hinders access. As women choose to act according to how they perceive their environments offer validating and meaningful messages about lesbian motherhood, they both resist and comply with normative discourses. Democratic practices which address equitable access to care must acknowledge and understand marginalized narratives of motherhood and reflect these in institutional environments.

**Summary of Components of Access**

These study findings have indicated that, for this couple, comprehensive inviting support for lesbian childbearing was not openly available and accessible in ways that maintained confidentiality or anonymity within their local community, despite their high situated privilege. Comprehensive care was that which addressed the preconceptual, prenatal, intranatal, and postpartum periods and, as well, issues relevant to families with older children. Such support would affirm both biological and coparent mothering roles, while acknowledging the diversity of lesbian mothering situated lives.

Despite this couple’s extensive privilege and connections, they sought support in term of how it was perceived to be inviting: safe, validating, celebrating, and available in ways that maintained confidentiality or anonymity as desired. They were often excluded from public venues for care, and depended on private points of access to support. On the surface, it appeared that they had a fair amount of support and had many strategies available to them. However, this was likely related to their determined efforts to minimize disinviting homophobic reaction in their environments, as well as situated access to the resources that could facilitate this.
These participants attributed the lack of predictability of inviting caregivers, institutions, and community resources to widespread lack of consistent commitment to addressing systemic heterosexism in educational and professional organizations and other aspects of the public domain, which is shaped by dominant homophobic messages. In addition, they identified issues related to professional hierarchies and government funding which hindered availability of inviting advocacy within institutional settings. On another tack, they acknowledged that the diversity of lesbian communities influenced the quality of support they could rely on for childbearing support.

Factors related to social location and intentionality have been identified as important contributors to the disininviting environments described. The unconscious dimensions of dominant social discourses as they shape awareness of issues related to safety, disclosure, and social privilege in relation to educational interactions in both the public and private spheres play an important role in understanding issues related to access. This discussion offers an understanding of the relations of power which underwrite how lesbian childbearing women constitute themselves in relation to their worlds. The performative aspects of disclosure, the ways in which dominant heterosexist discourses inform their isolation, support, identities, and choices in their everyday lives, indicate that childbearing women may at the same time resist, comply, and thus accommodate heteronormative discourses in order to access inviting support.

As a result of the couple’s lack of perceived support, there were consequences which affected the lesbian childbearing women themselves, their care providers, and the larger social environment. These will be addressed in the second section of the conceptual framework.
Section Two: The Consequences of Lack of Access to Comprehensive Support for Lesbian Childbearing Women

Introduction

This second section of the conceptual framework interprets the analysis of the study findings in terms of the repercussions of limited access to comprehensive public health support for lesbian childbearing to both lesbian women and the larger community. Invitational and feminist perspectives will be linked to the heteronormative strategies of omission, repression, and alienation, and stigmatization (Onken, 1998) as they contribute to oppression. Each of these four concepts will be described under subheadings, but there will be continual overlap in discussion as they are interrelated. The pertinent themes which emerged from the analysis of the findings and which relate to consequences will be elaborated and contextualized in relation to the components of access discussed previously as well as the current literature.

The Effects of Heteronormative Strategies Which Limit Access to Care

Focusing on the consequences of the oppression engendered through homophobia and heterosexism "to the victims and to the culture in general" (Martindale, 1993, p. 450; Onken 1998) is essential in order to address current social practices which contribute to inequity and thus to enable change to the status quo. The Ontario Human Rights Code (Ontario Nurses' Association, 2000) differentiates between direct discrimination and systemic discrimination. The former describes intentional acts of withholding of rights, privileges, or access to resources on the basis of one's membership in a protected group. The latter focuses on the "effects of policies, procedures, and practices on [such] groups which are not felt by others" (p. 16).

Despite the many caring public health practitioners across communities, in this section I
will argue that the study findings suggest that lack of access to comprehensive and safe public health institutional resources reflects support for dominant discourses of subordination and invisibility of childbearing lesbian women. This contributes to consequences for lesbian women which have impacts on their rights, privileges, and access to care. This lack of support in a public domain facilitates widespread tolerance of both direct and systemic discrimination for childbearing women who partner with another woman. The findings of this study identified several themes related to such consequences in the descriptions of the everyday experiences of these participants. These include: isolation, determination, strategies perceived to be available, barriers to support, and childbearing as a turning point.

Onken (1998) has framed institutional heterosexism as a form of oppression which legitimizes heterosexual relationships at the expense of same-sex relationships through strategies of direct and indirect violence at the institutional level. From this perspective, the structural-cultural basis which underwrites the ideological and normative values reflected in institutional forms is largely invisible and thus unavailable for general questioning. Onken names the practices of omission, repression, and alienation which operate on intrapersonal, interpersonal, and collective levels as socially sanctioned actions which refuse to recognize and assist those in need, violate civil and human rights, and deprive individuals of self-esteem and identity (p. 8). The stigmatization which is produced through these practices acts further to contribute to such oppression. The consequences of each of these strategies as they affect lesbian women and their communities of care will be discussed. The effects on potential advocates in the community are discussed later in this section.

**Alienation.** Throughout this discussion of access based on the narrative findings of this
study, issues of isolation and alienation have surfaced often as the participants encountered heterosexist and homophobic environments in both public and private spheres. In the couple’s experiences, both individuals and institutions participated in activities which devalued and delegitimated their identities as childbearing lesbian women: biological mothers and coparents. It was apparent that otherwise well-intentioned individuals participated in such behaviour; however, in other instances this was overt and destructive in intent.

Alienating experiences which inhibited inviting connections with others, as well as the right to claim motherhood status, included withholding social privileges that are offered to mothers assumed to be heterosexually partnered or privileging the biological mother over the coparent. Conditions which discouraged disclosure promoted unsafe physical and emotional care and prevented lesbian women from locating others who could offer sustenance and encouragement.

Even within the local lesbian community, the couple encountered variable support for mothering and for raising sons. Although the dynamics were different from those previously described as they were not directly linked to institutional heterosexism, this conditional care also contributed to alienation from their claimed identities as lesbian women and represented another form of exclusion.

The isolation and homophobic reaction that this couple experienced as nonchildbearing lesbian women as described in the narrative was exacerbated through childbearing. The alienation to which Onken (1998) alludes contributes to felt difficulties (Dewey, 1933), incorporating cognitive dissonance, feelings of disempowerment, and limitations in available choices based on such reactions. Despite the couple’s determination to openly declare their
family to others, power dynamics inherent in language, withholding of social privileges, and limited emotional and material support contributed to understandings of oppression which devalued and delegitimized these identity claims and stigmatized the couple in the process.

**Repression.** Repression is conceptualized as denial of rights (Onken, 1998). These rights apply not only to social conditions which enable reproductive choices by providing tangible support for lesbian childbearing and access to safe health care, but also the fundamental ability to live and work openly as lesbian women in diverse expressions of family without fear of stigmatization or violence. I have previously described how the factors identified in the first section of this conceptual framework interact to limit the participants’ access to support. Their perceptions of the safety of resources, perceived options for disclosure, situated privilege available to them, and public or private points of access to information influenced their perceived choices in a way that was related specifically to their status as same-sex partners.

The oppression experienced by this couple in the form of inconsistent support to meet their educational needs impaired their ability to exercise their democratic reproductive rights as childbearing women. The reproductive freedoms of lesbian women situated in diverse locations are controlled and marked by the intersection of patriarchal, racial, ethnic, and other oppressions (Nestel, 1994; Royal Commission, 1993; Shroff, 1997) in which the violence and curbs on their freedom to choose inherent in the lives of many women in opposite-sex relationships (Coomaraswamy, 1999) are often magnified by their same-sex status.

For lesbian women the cultural domination of heteronormative social and reproductive contexts restricts their ability to choose childbearing because of societal conditions that inhibit relevant resources and explicitly limits their access to them (Morgan, 1993). The participants related instances of outright exclusion from resources, but also interpreted the existing
childbearing resources as overwhelmingly geared to heterosexual partnerships, and thus unsafe.

As well, the sexual objectification (Overall, 1993) of lesbian women perpetuated by media stereotypes is also practiced by health institutions which often address lesbian women exclusively in relation to sexual health contexts (Stevens, 1992). This constant association of their identity with their sexual relationships undermines the holistic nature of their life experiences and contributes to further alienation from self.

How lesbian childbearing is depicted in public discourses affects options for women who are partnered with another woman. One participant spoke of how her understandings of her capacity as a lesbian woman to bear a child changed over time. As well, she addressed how other lesbian friends could not conceive of childbearing within such negative environments. The potential for the negative social context to limit the life choices available to these women is disinviting in its impact on self-determination and autonomy. An internalization of such negative stereotypes occurs as discursive processes unconsciously shape the embodied self-concept. This is also experienced on affective and cognitive levels, or “felt difficulty” which consciously or unconsciously also affects behaviour.

Inherent in this effect of oppression on perceived reproductive options are consequences for health as well. The perceived choice to become a biological mother does have health implications. Childbearing and breastfeeding may confer a protective effect with respect to breast cancer (Ramsay, 1994; Waitkevicz, 1996), in addition to offering the emotional delights which may come with parenting.

An all-encompassing term for the avoidance of health care, and the effect of oppression thorough discriminatory attitudes and practices within the health care system on lesbian women’s
morbidity and mortality, is “homophobic fallout” (O’Hanlan, 1998). In addition to the emotional and physical effects of isolation and feelings of oppression on their lives, choices related to health affect the strategies used by women to deal with marginalization. As noted by the participants, many childbearing lesbian women choose alternative providers rather than face an unwelcoming mainstream system. Lesbian-identified women deal with an often hostile world, and this puts them at risk for relationship and depressive disorders (O’Hanlan, 1998). Coparents and biological mothers both encounter relationship struggles precipitated by childbearing in a same-sex partnership (Comeau, 1999; Dundas, 1999; Epstein, 1993); yet as the participants noted, their efforts to locate academic resources to negotiate such postpartum concerns were unsuccessful.

Stevens (1998) has described a major effect of prejudice on lesbian women as “fear and foreclosed options” (p. 87). In addition to the many issues of anticipating homophobic reaction in everyday interactions, the couple described their perspectives of raising two sons in a homophobic world as similar in some ways to any feminists raising sons, except for their fear for them as sons of lesbian women. With the knowledge that males associated with same-sex orientation can be at risk of physical violence, the couple’s anticipation of potential safety issues has influenced their decisions regarding day care, place of residence, as well as issues related to future educational settings. The right to live safely within a community is overlooked for these women for whom the threat of violence specifically linked to their lesbian childbearing is a part of their everyday lives.

Omission. Onken (1998) frames the strategy of omission as intentionally or unintentionally “failing to help someone in need” (p. 8). This is intentional when information is
available, but is not acknowledged; it is considered unintentional when the skills or knowledge are lacking.

The literature related to lesbian women and feminist struggles underscores how in the past, and continuing today, issues related to the everyday experiences of resistance and lesbian culture are for the most part left out of public discourses and educational processes (Boston Woman’s Collective, 1992; Rich, 1980; Stevens, 1992; Vida, 1996). This, together with the unconscious learning of dominant discourses which privilege heterosexual mothers over lesbian mothers, influences the information available to educators and potential advocates. As the dynamics of power shape social environments, high quality communication between lesbian childbearing women, their personal and professional supports, and institutional providers frequently remains elusive. As a result, educators often remain unaware of the intensity of feelings of oppression (Dei, 1999; Onken, 1998), issues relevant to disclosure, safety concerns, or lesbian childbearing and the impact that this has on lesbian women’s perceived choices in health contexts or their own contribution to maintaining this marginalization (Ramsay, 1994; Stevens, 1992; 1998). As Stevens (1998) notes, health care providers

will not see the clients who have been so traumatized in health care encounters that they change providers, or simply stop seeking help altogether . . . . Furthermore, until providers take action to stop themselves and their colleagues from behaving in harmful, frightening, and disrespectful ways, lesbians of color and other persons marginalized from the societal center cannot possibly risk changing their cautionary stance toward health care. (pp. 92-93)

Such lack of awareness of everyday struggles leaves practitioners working at levels of
tolerance and acceptance with respect to lesbian women, rather than acquiring skills which reflect the admiration, appreciation, nurturance, and support necessary for advocacy (Riddle as cited in Canadian AIDS Society, 1992).

Dewey (as interpreted by Gatens-Robinson, 1999) attributes this to deeply entrenched ways of responding which he calls habits. In his view, to function in democratic and inviting ways, individuals must develop skills which connect thinking and actions such that responses are attuned to current environments. His view of democracy is one in which "conflicting [interests are brought] out into the open where they can be seen and appraised . . . in the light of more inclusive interests" (p. 185). This is in line with Riddle's (1991) focus on the need to reflect on current behaviours and values in order to achieve more effective ways of functioning. For Dewey, resistance to such change is found in the "inertia of our habituated social, emotional, and moral responses" (as cited in Gatens-Robinson, 1999, p.184). Social norms facilitate the perpetuation of individual habits which promote heteronormative strategies.

The impacts of institutionalized heterosexism are felt by individual lesbian childbearing women as well as communities who provide care. However, heterosexist norms are also enforced through research venues. The lack of acknowledgement and dissemination of the existing body of over 20 years of research related to lesbian health and lesbian childbearing bears marks of repression and omission. This has affected health providers' knowledge base, and has thus also indirectly contributed to isolation of the women themselves.

**Stigmatization.** As Onken (1998) has indicated, the invisibility, exclusion, stigmatization, labeling, and mental anguish, which are consequences of institutional heterosexism, produce and reproduce forms of violence through omission, repression, alienation,
and stigmatization. He links such widespread tolerance of such behaviour by public institutions to socially sanctioned structural-cultural violence in which exclusion and labeling are justified for moral reasons, but which is often supported by a medical model.

Thus, any efforts to identify and examine individual or institutional belief systems for discriminatory patterns and attempts to change them are often discouraged through these same strategies, and those who attempt to do so are instead often stigmatized in the process (Onken, 1998; Shroff, 1997). These factors contribute to antigay sentiment and violence experienced on intrapersonal, interpersonal, and collective levels, all of which are tolerated by both individuals and institutions because this is not widely recognized as a form of violence.

A key concept is how Onken (1998) defines violence: that which contributes to damage to physical or psychological integrity and which includes both direct and indirect contact between perpetrator and victim, as well as social, institutional, group, and individual forms of violence He bases this on Van Soest & Bryant's (1995) framework which recognizes the various interrelated levels and types of violence in relation to oppression. Using a broad definition of assault on individuals which prevents them from reaching their potential by restricting their physical and emotional opportunities, links this analysis to goals of invitational theory (Purkey & Novak, 1996) which emphasizes educational interactions which facilitate the development of life possibilities and which advocate enabling, caring, and nonviolent communities. This is congruent with a common goal of diverse feminist perspectives which address violence as a complex, systemic force structuring women's lives. Strategies which enforce heterosexuality (Rich, 1980) contribute to the dominant partriarchal interests which interact with other oppressions to shape the lives of all women (Amin, et al., 1999; Kemp & Squires, 1997, Mandell, 1998; Miles, 1996;
Rich, 1980; Shroff, 1997; and others).

It is apparent that the consequences of oppressive strategies which deny lesbian childbearing women their rights, and identities, and care by inadequate access to support in public institutions include increased isolation and impacts on perceived choices, as well as limited access of health providers to information which can support their care. However, the findings of this study also suggest a need for these women to exhibit determination and courage in order to locate resources, given the widespread barriers to lesbian childbearing.

When safe and publicly accessible services are not consistently available, tenacity and physical and emotional well-being, in addition to situated privilege, may shape what support is located. The couple’s ability to devote time to researching possible resources using their networks and knowledge of the system, in addition to their often apparently vast energy reserves, were important factors in their ability to locate support. Most of this was carried out in the preconceptual period while the women were working full time and had no child care responsibilities. However, once the children arrived, their knowledge of inviting services within an hour’s drive was at times frustrating, as these resources were perceived to be inaccessible because of energy required to bundle up two young children, etc. Their lack of use of internet resources was also attributed to a lack of time or energy.

The determination, energy, and courage to counter such pervasive invisibility in environments that continue to negate and undermine ways of knowing which relate to childbearing as a lesbian woman are not only stressful, but necessitate ongoing resolve in which locating intentionally inviting relationships is the goal. The couple’s priority on open validation of each member of their family entailed responding to and clarifying issues which they perceived
as an ongoing need to teach others in virtually all of their everyday environments.

The barriers to locating supportive networks and relevant information have been discussed as they relate to disclosure and situated privilege. Evaluating daily interactions in terms of their safety exacts an emotional toll that cannot be underestimated in lesbian women’s lives. Energy is required to deal with disclosure issues day-to-day, yet it is also required to remain closeted (Stevens, 1992). Each entails a risk of alienation from self or others, as well as physical or emotional violence in the form of less than optimal care or homophobic stigma (Onken, 1998). Having access to time which is required to locate any supportive networks and determine safety of resources is also a form of situated privilege. How publicly or privately available resources represent the diversity of lesbian mothering experiences will contribute to their perceived safety or relevance in terms of validating cultural, racial, ethnic, (Comeau, 1999) or other expressions of self.

Childbearing was a turning point in the kinds of support this couple could rely on within their communities: in terms of time, energy resources, as well as specific lesbian-positive supports who could provide unconditional and instrumental care. Dealing with exclusion by other lesbian women demanded a rethinking and rationalization of the support available from the community with which they were associated. On one hand, they acknowledge the diversity of stances, but on the other hand, they deal with intensified emotional responses as they feel doubly excluded. They cherished the positive support available to them. Given the tremendous toll on these women, safe spaces locally for social networks are important.

Dominant discourses remain persistent as they remain largely unchallenged. Issues related to disclosure, safety, situated privilege, and limited public availability of information
contribute to feelings of isolation for lesbian childbearing women. As discourses related to same-sex orientation promote isolation for those individuals who do not have children, childbearing experiences exacerbate feelings of isolation. This isolation is both produced by and contributes to dominant public discourses of the invisibility of childbearing lesbian women and the nonimportance of their issues (Armstrong, 1996).

Discourses available at specific points in time affect how lesbian women are perceived in relation to larger society. Armstrong (1996) notes that “mainstream media continue[d] to repeat a discourse of “progressiveness” around the representations of lesbians” (p. 11) throughout the 1990s with a shift from representing lesbians as “invisible homosexuals to a homosexuality of no importance” (p. 11). However, as she states, “this discourse of acceptance and even boredom” (p. 12) does not mesh with the ongoing oppression experienced by lesbian women. Since these discourses represent preferred realities which serve certain interests at the expense of others, it is important to consider what effect this has on public educational contexts.

Inviting environments offer acceptance, validation, and celebration of diverse expressions of lesbian families. However, in public spaces the boundaries which are circumscribed around the acceptable lesbian parent have been linked to how these deny lesbian women their sexuality (Driver, 1996; Gabb, 1999). Gabb explains that public suitability is equated with being discreet, and therefore invisible. The ways in which desire is represented and/or repressed in public spaces is related to dominant power relations which contain lesbian women within boundaries of acceptability--if they are permitted to take up public space at all. A discussion of public access for supporting lesbian mothers thus must include an acknowledgement of the effect of discursive strategies on educators’ perceptions of lesbian mothers and how they contribute to childbearing
lesbian mothers’ “erasure, denial, invisibility, and tokenism” (Cassidy, Lord, & Mandell, 1998, p. 48) within public domains.

As well, persistent heteronormative discourses contribute to further stigmatization of lesbian women and justification of exclusion of their supports on moral grounds. This again promotes discourses of invisibility and discourages critical analysis of these practices (Onken, 1998).

The dominant worldview uses heterosexist frames. Pervasive discourses which have been described as forming the backdrop for our ways of knowing are learned at an early age and assimilated through religious, educational, and other social institutions. Behaviours which are shaped by these assumptions are for the most part unconscious. It is this lack of consciousness which results when assumptions are left unexamined that can account for the unintentional ways in which a range of otherwise well-meaning individuals interact in disinviting ways. The lack of others’ understandings of their everyday struggles and philosophies is a major gap in how lesbian childbearing women feel validated and cared for.

Discourses which promote the invisibility and lack of importance of lesbian women and their issues shape the awareness level and knowledge base of educators with respect to childbearing lesbian women. As Stevens (1998) explains: “With little access to clients’ perspectives, providers are in a position of not knowing what they do not know about clients’ experiences within the health care encounter. It is the existence of these blind spots that is particularly problematic” (p. 79).

The invisibility of resources which visibly and explicitly address lesbian childbearing in public spaces contributes to these dominant discourses. The omission of lesbian childbearing in
public spaces, the denial of lesbian women’s rights to bear a child through discriminatory resources and dominant stigmatizing discourses, as well as the alienation of lesbian childbearing women who claim lesbian mothering roles, perpetuate dominant discourses of invisibility and lack of importance.

Although there is an acknowledgement of difference within professional and educational systems, the ways power is structured at an unconscious level minimizes how difference is prioritized or valued in educational contexts (Dei, 1999) and this is reflected in how the voices of the marginalized are represented and how visible is their presence. As a result, educators often remain unaware of childbearing lesbian women’s unique issues, their everyday struggles to locate support, and do not perceive how they themselves contribute to this marginalization. As providers, professionals carry the responsibility for creating openness and receptivity (Stevens, 1992, p. 115).

I would argue that given the previous discussion and the pervasive and multiple ways relations of power are structured, issues of disclosure, situated privilege, social location, and the role of public institutions in affirming diverse expressions of family relationships influence the possibility of facilitating consistently inviting relationships within community contexts. While supportive individual advocacy or programming is beneficial, the circumstantial nature of such support contributes to unintentionally inviting encounters. Addressing the structural components of social relations in which various conceptualizations of power are at work is necessary to promote access to care that is predictably, and therefore intentionally, inviting.

Intentionality is thus a key concept in how lesbian women and educators (while acknowledging that these are not mutually exclusive) participate in enabling or hindering
inviting educational encounters. It is the purposeness of the actions which is the important component, and the consistency under adverse conditions which facilitates inviting encounters. Determination to act for lesbian women in ways that continually counter prevailing heterosexist and homophobic messages requires more than good will. Dei (1999) cites Michelle Fine’s “good intentions” which often mask a reluctance to delve deeper or acknowledge one’s own involvement in perpetuating the status quo. However, the unconscious ways in which power enables or limits lived experiences and perceived strategies for action necessitates critical reflection and possibly emotionally disturbing awareness of the role that educators take in maintaining oppressive dominant social relations, individually and collectively. This contributes to instances of both direct and systemic discrimination for lesbian women who are considering pregnancy or parenting, findings congruent with similar statements in CLGRO’s (1997) report of health and social services.

Certainly educational or religious institutions which enforce patriarchal structures and limit any expression of resistance to this will shape homophobic and heterosexist encounters in a way that may be disinviting—both intentionally and unintentionally. If the goal of invitational care is facilitating the development of communities in which trust, respect for the uniqueness of each person, and unconditional acceptance and celebration of diversity are paramount, invitational processes must address the power dynamics inherent in the intentionality of interactions. Institutionalized power relations are persistent and create tremendous barriers to care.

Moreover, the long-standing and widespread cultural acceptance of homophobic norms and heterosexist values within social institutions also underscores an intentional force to sustain
heteronormativity. Yet, the consequence of intentionally disininviting environments is what Purkey and Novak (1996) have described as a “lethal presence” (Course materials, EDUC 5P43, January, 1997). The reality of heterosexist and homophobic public institutions (Coalition for Lesbian and Gay Rights in Ontario, 1997; Eichler, 1997; Epstein, 1996b, 1999; Ramsay, 1994; Stevens, 1992) which dominate childbearing lesbian women’s worlds reveals just how difficult finding meaningful support can be.

Despite oppressive conditions, childbearing lesbian women’s lived experiences reflect creative ways to find meaning and negotiate relationships within their communities. The ongoing “felt difficulties” that lesbian women experience as nonchildbearing women are intensified and understandings potentially enriched (depending on one’s stance) by both experiences of mothering as a lesbian woman and discourses of lesbian motherhood, race, ability, and other locations. Certainly it is important to acknowledge and focus on the potential for transgressing social boundaries and the lived experiences that celebrate the value of such strategies, given the realities of social circumstances in lesbian women’s lives and goals of social action which promote expression of diversity.

However, the barriers to care are real. Persistent heteronormative discourses prevent childbearing lesbian women from claiming their rights and identities and shape their lives in terms of seeking safety.

**Summary of Section Two**

When comprehensive inviting support is not available in the public domain, there are consequences for childbearing lesbian women as well as the larger community. The isolation experienced as lesbian women, marginalized by gender and sexuality, in addition to other aspects
of social location, is exacerbated. Their perceived choices to act are limited by oppressive constraints that are related to situated privilege and ability to locate safe environments. This sustains dominant discourses of heteronormativity which perpetuate the invisibility and lack of importance accrued to lesbian childbearing women or their families, as well as which block educators’ access to understanding their issues. There are negative health impacts which are linked to the alienation, repression, omission, and stigmatization of institutional practices. Access to services is hindered by both direct and systemic discrimination.

However, social constraints also offer opportunities to resist and push normative social boundaries of motherhood: creative responses which celebrate the diversity of maternal experiences and expression. Recognizing the ways in which lesbian childbearing women have found support, in addition to understanding the complexities of the social context offer implications for how communities can provide caring support for these families.

Section Three: Educational Possibilities

Introduction

This exploratory study which addresses access to supportive education for expectant lesbian women has implications for professional practice in a Canadian public health context. The first two sections of the conceptual framework presented factors affecting access and the consequences of limited access to support for lesbian childbearing women and their communities. In this third section I have interpreted the narrative findings presented in Chapter Four under the final study question of future possibilities and contextualized them in terms of relevant literature, contacts with key informants, and my experiences with childbearing education in a public health setting. As well, I have highlighted relevant issues that became
evident during the research process itself, as they have implications for future research and practice.

I will first briefly provide theoretical support using invitational and feminist perspectives for this third section of the conceptual framework. The focus will be on the dynamics of a joint research dialogue between participants and researcher with respect to reflecting on experiences and visualizing potential changes to current practice. Secondly, I have presented one approach for framing this discussion using the 6 Ps of invitational theory: how these factors may contribute to more inviting educational interactions. Given the expansive nature of the issues that emerged from this study, I have limited this discussion to two major points under each of the 6 Ps.

**Imagining Possibilities: Invitational and Feminist Perspectives**

According to invitational theory, “perceptions change over time. . . . [Because] perceptions serve as a reference point for behaviour, . . . [they] affect the possibilities that people can imagine, and the goals that they are willing to work for” (Purkey and Novak, 1996, p. 23). Although individuals cannot change the past, they can change their perceptions of previous events and consequently become open to more possibilities in the future. Seigfried (1992) notes that “the power to reflect on the result of our actions on the environment and its effects on us [gives us] the ability to imagine a future different from the present” (p. 202). This future orientation is an essential component of invitational perspectives. There is a focus on process which acknowledges the importance of past contributions to shaping current circumstances and creating new possibilities.

address deeper, structural issues of societal practices with invitational communities in mind. The pervasive nature of dominant heterosexism and homophobia throughout individual and institutional discourses as they interact with other forms of oppression necessitates the systematic assessment of educational environments. Both the findings presented in Chapter Four and those in the following section use the invitational framework to underscore the multilevel approach to effecting change that the participants and literature emphasize are needed (Abbey & O’Reilly, 1998; Amin et al., 1999; Coalition for Lesbian and Gay Rights in Ontario, 1997; Labonte, 1990; Mandell, 1998; Novak, 1992; Stevens, 1992, 1998; and others). Sustained dialogue, deep reflection, and systematic assessments of educational communities using the invitational model are strategies for addressing power inequities which can contribute to such change (Purkey & Novak, 1996). Its focus on democratic ideals and social responsibility are consistent with many feminist endeavours (Kemp & Squires, 1997; Mandell, 1998).

Promoting social change which improves the everyday lives of women in their diversity is a common goal of feminist approaches (Abbey & O’Reilly, 1998; Amin et al., 1999; Kemp & Squires; 1997; Mandell, 1998; and many others). One such process, the concept of “opening space” for reflection within interactions, will be discussed as it facilitates the visibility and voice of subjugated knowledges (Sawicki, 1991). The use of narrative processes (Abbey & O’Reilly, 1998; Seidman, 1998; Stevens, 1998) is deemed potentially enabling as lived realities are restoried and power is effected through performative actions.

By reconstructing the details of their childbearing lives through an interactive couple narrative, these study participants contextualized their personal and joint experiences of mothering in the broader social context and acknowledged the political dynamics at work in their
environments. By consciously naming the effects of heterosexism and homophobia in their worlds (Amin et al., 1999; Canadian AIDS Society, 1992), and their responses to them, they could construct preferred realities, opening space (Freedman & Combs, 1996) for imagining potential strategies to address current conditions that contributed to their everyday childbearing struggles. These were opportunities to reflect on the meanings of childbearing in their situated lives and construct alternative or counter mothering discourses (Abbey & O'Reilly, 1998; Freedman & Combs, 1996) for consideration along with dominant understandings of motherhood.

Another way to conceptualize the notion of opening space relates to feminist theorizing of identity and difference in relation to alliance-building. Instead of pitting identity and difference together as a dichotomy, Janet Jakobsen (1998) focuses on the need to recognize issues of difference among, difference within, difference between, and differance (pp. 12-13) as these contribute to the diversity and complexity of social relations. She highlights the gaps and spaces within the normative social matrix as sites of potential action and alliance, while emphasizing the instability of categories, disparity between ascribed categories and lived experiences, the contradictory and shifting nature of political alliances, and the impacts of political hierarchies and linguistic meanings as relevant to such understandings.

There are implications for this research context regarding the fluid, contradictory, and political nature of identities and positionality of all research participants which influence this discussion of educational change. The study couple and I, as a public health nurse researcher, are each marginalized or socially privileged within a specific context according to our claimed or assumed subject positions. Through this process of articulating our experiences (Borsa, 1999)
and from these multiple and often contradictory situated locations, we reconstrue our selves in relation to our worlds (Seidman, 1998) and question how things might change.

Kathleen Rockhill’s (1996) approach to power and privilege offers an important foundation for understanding the issues shared in this participant-researcher dialogue as all participants contribute to an alternative vision of supportive childbearing. She stresses that instead of conceptualizing privilege as

a commodity that one does or does not have, . . . think instead of acts, of what it is that one can do, in varying situations, and in relation to whom. Privilege is about power, the power to effect the actions of others, the power to exert some control over one’s life, to know that possibility of choice and rights that are inscribed by “the normal.” Power is about having value, that is skills, abilities, performances, that effect possibilities for others, that others desire. We learn to perform ourselves in ways that will maximize our power to realize our desires. That these desires are socially constituted matters. (p. 98)

Acknowledging and valuing participant-researcher positionality and the privilege and power inherent within each of our situated locations was an important aspect of the process of mutual reflection on past experiences while considering potentially inviting factors in changing the current situation.

Nancy Fraser conceptualizes effective social activism as that which includes the “translation of socially marginalized women’s discourses to officially recognized discourses” (as cited in Mehuron, 1997, p. 214). In order for this to occur, an understanding and “politicization of the actual needs and civil rights” (Mehuron, p. 214) of marginalized groups is necessary.

Since a priority in this research process was to elicit and define issues from the
perspective of lesbian childbearing women, the previous chapter’s discussion of future possibilities as presented under the final study question is an integral component of this discussion. The wide scope of strategies described in these two chapters under future and/or educational possibilities, offers a starting point for public health educators involved in addressing conditions which can enable access to inviting and comprehensive support for expectant lesbian women.

Educational possibilities using the 6 Ps

People.

- Awareness of the diversity of childbearing lesbian women’s situated experiences across social locations of age, race, culture, ethnicity, ability, class, and sexuality and communities and the range of expression of their motherhood and other identities to others.

In order to counter dominant discourses of invisibility and narrow stereotypical representations of lesbian childbearing, the findings of this study suggest that inviting educational environments must acknowledge the lived realities of these women’s lives. Educators must take into account the diversity of childbearing lesbian women and the communities with which they connect, as well as the varying mother roles they may perform. This necessitates an attentiveness to the assumptions of heterosexuality and those regarding the binary nature and consistency of same-sex orientation which often shape interactions, but which are barriers to addressing care for childbearing women. Understanding factors such as the perceived safety of resources and potential situated privilege which influence contexts of disclosure for women who partner with another woman are essential for facilitating supportive
practices.

The consequences of pervasive heteronormative discourses for the participants and others described in the literature have been outlined. The study findings have offered insight into the extensive feelings of oppression, cognitive dissonance, “foreclosed options” (Stevens, 1998), isolation from self, others, and communities experienced by this couple, and the ongoing barriers to locating supportive care for childbearing as lesbian women. It is only with an understanding of how oppression shapes lesbian women’s everyday struggles and the systematic marginalization within the historical and cultural context of their lives as lesbian women that educators can begin to address issues of care in inviting ways.

- Educators represent a diversity of situated experiences, professional and community affiliations, as well as the spectrum of sexual identities. Dominant heterosexist norms influence their perceptions of lesbian childbearing and what information is available for educators. As such, in institutional environments which marginalize these issues, their capacities to engage in inviting ways are shaped by their often limited insight into and ease dealing with same-sex orientation issues and specifically lesbian motherhood.

   Educator positionality can be couched in terms of personal and professional experiences, social location, affiliations, and education, all of which influence educators’ comfort and knowledge levels regarding lesbian childbearing. Lesbian motherhood and educator roles may not be mutually exclusive. The choice to openly disclose same sex orientation as an educator bears a relationship to the perceived safety of individual and institutional environments (Coalition for Lesbian and Gay Rights in Ontario, 1997), as well as the perceived privilege of being out in a specific context.
Educators internalize dominant discourses regarding lesbian childbearing and may intentionally or unintentionally contribute to disinviting interactions in their educational practice. These dynamics, which are experienced every day by women who partner with other women, suggest that the current institutional environments for expectant and parenting lesbian women contribute to their societal marginalization. In fact, as Onken (1998) has indicated, the invisibility, exclusion, stigmatization, labeling, and mental anguish, which are consequences of institutional heterosexism, produce and reproduce forms of violence through omission, repression, alienation, and stigmatization. Yet, the vast majority of professionals who decry violence on both individual and institutional levels are unaware of the ways in which their own practices may perpetuate violence on intrapersonal, interpersonal, and collective levels (Onken).

Public health practitioners are ethically, legally, and professionally mandated to provide safe access to information and holistic programming to the diverse lesbian childbearing population as culturally sensitive practice which demonstrates respect and which values and celebrates difference within communities. The invisibility of childbearing lesbian women in public discourses contributes to a misconception that lesbian women and families are not part of all practitioners' everyday personal and professional lives, and this shapes priorities for education. As well, lesbian concerns may be addressed exclusively within a narrow context of sexual health rather than across all public health programming. All public health educators and support staff, regardless of their program affiliations, contribute to potentially inviting environments for childbearing lesbian women (Coalition for Lesbian and Gay Rights in Ontario, 1997).
Places.

- Places are marked as safe or unsafe by lesbian childbearing women according to whether these convey information and support in ways that offer optimal physical and emotional care.

Important components of safety are those which consistently validate and celebrate difference while respecting and maintaining confidentiality and anonymity as desired. The historical and social contexts of individual and institutional interactions also influence how lesbian childbearing women perceive whether places are accessible to them: their decision to connect with them and how the interactions proceed. Institutions and educators that consistently advocate for, collaborate with, and represent lesbian childbearing women in resources in ways which make visible their diverse voices and issues will facilitate accessibility to inviting care.

Explicit inclusion of information and networks relevant to same-sex biological mother and coparent concerns in printed and audiovisual resources that recognize these issues across cultures and ages are examples. Social and health institutional resources and those of their community partners can support lesbian childbearing by addressing breastfeeding, relationship dynamics, and kinship struggles in all venues where families are represented. Inservice opportunities which address multicultural issues in a way that is inclusive of same-sex orientation as it intersects with other issues of oppression could be deemed inviting. Publicly displayed lesbian-positive posters and events, as well as antidiscrimination statements within institutions, can be affirming.

In addition, communities of same-sex affiliations offer potential support for couples. However, public health institutions cannot assume that childbearing lesbian women will locate
relevant care as biological mothers and coparents within lesbian communities. The availability of local lesbian networks and communities varies, and according to Jordan and Deluty (1998) women must disclose as lesbian or be affiliated with a lesbian community to gain such support. The physical, emotional, and social isolation of childbearing women who partner with a woman, environments which discourage disclosure, varying political stances for childbearing, and diversity of situated lives of women who identify a same-sex orientation contribute to the variable and unpredictable support for lesbian childbearing within and between communities of lesbian women.

Lesbian communities which acknowledge and plan for the diversity of their families, including those who seek support for AI, can validate and celebrate same-sex relationships by providing networks of role models, as well as social and support services for childbearing women and their families. Inviting connections between institutions and communities can enable this care.

- Geographic location may influence the accessibility of safe resources as it affects the possibility of and visibility of lesbian communities, as well as the perceived safety of environments in which educators and lesbian women interact. On-line options may offer inviting information and supportive communities.

Community environments which visibly support disclosure of same-sex orientation by women considering motherhood and which acknowledge and validate expressions of diversity of race, ethnicity, and other social locations may be found in several large metropolitan centers across Canada.

Toronto is one such political and social hub for the provincial community. Preconceptual
and prenatal classes which are geared to lesbian and/or bisexual women are regularly offered by the lesbian community and are well attended. Health and legal professionals participate and a range of social supports for same-sex partners and children including a drop-in center for childbearing lesbian women are offered (519 Church Street Community Centre, personal communication, March, 2000).

However, these study findings supported by the literature indicate that same-sex mothering partnerships are not confined to these centers (Coalition for Lesbian and Gay Rights in Ontario, 1997). In addition to the isolation perpetuated by limited disclosure and safety concerns, support from family, institutions, and communities may vary over time and with location (Coalition for Lesbian and Gay Rights in Ontario). As well, with the downloading of funding of public health services to municipal levels, the effect of conservative political influences and media representation of issues across regions will influence what programming is available. This contributes to limited access within both public and private networks. Service providers must enable access across regions.

Face-to-face encounters with individuals and institutions are frequently perceived as potentially inviting sources of support. However, one strategy for care which has not been explored in depth in this study is the use of on-line resources. Yet, confidential or anonymous access to resources was considered a desirable option to maintain safety for lesbian and/or childbearing women in various circumstances (Pepper, 1999).

The wealth of educational and interactive sites available offer childbearing lesbian women potential access to confidential and anonymous support in a way that may be unavailable given the unpredictable support across communities. The internet offers a potential venue for
social support for isolated women or those who seek information on a range of childbearing issues and lesbian health concerns, including prospective parenting and AI, and also provides resources which are not restricted to same-sex supports (519 Church Street Community Centre, 2000; Alternative Family Project, 2000; Babydancing: A Page for Mama-Wannabes, 1999; Family Pride Coalition, 1998; Lesbian Moms Web Page, 1999; Lesbian Mothers Support Society, 1999; Love Makes a Family Exhibit, 1999; Momazons, 1999; Prospective Queer Parents, 1999).

Exploration of this resource may offer practitioners across a wide geographic area inviting resources for potentially childbearing women in their communities. However, the development of on-line resources should not preclude the need to address comprehensive support within communities. Given the issues of privilege required for on-line access and potential concerns regarding the marginalization of cultural diversity on-line (Nawratil, 1999), further research on the quality of care perceived by lesbian women through on-line and personal interactions could offer insight into the effectiveness of this option as a support.

**Programs.**

- Inviting educational processes which are part of programming for childbearing lesbian women and educators address structural relations of power as they contribute to everyday struggles to seek care and enable support. Situating individual realities within patriarchal and other hierarchies of power, with a focus on social location and situated privilege, can be valuable approaches to understanding the impact of heteronormativity on personal and professional practices.

**Comprehensive curriculum for childbearing lesbian women.** The findings of this
study suggest that addressing lesbian childbearing education in an inviting way necessitates inclusion of lesbian childbearing issues in all existing resources targeted to expectant women, parents (Coalition for Lesbian and Gay Rights in Ontario, 1997), and their families, in addition to the development of supportive networks and spaces which are geared specifically to same-sex families and their communities. Given the nature of decision-making with respect to lesbian childbearing, inviting information and support must comprise the preconceptual, prenatal, intranatal, postpartum, and parenting time frames.

Through the research dialogue, the participants shared a number of topics particular to childbearing lesbian women. These included: disclosure and language concerns, visibility of both biological mothers and coparents within class settings, as well as representations of lesbian families in both visual and verbal contexts and discussion of interactional barriers specific to childbearing lesbian families. They also emphasized the importance of developing meaningful family, social, and professional networks.

Currently several supportive community resources do exist specifically for childbearing lesbian women in Ontario (519 Church Street Community Centre, personal communication, Sept. 4, 1999; E. Hampson, personal communication, May 26, 2000; D. Roedding, personal communication, July 18, 2000). However, these are inconsistent across communities, and public health connections are very limited. However, even in such large centers, some with large lesbian communities, lesbian women experience heterosexism in mainstream prenatal educational settings (J. Clipsham, personal communication, February 23, 2000; J. Luce, August 11, 1999, personal communication). Institutional supports for childbearing women who identify as single and/or adolescent may be implicitly geared to heterosexual partnerings or overlook the
diversity of expectant lesbian women who seek care. Prenatal information which focuses exclusively on institutional birth and mainstream providers of care may alienate women who perceive such systems as unsafe.

Certainly the participants indicated that issues relevant to lesbian childbearing are also important to a variety of females and males, those who are considering parenthood in various locations and those who may be providing donor, personal, or professional support within kinship or community relationships. Caring communities are those in which diverse individuals, families, and cultures are validated and celebrated. This can occur only if lesbian mothering is made explicitly visible and honoured in ways that motherhood in more traditional contexts is celebrated.

**Curriculum for educators.** The need for comprehensive diversity education has been emphasized by both the participants and literature (Coalition for Lesbian and Gay Rights in Ontario, 1997; Epstein, 1996b; Ramsay, 1994; Stevens, 1992). This entails the development of skills for all educators and public health practitioners which address institutional and cultural homophobia or heterosexism (Martindale, 1993). There are implications for the quality and intensity of such education in order to effectively promote inviting environments: those which are perceived as safe.

The unpredictability of encounters with individuals and institutions contributes to isolation and mistrust. While inviting communication between individuals is helpful, institutional and community environments shape the context in which messages are received and interpreted. Truly inviting interactions must address consistency, quality, and congruence of verbal and nonverbal messages.
The use of nonheterosexist language is only one indicator of a potentially supportive interaction, but development of empathy, which is a key consideration in inviting encounters, requires more than the use of inviting language. Effective educational opportunities for practitioners would include the discussion of issues related to lesbian culture and struggles, language issues, mothering roles, and the interaction of heterosexism with other oppressions like racism, ableism, and sexism, as well as the impact of their own social location and situated privilege (Shroff, 1997). Issues related to disclosure, respect for protection of information shared, and the importance of educator stance in interactions are essential elements of such sessions. As well, educators would benefit from understanding individual and collective strategies for advocating for lesbian women and their families.

Brief and one-time antihomophobia workshops are unlikely to convey the depth or breadth of understanding necessary to support activities designed to counter deeply ingrained heterosexist values and practices, experiences which may precipitate strong emotional reaction. Elective learning experiences related to equity may preach to the converted (Dei, 1999) or those who are receptive, yet these findings indicate that sexual orientation issues are relevant to all practitioners (Coalition for Lesbian and Gay Rights in Ontario, 1997; Epstein, 1996b; Ramsay, 1994; Stevens, 1992). Individual and community resistance to such educational practices can be expected (Onken, 1998). However, this does not invalidate the need to address this issue across public health practice.

Given the tendency for individuals to maintain existing ways of understanding the world (Kelly, 1955), it is evident that to view one’s self and the world in a way that overcomes the internalized dominant heterosexist perspective may entail a rupture in the existing structure
(Kelly) or way of construing the world, possibly of great magnitude. To examine assumptions which shape relationships, language, and other ways of representing power relationships to self and others in a way that consistently prevails over existing communication patterns and worldviews is potentially overwhelming. Changing one’s perspective is not confined to token acceptance or change in use of language alone. Determination, energy, and courage to counter such pervasive ways of thinking in environments that continue to negate and undermine this is not only stressful, but necessitates ongoing persistence to develop, structure, and sustain (Novak, 1992) commitments in which intentionally inviting relationships are the goal.

MacLeod (1992) speaks of the ambiguity of protest that women may make in their lives: at the same time resisting and complying with normative imperatives. Although there are very altruistic reasons for aspiring to facilitate inviting environments, I would venture that at times, acknowledging the ways in which we are complicit in maintaining existing power relations as educators, there may be an ambiguity of intentionality involved as a consequence of the deep reflection required to understand how to give up privilege through developing consciousness (Shroff, 1997) and the commitment necessary to using privilege for inviting goals.

In my experience, there may be an emotional component to this learning related to equity which occurs as one’s assumptions of privilege and worldview are eroded. Denial, anger, and uncertainty may be part of this process: grieving the loss of “knowing.” Fears of appearing politically incorrect or anxiety regarding disclosure are possible (Simpson, 1994). Sensitivity to such possibilities is essential in educational settings where these issues may be discussed, and given the documented consequences of alienation, stigmatization, and labeling, whether based on
rumor or sharing of such information (Coalition for Lesbian and Gay Rights in Ontario, 1997; Onken, 1998; Shroff, 1997; Stevens, 1992, 1998), provision for safety is a fundamental aspect of enabling this reflective process in institutional environments.

Processes.

- Despite recent legislation conferring spousal benefits on lesbian couples, documentation of systemic discrimination with respect to access in Ontario health and social institutions (Coalition for Lesbian and Gay Rights in Ontario, 1997; C. O’Brien et al., 1993; Simpson, 1994), and increasing media awareness of lesbian childbearing, public health educators face barriers to advocate for expectant lesbian women within their institutional environments.

Educators’ abilities to care for childbearing lesbian women are a function of their perceived safety in their personal, professional, and educational communities. According to Shroff (1997), in her discussion of childbearing lesbian women with respect to midwifery, “heterosexual women may argue/lobby/demand for the rights of lesbians. They may get labeled as lesbian in the process or may lose friends, jobs or more” (p. 269). CLGRO (1997), in its study of health and social service providers across Ontario, indicated that same-sex issues are rarely supported by institutional leaders, despite their professing adequate service provision and openness to working with such clients.

Advocates for childbearing lesbian women are challenged to offer care and effect change in isolation and on individual levels rather than addressing structural components of practice when environments with limited institutional support contribute to stigmatizing and negative public discourses through marginalization or silencing of both practitioners and lesbian women’s
communities’ concerns (Coalition for Lesbian and Gay Rights in Ontario 1997).

Inviting providers of care are found in many jurisdictions and on many levels (Coalition for Lesbian and Gay Rights in Ontario, 1997). However, there are implications for enabling material, educational, and networking support for all practitioners who potentially connect with families, as well as workplace disclosure of same-sex orientation. This issue will be further discussed under politics with respect to leadership and research issues.

- Understanding the historical, social, and cultural context of community development with respect to lesbian childbearing women is integral to inviting educational processes. Inviting community development respects the historical, social, and cultural context of issues: what has previously been done in specific conditions, by whom, and for whom. Services which have been developed by lesbian women in community with others represent forms of collective resistance to the status quo which has discounted their needs (Boston Women’s Health Book Collective, 1992; Canadian AIDS Society, 1992; White & Martinez, 1997).

According to Ramsay (1994), many communities feel that community-based actions are optimal for addressing issues of access for lesbian women. Elements of such community and institutional partnerships ideally feature “explicitness, respect, self-help, and empowerment” (Canadian AIDS Society, 1992, p. 42). However, issues of control may surface and contribute to conflict over time. This is inherent when professionals, who have power of privilege of discretionary practices (Labonte, 1990)--as well as possibly privilege of race, and other social locations--and often power supported by funding, are involved in community organizational change.

A key element in the way in which service provision can be perceived to be inviting is if
it promotes self-determination of the community group concerned. Labonte (1990) addressed how mandated programs uphold notions of deservedness as defined by professionals. The exclusion of same-sex orientation as a priority issue for public health care, despite the well-documented social and health consequences of such marginalization (Coalition for Lesbian and Gay Rights in Ontario, 1997), reflects dominant public discourses about lesbian motherhood which are based on patriarchal assumptions (DiLapi, 1989; Eichler, 1997; Nelson, 1996).

Given the historical context in which mainstream health institutions have often excluded and undermined lesbian women (Canadian AIDS Society, 1992; White & Martinez, 1997), any interactions which encompass invitational principles of respect, trust, and optimism in a consistent way could be helpful. As well, in light of institutional practices which have been perceived to represent colonization of resources or groups (Stevens, 1992; White & Martinez, 1997), fears of cooptation by mainstream organizations of resources developed for lesbian women, even by lesbian women or their allies, may be realities.

Institutional strategies which enable communities to act in ways that meet their needs for care are congruent with Labonte’s (1990) notion of empowerment which facilitates community care using professional privilege (Rockhill, 1996). An acknowledgement of power in this context has implications for individual and collective communities of professionals and marginalized groups. Supportive care by institutions recognizes the issues as complex and legitimate, builds on existing networks, encourages working partnerships, facilitates actions which enable individual and community agency, and provides material resources through provision of safe and comprehensive services (Labonte, 1990; Shroff, 1997; Stevens, 1992).

The childbearing couple in this study perceived public health’s role in promoting support
as that which openly addresses lesbian childbearing issues across programs and communities, as well as which facilitates community connections and dissemination of information. Advocacy, coalition-building with community partners, and community development are mainstays of public health care (Labonte, 1990). According to the participants, initiatives led by lesbian mothers would be deemed inviting with the support of public health and other institutional resources. However, provision for the complexity of the situated lives of the diversity of coparenting and biological lesbian mothers, safety, and disclosure issues must be a priority to facilitate equitable access.

Policies.

- Inviting educational environments address both formal and informal policies at both the macro and micro levels: social policy level, as well as institutional and program levels. This is a reflection of leadership and commitment to same-sex issues. However, policy changes must be addressed concomitantly with other educational initiatives.

- All policy issues will be described under one heading for reasons of brevity. The following sources specifically address suggestions for changes to Ontario policies: The Coalition for Lesbian and Gay Rights in Ontario (1997), Simpson (1994), and Epstein (1996b).

Public health units provide service to diverse communities across widespread geographic areas and their priorities are shaped by legislated regulations, provincial mandates, and local community needs. Their professional privilege and discretionary funding are political tools which can offer lesbian women access to supportive social policy and inviting resources.

Provincial mandatory guidelines for public health practice (Ontario Ministry of Health, 1997)
denote access to care as a key issue. Professional guidelines emphasize ethical practice and culturally sensitive care (College of Nurses of Ontario, 1996). However, multicultural approaches to practice which address issues of ethnicity and race (de la tierra, 1996; Reed, 1992) may not the address the complexity of lesbian cultures across communities.

Recent spousal legislation on provincial and federal levels has contributed to improved living conditions within which childbearing lesbian mothers may partner. However, with continuing controversies over the definitions of spouse and marriage, the dominant patriarchal assumptions that preclude equitable access to services remain part of public discourse. Public policies are an important reflection of how issues relevant to marginalized groups are named and validated in public spaces (Benhabib cited in Gatens-Robinson, 1999). In fact, legislation which acknowledges same-sex family issues may facilitate change which enables the development of inclusive social policy on many levels (Eichler, 1997; Epstein, 1996b).

The role of public institutions through advocacy at the macrolevel of policy development is an important contribution towards establishing explicitly and implicitly what is important in public discourse (Labonte, 1990). As Labonte emphasizes, this can be demonstrated “by the types of services they offer and the policies they create and make public” (p. 71). The report on the experiences of sexual minorities in Ontario’s health and social service systems (Coalition for Lesbian and Gay Rights in Ontario, 1997) outlined specific policy and other recommendations for enabling care which addressed multisector organizations and community groups. It emphasizes that for the most part these require shifts in attitudes rather than great expenditures, yet they remain low priorities for many institutions.

Specific formal and informal policies which emerged from this study as problematic for
accessing safe care included funding for reproductive caregivers, differential public or private access to AI systems of care for openly lesbian and/or single women (Coalition for Lesbian and Gay Rights in Ontario, 1997), and prohibitive costs (Epstein, 1996b), as well as written documentation policies within institutions (Coalition for Lesbian and Gay Rights in Ontario, 1997). The frequently inconsistent and/or disinvingiting resources were linked to the lack of systematic education for all community service providers regarding lesbian childbearing issues, as well as homophobic tolerance (Canadian AIDS Society, 1992; Coalition for Lesbian and Gay Rights in Ontario, 1997; DiLapi, 1989; Eliason et al., 1992; Epstein, 1996b; Ramsay, 1994). These formal and informal policies reflected heterosexist assumptions, homophobic discrimination, and/or lack of understanding of lesbian struggles for safe care and advocacy. Rachel Epstein (1996b) has listed a number of public policies that would facilitate care for childbearing lesbian women in Ontario, ranging from funding for AI to widespread educational programming.

Those in positions of privilege: health, educational, and media institutions shape how or whether to make difference visible and how to give voice to diversity. Development of public policy which incorporates lay knowledge, as opposed to exclusively critical analysis put forth by professionals, reflects a commitment to participatory democratic processes, as well as a valuing and legitimization of such understandings (Bryant, 1999). The couple that participated in this study had professional affiliations and a critical analysis. There are implications for seeking the input of diverse lesbian women with respect to policy.

Regular and open discussion of the implications of same-sex anti-discrimination policies for service during both interstaff and client-staff interactions have been noted to contribute to
inviting environments (Coalition for Lesbian and Gay Rights in Ontario, 1997; Simpson, 1994). Systematic assessment of all policies and assessment tools, including documentation procedures, was considered important by the participants, as was the development of an inviting complaints process.

**Politics.**

- Educators often lack support to provide relevant care for childbearing lesbian women. Systemic heterosexism not only produces consequences for marginalized women, but influences what information is available to educators and health providers, and funding priorities for research. As well, given the contentious nature of lesbian childbearing within both heterosexual and lesbian communities, and the ongoing political backlash regarding same-sex families, there are larger issues of facilitating education of providers, locating supportive political and institutional leadership to enable such educational priorities, and legitimizing such research in public health environments.

**Implications for leadership.** The reality of a current conservative political environment (Eliason et al., 1992) is an important consideration for enabling care for lesbian mothers. As the participants have emphasized, addressing issues for expectant lesbian women must be done within the broader social context of their worlds. This paper highlights the everyday effects of systemic discrimination experienced by these highly privileged lesbian women through childbearing. As such, it offers a challenge to consider how diversely situated lesbian women’s needs are addressed in the public domain.

With the downloading of public health services to municipalities, not only is discretionary power for social and health programming a function of professional privilege, but
as well may be controlled by elected officials. Because public health programming is dependent on local government for substantial funding, public health administrators may find themselves balancing their advocacy efforts for such important issues with the priorities that local politicians perceive as relevant to their communities. In times of budgetary restraint, there are risks that funding for specific caregivers and services providers may be tied to how visibly lesbian positive they are perceived, for fear of community resistance and loss of funding (Sloan & Gustavsson, 1998). Questioning who the real stakeholders are in a climate in which elected officials may be responsive to organized and vocal political opposition to support for same-sex issues requires a commitment to caring for those who lack a voice. Public health institutions place a priority on such issues and recognize their role in addressing the political and structural determinants of health.

Given the institutional heterosexism which pervades health systems and research venues and which is perpetuated by prevailing discourses which discount the impact of such oppression, the invisibility of lesbian families in the public domain is often overlooked as a priority for care. Yet it is evident that health institutions, by their exclusion of public profiles which explicitly support same-sex issues across programs, contribute to the same overt and covert violence, bullying, mental health, substance use, and homelessness issues that they are addressing in everyday professional practices.

In fact, Bonnie Simpson (1997), in her report of accessibility of substance abuse services for youth, named the agency public profile as an important strategy of visibility. Since this attribute is related to how both workers and clients perceive whether the service is exclusively heterosexual, in effect it is one that is linked to institutional and practitioner identity--with
implications for their professional practices.

Since dominant discourses often discount the presence of childbearing lesbian-identified women in all but large metropolitan centers, and the barriers for lesbian women to finding community with others across regions are immense, individual public health communities may be left scrambling to prove statistically that such publicly funded services are warranted. The barriers to obtaining such regional data, given the related issues of disclosure, perceived safety, research and funding limitations and variable community commitment to such issues, have been discussed (Coalition for Lesbian and Gay Rights in Ontario, 1997; White & Martinez, 1997). Establishing that inclusive programming for sexual minorities is indeed ethically, legally, and professionally sound (Coalition for Lesbian and Gay Rights in Ontario, 1997) in politically conservative times requires more than individual professionals’ or communities’ advocacy.

In order to facilitate consistent, safe access across regions, institutional, professional, and political leadership at the local, provincial, and national levels must be part of a comprehensive strategy of concerted action (Coalition for Lesbian and Gay Rights in Ontario, 1997; Labonte, 1990) to ensure commitment to care and program funding required for enabling such services for lesbian women.

**Implications for research.** Evidence-based practice requires a solid research base upon which to ground public health approaches. The invisibility of lesbian childbearing in public health contexts is reflected in a lack of Canadian research which specifically addresses same-sex parenting and lesbian health resources. Public health professionals base their practice on evidence from the research literature. A recent article in the *Journal of Public Health Medicine* concluded that “if public health wishes to continue to claim that it is in the forefront of
evidence-based decision-making, both the skills of the professionals and the resources available to them need to be improved" (Muir Gray, 1997). However, it is apparent that the literature on lesbian childbearing has been available for over 20 years. Neither educational programming for childbearing women nor inservice education for public health professionals offers information on childbearing lesbian women in a consistent and effective way.

Moreover, virtually no research exists which examines effective strategies for addressing same-sex concerns for childbearing and access to services within public health. Quantitative research studies may be inadequate to capture information in such a sensitive way and at the same time convey respect for lesbian women’s perceptions of care. Effectiveness studies which are geared to evaluating quantitative studies may not address the provision of high quality of support that the participants in this study are seeking; however such research is needed. Systems Failure (Coalition for Lesbian and Gay Rights in Ontario, 1997) briefly addressed lesbian parenting in its review of access to institutional services across Ontario and offered recommendations addressing childbearing and parenting.

The conceptual framework which emerged from this qualitative study may offer potential for developing a research tool which incorporates qualitative and quantitative approaches to sensitively research issues of access. Interactive factors for access to comprehensive support were identified through this research dialogue. Further research is needed to understand how situated privilege across a range of ages, classes, races, abilities, and ethnicities might influence supports which will invite disclosure and safety for women.

Structuring an interpretation of the narrative findings in a conceptual framework of this format not only accounts for some of the complex issues related to disclosure decisions and the
cultural and professional attributes of participants, but as well, incorporates the participants’ perceptions of strategies that facilitate or hinder care. Using ethnographic dialogue to reflect with the participants on their experiences, frame their issues in relation to the larger social context, and make visible and give voice to their situated lives in a systematic way offers a research process which values and politicizes their stories. In order to understand the particular dynamics of individuals’ situated lives in a way that respects the limitations of survey research, further research which combines both qualitative and quantitative approaches might be used to determine relationships between disclosure, situated privilege, perceived safety, public or private availability and other factors which influence access to inviting comprehensive care.

The research process itself offered insight into how information related to lesbian childbearing may often be unavailable to educators. Heterosexism also influences what information is published and disseminated to health professionals. The abundance of relevant information in journals focusing on feminist analyses, lesbian health, homosexuality, as well as many nonmedical books related to lesbian or women’s issues, was in direct contrast to that located in lay or academic health sources addressing childbearing, preconceptually to postpartum.

In order to access information on lesbian childbearing, a search of the health literature was often inadequate to locate the wealth of current information which addressed the issues. In fact, because of the scarcity of Canadian public health research related to lesbian women, community contacts provided me with the few studies that have been completed on access to provincial public health services. However, many of these publications may not be indexed in a way that this information is accessible to professionals who require it.
Both lesbian health and motherhood have been marginalized in mainstream research and academic contexts (Abbey & O’Reilly, 1998; White & Martinez, 1997). This affects research funding, publishing, and dissemination priorities. The strategies previously discussed which maintain heterosexist practices: omission, repression, alienation, and stigmatization (Onken, 1998) must be addressed with respect to lesbian health research contexts.

This study process suggests that the resources available to educators within health or educational institutions should include feminist journals and access to publications that are not necessarily peer reviewed but which are valuable sources of information with respect to motherhood, lesbian health, and women’s issues, including critical analyses of heterosexism as they pertain to health care environments. As well, articles related to same-sex orientation which reflect the holistic nature of their issues should be published in mainstream journals.

The numerous on-line offerings, which may not be academically focused, yet which offer potentially useful support, should also be included in available resources. In line with this premise I have included nonscholarly on-line sites in the reference list. Strategies which address professional access to information and indexing of such resources should be incorporated into other initiatives which promote evidence-based practice.

Although this exploratory study has been one which emerged from my own awareness of heterosexism as an educator, my position as a nonlesbian identified researcher was at times a barrier to connecting with lesbian women. Further research which incorporates a team of individuals identified across a range of social locations, including lesbian or bisexual women, would likely facilitate the research process. There are implications for institutional and community collaboration as they relate to such work.
A number of political issues related to research have been noted throughout this paper. Certainly the ways in which research issues are prioritized, funding provided, findings disseminated, and recommendations carried out reflect issues of power within communities. This research process indicates that the limited research base for practice and limited funding for lesbian health research within Canada require leadership at the institutional, provincial, and federal levels as health professionals and communities seek the information required to enable inviting care for childbearing lesbian women.

**Summary of Educational Possibilities**

In this third section of the conceptual framework, I have illustrated implications for addressing systematic change through practice and research venues which may enable comprehensive care for expectant lesbian women in a public health context. The focus on politicizing the research findings using the invitational framework is congruent with the theoretical focus of this paper which addresses the structural components of access to education with a view to facilitating change in an inviting manner.

**Summary of Chapter Five**

I began this chapter with a goal of focusing on the political dimensions of educational practice with an analysis of power relations as informed by feminist perspectives. By conceptualizing power in its positive forms, as produced through action, as well as how it shapes oppressive and other hierarchical positionings, I have demonstrated that the political aspects of interactions are an inherent part of how individuals constitute themselves in relation to others. In doing so this interpretation of the findings has provided support for the use of the 6th P in an invitational analysis of access to comprehensive care for lesbian childbearing women. This
approach, which links feminist and invitational theoretical perspectives with a goal of social action in a very grounded research context, enhances educators’ understandings of processes which may facilitate caring environments.

The first part of the conceptual framework focused on how power relations are implicated in the four components of access which emerged from this ethnographic study: perceived safety of resources, disclosure status, situated privilege, and public or private points availability of support for childbearing. These concepts interact to facilitate or hinder access to relevant support through perceived choices for action informed by felt difficulties related to the lived realities within their social context.

It was apparent that, despite this couple’s extensive situated privilege and connections, they sought support in term of how it was perceived to be inviting: safe, validating, celebrating, and available in ways that maintained confidentiality or anonymity as desired. They were often excluded from public venues for support and depended on private points of access to support. At first glance, it appeared that these women had a fair amount of support, and had many strategies available to them. However, this was likely related to their determined efforts to minimize disinviting homophobic reaction in their environments, as well as situated access to the resources that could facilitate care.

In the second section of the framework, the consequences of lack of access to comprehensive support were framed by naming the heteronormative strategies of omission, repression, alienation, and stigmatization which shape environments and hinder change within them. The effects on lesbian childbearing women, institutions, and the larger community were noted and were linked to practices of direct and systemic discrimination, and which impede
processes of culturally sensitive care congruent with ethical and professional public health practice.

Institutional heterosexism was identified as problematic in terms of the barriers it presents to promoting communities which not just tolerate childbearing lesbian women, but advocate for them. Integral to invitational practices is the necessity of understanding the felt difficulties and details of everyday lives within individuals' social and historical context as well as the ways in which positionality and intentionality of interactions are implicated in such educational exchanges.

In the third section of the conceptual framework, I systematically presented possibilities for change related to people, places, programs, processes, policies, and politics as they contribute to facilitating access for childbearing lesbian women. Having described the educational needs of the participants as they perceived them, their everyday experiences, their definitions of inviting support, the barriers to access they identified, and the strategies they used to create support in a historical and social context which highlighted their rights to care, this part of the research process could frame imaginative possibilities for the future extending from the participant-researcher dialogue. In doing so, this framework offers a potentially enabling process of giving voice to marginalized discourses for expectant lesbian couples and making visible the needs and strategies that may effect inviting educational environments by extending current invitational processes and understandings of care.


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Ottawa, Canada.


Appendix A

Letter of Approval from Brock University Standing Subcommittee
On Research with Human Participants

FROM: Robert Ogilvie, Chair
Standing Subcommittee on Research with Human Participants

TO: John Novak, Education

FILE: 98-163 Judith MacDonnell

DATE: March 2, 1999

The Brock University Standing Subcommittee on Research with Human Participants has reviewed the research proposal:

Educational Issues Perceived By Expectant Lesbian Couples

The Subcommittee finds that your proposal conforms to the Brock University guidelines set out for ethical research.

RO/tar
Appendix C

An Invitation to Lesbian Couples

I am a public health nurse who has been involved in prenatal and parenting education with women for many years. As part of a graduate program, I am undertaking a study of educational issues perceived to be important to expectant lesbian couples. As part of this study, I would like to have the opportunity to meet with childbearing lesbian women who are currently pregnant and partnering with a woman. The hope is that the information gained from this study will be helpful for all lesbian women who may be considering childbirth and/or parenting.

I understand that this can be a sensitive issue and will respect confidentiality. My hope is to spend some time speaking with the birth mother and co-mother, as a couple, prenatally and again 4-8 weeks postnatally, in order to look at the issues from the couple's perspectives at both stages. Arrangements will be made to suit the couple's preference for time and place to meet.

If you are interested in participating, or just want to know more about the research, you can contact me via e-mail at [e-mail address] or to obtain more information, please contact me at: [phone number] to leave a message.

Thanks, Judy MacDonnell.

Public Health Nurse

BROCK UNIVERSITY

DEPARTMENT OF EDUCATION
Appendix D

An Invitation to Midwives

Have you been involved in the care of childbearing lesbian women?
As part of a study of the educational needs of expectant lesbian couples, I am looking for midwives to be part of a focus group in April or May (at a time and Place convenient to participants). The hope is that the information gained from this study will be helpful for all lesbian women who may be considering childbirth and/or parenting.

I have also attached more detailed information for your use if you are aware of lesbian couples who may be interested in participating in an informal, confidential interview with the researcher prenatally and on 1-2 months postpartum.

If you are interested in participating, or just want to know more about the research, you can contact me via e-mail at: [e-mail address]
or to obtain more information, please contact me at: [home and business phone numbers] and feel free to leave a message.

Thanks,

Judy MacDonnell

Public Health Nurse

BROCK UNIVERSITY

DEPARTMENT OF EDUCATION
June 29, 1999

Karyn Kaufman  
Professor, Family Medicine  
& Chair, Midwifery Education Program  
c/o St. Joseph's Hospital  
50 Chariton Avenue East, F610  
Hamilton, Ontario  L8N 4A6

Dear Karyn:

I am writing to ask you to support the graduate study of Judy MacDonnell. Judy MacDonnell is a Public Health Nurse and a Brock University, Masters of Education student. She is undertaking a descriptive exploratory study related to the experience of childbearing lesbian women. She would like to meet with a focus group of midwives, to receive their insight regarding the issues.

We at the Social and Public Health Services Division have approved the study following a methodological and ethical review. A Toronto midwife who you may know, is also supportive of this work.

We would appreciate your help in distributing the attached flyers and encouraging the participation of midwives.

Thank you for considering this request.

Sincerely,

Jane Underwood, RN, BScN, MBA  
Director, Community Support & Research Branch
Appendix F

Guidelines for Prenatal Couple Interviews

1. Tell me about the pregnancy. How have you both been feeling? Is this the way you expected to feel during the pregnancy? Can you tell me about planning for the pregnancy and making it happen? How did you make your decision? What factors were involved: information, supports, resources, networks for donor sperm, pre-conceptual counseling/information, and cost incurred?

2. What words do you use to describe your partnering with a female (e.g., do you identify with lesbian, gay, queer, or women loving women)? What language issues are relevant for an expectant couple in a lesbian relationship (e.g., comother, coparent, mom, othermom, first names, legal names and assisted, artificial, alternative insemination/conception/baby dancing)?

3. Whom are you seeing to meet your health needs during pregnancy (include all providers)? How did you choose your caregivers for the pregnancy? How do your caregivers meet your needs? What would you consider ineffective in meeting your needs? How do you figure out whether a health care provider is lesbian-positive? Is disclosure of lesbian status usually necessary in order to obtain specific information? How do you access lesbian-positive resources (e.g., written information/human supports/networks/videos)?

4. Whom do you consider to be personal supports during this pregnancy? Have these changed since you announced the pregnancy? Does this differ with biological or comother roles? What concerns do you have about supports during the pregnancy, labour, or after the baby arrives?

5. What do you see as important education issues for expectant lesbian couples? What would be important component of education that would be meaningful to your prenatal
experience? How do you obtain information on these issues? What kind of legal and ethical issues are you concerned about? What are specific educational issues for the coparent? In what ways are these issues similar to or different from those of heterosexual couples? What have you heard or experienced with regard to expectant lesbian regarding prenatal classes?

6. How are families involved in expectant lesbian women's experiences? How is the lesbian community involved? What kind of connections do you have with other expectant lesbian women or parents? How did you connect with them? What makes this easier? Are you aware of specific groups/resources for women partnering in a pregnancy who want to get pregnant, are pregnant, are postpartum, or have kids? Are on-line supports part of the life of those expectant lesbian couples you have known? How are males part of the parenting experience/your lives? Bisexual women? Lesbian grannies?

7. Couples in an expectant lesbian relationship may experience role conflict and/or stress during pregnancy and with the birth of a child. How does this apply to your relationship? What relationship issues did you deal with when you planned this pregnancy (if applicable)? How do you manage stress during the pregnancy? What kinds of issues are particularly stressful during the pregnancy? Who might be considered supportive community contacts?

8. What are your experiences of disclosing lesbian status to others? Has this changed with the pregnancy? How is disclosure of lesbian stature to other expectant couples and providers of care facilitated (if desired)?

9. How can providers of care offer gay-positive information if anonymity is desired? There is often no provision for identification of sexual orientation status on intake forms. Many providers of care are not aware of the expectant lesbian population/do not perceive the need to
know/feel uncomfortable knowing the sexual orientation status of couples. How do you deal with this?

10. Do you identify yourself with a particular political philosophy (e.g., have political affinities or participation in women's groups, etc.)? Has this affected your approach to seeking care (i.e., information and support) during the pregnancy? Many feminists feel that motherhood is the telling time in many relationships because of the birth link and work which is done by mother (often not celebrated/valued) and the default roles which are assumed. Has this been an issue (with a toddler) and to you have plans to change this with the birth?
Appendix G

Guidelines for Postnatal Couple Interviews

1. What have you learned about yourself and your partner through this childbirth experience (e.g., strengths, vulnerabilities)? What would you have done differently knowing what you know now?

2. How has this childbearing experience been similar to and different from your previous childbirth experience in terms of identity as biological mother, comother (and your preferred language for these)?

3. The heterosexism and homophobia that you have both named have been present through your childbearing experience: the decision-making, prenatal, intranatal, and postpartum phases. How would you say you have resisted this everyday presence?

4. In light of having accomplished childbearing together, what characteristics does it show--what does it say about you as a person? What would your partner say about his? What implications does this have for your decision to experience childbearing as a lesbian couple?

5. What kinds of issues have contributed to your postpartum experiences--the good times and the periods of stress?

6. As you reflect on your childbearing, what kinds of experiences, information or support were helpful or not so helpful in shaping your lives?

7. What factors contributed to inviting individual interactions and institutional interactions (e.g., policies, etc.)?
Appendix H

Informed Consent Form

BROCK UNIVERSITY

DEPARTMENT OF EDUCATION

Title of Study: "Educational Issues Perceived by Expectant Lesbian Couples"

Name of Researchers: Professor John Novak and Researcher, M. Ed. Student, Judy MacDonnell

Name of Participant: (Please print) ___________________________________________

I understand that this study in which I have agreed to participate will involve written completion of a brief information form and participation in either a focus group or an interview with the researcher.

I understand that my participation in this study is voluntary and that I may withdraw from the study at any time and for any reason without penalty.

I understand that there is no obligation to answer any question/participate in any aspect of the project that I consider invasive.

I understand that all personal data will be kept strictly confidential and that all information will be coded so that my name is not associated with my answers. I understand that only the researchers named above will have access to the data.

Participant's Signature _____________________________ Date _______________________

If you have any questions or concerns about your participation in the study, you can contact Judy MacDonnell at [phone number] or Professor John Novak at (905) 688-5550, Ext. 3361.

Feedback about the use of the data collected will be available during the month of November 1999, through the above researchers. A written explanation will be provided for you upon request.

Thank you for your help! Please take one copy of this form with you for further reference.

***
Appendix I

Information Form for Expectant Lesbian Women

BROCK UNIVERSITY
DEPARTMENT OF EDUCATION

Thank you for agreeing to participate in this research study. I would appreciate if you could tell me about yourself.

Name ____________________________________________

Date of birth ______________________________________

Address (street, city, postal code) ____________________________

Daytime phone number ______ Business phone number ______

Occupation ____________________________________________

Highest level of education obtained _________________________

Expected due date ______________________________________

Role in this relationship (e.g., birth mother, coparent) ______

How long have you been involved in a relationship with your partner? ______

Have you been involved in a parent role previously (e.g., birth mother/coparent/step-parent)? ______

Please explain. __________________________________________

Number and ages of other children __________________________

Primary health care provider _____________________________

Other health care providers ________________________________

Planned location of delivery ______________________________

Participant's Signature __________________________ Date ______

Researcher's Signature __________________________ Date ______